

Health promotion in secondary schools: a qualitative exploration into the health literacy of parents

J.M. Keyser



orcid.org/0000-0002-2420-7802

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Supervisor: Prof. L. Wood

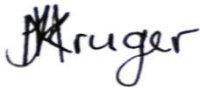
Co-supervisor: Dr. E. Fouché

Graduation: May 2022

Student number: 23593539

DECLARATION

I declare that: **Health promotion in secondary schools: a qualitative exploration into the health literacy of parents** 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 8/12/2021

PREFACE

The journey was long but worth it. This is, without a doubt, my proudest work and a moment of serenity to be able to submit this study. I dedicate this study to:

- First and foremost, our Lord Jesus, in whom I could find peace and courage to complete this study.
- My darling husband, Dylan, my parents and family and friends who always motivated me to give my best. I appreciate you more than words can describe.
- Dr. Charles Viljoen, for his guidance and mentoring.
- Andri Schoonen, who laid down the foundations of my research knowledge.

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ABSTRACT

In current research and literature worldwide, it has been emphasised that families are an important environment in which to teach health literacy and that parents are required to co-operate with school caregivers to identify their children's health problems. Parents of secondary-school children play an essential role in ensuring their children's health literacy especially if they are living in contexts of poverty. Limited research exists within the South African and the international context regarding the importance of parents' health literacy in supporting their children's information and behavioural health development. Knowledge about the level of parents' health literacy, in terms of parental knowledge, skills, attitudes, practices and behaviour, is limited. This study was guided by the research question: How do parents of secondary-school learners perceive and construct their health literacy? Since the study stemmed from an interpretive research paradigm, I used a qualitative research methodology. I used purposive sampling to select the participants. I selected the secondary schools that formed part of the study from the Dr. Kenneth Kaunda Educational District surrounding Potchefstroom. I approached the schools based on their willingness to partner in the research project. These schools were situated in socially and economically challenged communities where the risks of multiple health problems were prevalent. Two schools were willing to participate in focus groups. Data were analysed to develop themes. The findings showed the health literacy levels of parents could be a barrier to raising healthy children in areas of low socioeconomic status, as parents may lack the necessary health knowledge, skills, attitudes and practices. Parents did not know how to address the lack of sport and recreation opportunities in their environment that affected the physical and social health of their children. They understood, however, that parental involvement is a critical requirement for any school programme on health to succeed and called for unity amongst parents, learners and teachers to address health issues related to their children. However, the lack of research about the health literacy of parents is a gap in the field and is an area that could be researched further, specifically the development of programmes to educate parents more on health literacy for themselves and their children. Training material, such as pamphlets provided to parents by the Department of Education, would help to broaden their knowledge, skills and perception with regard to health literacy.

Key terms: health, health literacy, health promotion, health promoting schools, parents

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CHAPTER 1: INTRODUCTION AND BACKGROUND TO THE STUDY

1.1 Introduction

In this chapter, I outline the study, which aims to explore and understand how parents, as key role-players in schools, perceive and construct their health literacy. First, I explain the background of the study and the rationale for formulating the research problem. Then I outline the purpose and research methodology of the study. Finally, key ethical measures are discussed.

1.2 Orientation towards the Research Problem

Parents of secondary-school children play an essential role in their children's health literacy education. Limited research exists within the South African and the international context regarding the importance of the health literacy of parents in supporting their children regarding information and behavioural health development (Bröder *et al.*, 2017; Sanders *et al.*, 2009). Furthermore, there is a lack of research that can provide an understanding of parents' health knowledge and access to health information and whether they manage their children's, and even their own, health literacy effectively. Such knowledge could provide valuable insight into enhancing parents' information about health literacy at home, to enable them to communicate health information to their children effectively, and to support the development of their children's health behaviour through role modelling and through reinforcing the health education received at school (Lam *et al.*, 2015; Morrison, 2008).

Research worldwide has emphasised that families are an important environment in which to teach health literacy and that parents are required to co-operate with school caregivers to identify their children's health problems (Gadsben *et al.*, 2016). As indicated in a recent study (Vamos *et al.*, 2020), in several countries such as Canada, America and Germany, the focus of health literacy research, policies and practice has changed from considering health care and medical settings to a broader conceptualisation. As part of this broader conceptualisation, health literacy can be developed and used across different settings (e.g. homes, schools) towards reaching wellness and health goals across the life-course for individuals, families and communities. Home and the educational sector are critical domains for health literacy education (Vamos *et al.*, 2020). The health literacy of parents impacts the development of health literacy, health behaviours and health-related beliefs, competencies, decision-making skills, and health knowledge of their children (Velardo & Drummond, 2013).

As Nyama (2010) emphasised, the health literacy levels of parents can be a barrier to raising healthy children in areas of low socioeconomic status, as parents may lack the necessary health

knowledge, skills, attitudes, and practices. As a result, the gap between the school and the community in poorer areas of the country widens with regard to health literacy (Calitz *et al.*, 2002; Sorte *et al.*, 2011). Being poor in itself does not cause poor health outcomes, but it is a contributory factor because children who live in poverty are more prone to health risks associated with malnutrition, disease, infection and injury than those who are not poor (Sorte *et al.*, 2011; Pool, 2017).

Children from low-income families might be malnourished because families are compelled to select low-cost rather than nutritious food (UNICEF, 2019). Malnutrition, in turn, might prevent children from learning and excelling in the classroom (Food and Agriculture Organization of the United Nations, 2018). Health, nutrition and safety work together to increase children's ability to develop within an educational setting. These are the building blocks on which wellness is built (Sorte *et al.*, 2011).

Calitz *et al.* (2002:112) indicated that parents, especially in rural areas, might not have the necessary knowledge and skills (literacy) to assist their children in promoting health literacy. Shilubana and Kok (2005:101) argued that parents have a critical role to play in their children's wellbeing, including improving their health literacy.

Previous research primarily focused on how children were affected when their parents lacked skills and knowledge when making decisions concerning their children's health (Bröder *et al.*, 2017; Sanders *et al.*, 2009). Thus, the level of health literacy of parents of an adolescent learner's health literacy in the North West Province of South Africa, in terms of understanding, knowledge and practice, was unknown. Very limited published research is available regarding the role of parents in promoting health literacy and, therefore, it is important to focus on this aspect. Several questions remain unanswered at present, and, therefore, it is essential to focus on the degree to which parents can obtain, process and understand the basic health information and services they need to make appropriate health decisions and how they can apply this knowledge in raising their children.

1.3 Health and Health Promotion as Concepts

Throughout history, society has interpreted health according to various concepts (Edelman & Mandle, 2002). Differences in interpretation of health also vary according to culture, age, sex, social class and nationality (Becares & Priest, 2015).

The term health was first used in the 1970s and has increasingly come into prominence in public health and health care (Muslu, *et al.*, 2020). Health was defined by the World Health Organisation

(1984:2) as “a state of complete physical, social and mental wellbeing, and not merely the absence of disease or infirmity”. Waltner-Toews (2004) criticised this definition as being idealistic and argued that such a state could never be achieved. Lucas and Lloyd (2005:6) suggested that the definition implied that anyone with slight imperfections in their physical, psychological or social functioning could not be healthy. The Ottawa Charter for Health Promotion (Hancock, 2011:405) further emphasised that health is a result of people’s behaviour and that it is thus within their control, as it is:

... created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to make decisions and have control over one’s life circumstances, and by assuring that the society one lives in creates conditions that allow the attainment of health by all its members

Naidoo and Wills (2000:6–7) argued that a definition of health should be holistic in nature and should include physical, social, emotional, mental, spiritual, societal and environmental dimensions and aspects of the self. In this study, the holistic approach of Naidoo and Wills (2000:6–7) has informed my thinking about health, as well as the notion that health promotion is controlled by, and is thus the responsibility of, individuals such as parents. The school and the family are the two entities that play the most important role in promoting the health of children.

O’Donnell (2008:11) defined health promotion as “the art and science of helping people discover the synergies between their core passions and optimal health, enhancing their motivation to strive for optimal health.” He explained further that “optimal health is a dynamic balance of physical, emotional, social, spiritual, and intellectual health” (O’Donnell, 2008:11). It is thus important to encourage people to change their lifestyles through a combination of learning experiences that increase motivation enhance awareness and build skills. Most importantly, as emphasised by Bronfenbrenner (Addison, 1992), change comes through the creation of opportunities that open access to environments as well as ecological systems (micro-, meso-, exo- and macro-systems) that make positive health practices the easiest choice. Parents should practice these positive, healthy lifestyles and encourage their children to do the same.

According to the World Health Organisation (WHO, 1986), “health promotion is the process of enabling people to increase the control they have over their health to improve it”. Health is seen as a significant resource for everyday life, and it is not just the responsibility of the health sector, but of each individual to attain wellbeing. It is evident from these definitions that health promotion refers to a holistic activity (process) that can be undertaken to assist, guide and, through engagement, empower people to take control of their own health.

Some researchers believe that illness and health care can be viewed as two contradictory points on a continuum (Billings & Hashem, 2009; Lindström & Eriksson, 2005; Mittelmark & Bull, 2014). Other researchers argue that wellbeing is a problem that encompasses more than only the factors that influence health and that it should be broadened to include sources of strength as well (Akhter, 2015). Health promoting school policies tend to favour this view.

1.4 Health Promoting Schools

According to Rowling and Samdal (2013:3), the health promoting school approach – an international movement – is an initiative of the health sector that has been adopted and developed by the education sector to promote learners' health. The focus is on how to implement health promotion and health education at school level. The health promoting school's framework thus requires that all role-players or stakeholders have the knowledge, skills and model behaviours that promote health within schools better (Cohall *et al.*, 2007; Johnson *et al.*, 2014:359; Mittelmark *et al.*, 2007).

The World Health Organisation (1999:8) defined a health promoting school “as a place where all school community members work together to provide students with integrated and positive experiences and structures that promote and protect their health”. Health promotion at school encompasses several aspects and social determinants of health, such as informal and formal curricula in health, the establishment of a safe and healthy school environment, the provision of appropriate health services, and involvement of the family and broader community in efforts to promote health (Barnekow *et al.*, 2006). Drawing from the definition of the World Health Organisation (1996), a health promoting school is viewed as a school where its capacity as a healthy setting for living, learning and working is being reinforced continually. Positive changes in health are more likely to occur when changes in people's direct environments support them and are established within the framework of people's everyday lives. Thus, the school plays an essential role in the health of children.

In South Africa, the school health services are driven collectively by the Department of Health (DoH), the Department of Basic Education (DBE) and the Department of Social Development (DSD) (Shung-King, 2013:896). The Integrated School Health Policy (2012) states that being unhealthy can create barriers to learning. Such barriers are caused by poor nutrition, poverty, environmental factors such as poor water and sanitation provision, illness and disease, and disabilities. Social determinants of health affect learner attendance and learners' ability to concentrate in the classroom, resulting in an inability to perform well academically, leading to poor pass and retention rates for schools (Coovadia *et al.*, 2009:817–834; McGill, 2016).

Although in health promotion through education cognisance is taken of the unhealthy pathological state of the individual, the school or the community, the central focus is on a better understanding of the growth, strengths, enablement, empowerment, prevention, protection and enhancement of the individual, the school and the community (Roux, 2013:38). In this study, I have focused strategically on understanding the nature and scope of health literacy demonstrated by parents, who are the key role-players in promoting the health of their children. The health literacy of parents determines whether they will be able to support, or will hamper, the school's efforts in promoting the health of their children (Bröder *et al.*, 2017).

1.5 Health Literacy

There are many ways to conceptualise and define health literacy. Early definitions of health literacy were focused on the individual's ability to read, understand and write information in health-related settings (Jordan *et al.*, 2010; Velardo *et al.*, 2013). Being a relatively new concept, emerging from the medical and published scientific literature, there are several views and interpretations of what health literacy entails.

Health literacy encompasses knowledge relating to different areas, such as the body, healthy behaviours and the functioning of the health system (U.S. Department of Health and Human Services, 2010). For some researchers, health literacy denoted the personal characteristics and social resources needed for individuals and communities to access, understand, appraise and use information and services to make decisions about their health (Pearson & Saunders, 2009). Kickbusch *et al.* (2005) viewed health literacy as “a critical empowerment strategy to increase people's control over their health, their ability to seek information and their ability to take responsibility for their wellbeing.” Abel *et al.* (2014) explained that health literacy provides an expanded perspective of literacy and a set of skills used to organise and apply health knowledge, attitudes and practices relevant when managing one's health environment.

The current and previous evidence on the nature, the scope and the practical implications of health literacy as a concept has been produced mainly in the medical field and, as such, is very much patient-focused and targeted at clinical interventions (Coulter & Ellins, 2007; Mitic & Rootman, 2012; Pignone *et al.*, 2005; Ronson & Rootman, 2004). From this perspective, health literacy comprises various approaches, programmes and interventions, such as the reduction of maternal and child mortality, combating under-nutrition, preventing HIV transmission, smoking and the use of tobacco, averting obesity and other eating disorders, and educating individuals and communities on the causes and treatment of pandemic diseases, such as influenza, diarrhoea, physical inactivity, chronic respiratory diseases, tuberculosis and diabetes (Murray *et*

al., 2003; Ronson & Rootman, 2004; WHO, 2015; Yajima *et al.*, 2001; Zaza *et al.*, 2005). From the various definitions, I have chosen the following as the most appropriate for this study: “Health literacy represents the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health” (Nutbeam, 2008:274).

Health literacy can be influenced by socioeconomic status, cultural background, age, the language we speak, our ability to communicate clearly and listen carefully, past experiences, cognitive abilities and mental health. These factors influence the way an individual communicates, responds to and understands health information (U.S. Department of Health and Human Services, 2010). The literature on health promoting schools does not contain much information about the way in which the different key role-players perceive and construct their own health literacy (Cushman & Clelland, 2012:160; Estacio & Comings, 2013; Hagell *et al.*, 2015; Speros, 2011). Hence, an investigation into the extent to which, and the nature of the way in which, key-role players construct health literacy can contribute towards effective school–community communication and collaboration for the implementation of health promotion in schools. To expand the evidence base and inform practice within health promoting schools, there is a need to examine how the various role-players in schools perceive and construct their health literacy, as this will impact directly on how they influence others (Cushman & Clelland, 2012:160; Estacio & Comings, 2013; Hagell *et al.*, 2015; Speros, 2011). In this study, I have focused on the health literacy of parents as the main influencers of the health of their children. Good health, and health promotion, are crucial for effective teaching and learning in schools (Department of Basic Education, 2018). However, a lack of a clear understanding of the role that key stakeholders, such as a parent, can play to promote health in schools might compromise the health of children in schools and might derail efforts to create an environment that is conducive for teaching and learning.

1.6 Parents’ Knowledge, Skills and Attitudes Regarding the Concepts of Health and Health Promotion

Parents’ knowledge is multi-dimensional (Winter *et al.*, 2012). Parents’ knowledge can be defined as “understanding developmental norms and milestones, processes of child development, and familiarity with caregiving skills” (Benasich & Brooks-Gunn, 1996:1187). In this study, I am concerned with finding out not only their knowledge level, but also their skills and experience

about and understanding of the phenomenon of health literacy and health promotion (Gadsben, *et al.*, 2016).

Parents' skills are a significant factor that guides children into health education as they inform children's negative and positive behaviours with regard to health and health promotion (Winter *et al.*, 2012). Children's health literacy also depends on the parents' circumstances, including their health status, risks or problems, socioeconomic status and cultural beliefs about health and wellness (Bröder *et al.*, 2017).

Parental attitudes are seen as parents' perspectives, viewpoints, reactions, or settled ways of thinking about parenting or child development aspects. Parental attitudes also encompass the roles and responsibilities of parents regarding health and health promotion among their children (Lou *et al.*, 2013). Parental attitudes can be linked to cultural beliefs founded on common experiences. According to the Behaviour Modification Theory of Ajzen and Fishbein (1980) and Fishbein *et al.* (2001), parents' attitudes often determine whether they will transform knowledge into practice. Jones and Prinz (2005) emphasised that parental attitudes are influenced by self-efficacy, and they can be explained as the level of parents' self-belief that they have the ability to succeed in their parenting role (Gadsben *et al.*, 2016). It can be concluded that parental knowledge, skills and attitudes are shaped by a number of contextual factors, parents' own experiences and circumstances, expectations learned from others, and social networks and cultural systems (see Chapter 2 for a more detailed discussion).

1.7 Problem Statement

Based on the background information above, it is evident that schools provide a key platform for promoting health in young children. However, despite a long history of initiatives to create health promoting schools, and extensive literature produced by the public, scientific and medical fields on health literacy (Sørensen *et al.*, 2012), limited research has been carried out on the health literacy of the key role-players, namely parents, who have a direct influence and effect on the health of their children, and who can support or hinder the efforts of schools to promote health.

Health literacy requires more than simply transmitting information; it can benefit all role-players involved in schools to become competent in terms of the latest developments in participatory approaches to promoting health in schools. This entails skills, knowledge, and practices supporting health promotion in school contexts (WHO, 2015). To state this idea differently, awareness and understanding of health literacy amongst the various role-players in the school context unquestionably promotes health and developmental goals on the one hand and, on the

other hand, deters and prevents emerging threats that might have a negative impact on teaching and learning.

Fine and Hicks (2008) explored the role of health programming, seeking to identify effective practices and services required to support the promotion of healthy development for children and families. They found that by building a strong, mutual relationship between teachers and families, there appeared to be an increase in the likelihood that the idea of wellness would be reinforced in the family setting. The relationship provides a mechanism for parents to inform teachers about how families can help to promote the communication of health literacy, of which role modelling is an essential element (Sorte *et al.*, 2011).

From the preliminary literature review that I carried out for this study, it was clear that it was necessary to focus research on how parents perceive and construct their health literacy. Such research can provide valuable insight into enhancing parents' health literacy to communicate information about health effects to their children and to support healthy behaviour development through role modelling.

The central argument of this study is that parents who have a high degree of health literacy themselves will be able to influence the health outcomes of their children better and will also be more willing to support the health promotion efforts of the school. However, before any measures can be implemented to improve the health literacy of parents, it is important to first find out their existing knowledge, attitudes, feelings and behaviour regarding health literacy. This research was undertaken to listen to, understand and learn from parents about the way in which they gather and use information to construct their health literacy.

1.8 Primary and Secondary Research Questions

A research question specifies the focus of the study (Maree, 2011). Based on the above discussion, the following primary and secondary research questions were formulated.

1.8.1 Primary Research Question

The primary research question that I used to guide this study was the following:

- How do parents of secondary school learners perceive and construct their health literacy?

1.8.2 Secondary Research Questions

I formulated the following secondary research questions to assist and guide in answering the primary question:

- What knowledge, skills and attitudes do parents possess about the concepts of health and health promotion?
- What factors are perceived as barriers to supporting health promotion activities in the school?
- What suggestions do parents have for overcoming the stated barriers to support the health of their children in secondary schools?

1.9 Theoretical Framework

I discuss the Ecological Systems Theory of Bronfenbrenner (1979) in the following sub-sections to show how it is a suitable theoretical framework for this study. I also explain the social determinants of health as a guiding concept in the study.

1.9.1 Bronfenbrenner's Ecological Systems Theory

Children do not develop and grow in isolation. Rather, children's wellness is influenced by the context in which they develop, including their environment and the conditions that affect their experience (Ettinger, 2004). The system in which the family operates, such as the family level of education, economic status, cultural belief and other factors, contribute positively or negatively to a learner's development (Brewer, 2007). These processes and spheres of influence are described and explained in Bronfenbrenner's (1979) Ecological Systems Theory as a way to reinforce the importance of viewing the child's health and wellbeing within the context of the environment (Addison, 1992). According to the ecological system theory, learners develop within a social system and structures within a nested series of surroundings. Five types of environmental systems that surround the child are identified in the Ecological Systems Theory, namely: The micro-system, the meso-system, the ecosystem, the macro-system and the chrono-system (Addison, 1992).

For the purpose of this study, I have focused on the micro-system. According to Landsberg *et al.* (2005:11), the micro-system is the immediate environment in which an individual develop and interact with the immediate family, day-care centre, the school and the neighbourhood (Donald *et al.*, 2010). Within the different levels of the environment, the *modi operandi* have an impact on how a child develops (Landsberg, 2011; Ntagungira, 2014).

1.9.2 Social Determinants of Health

Literature discussion on social determinants includes structural factors in society such as policies, everyday conditions of life, the economy and the living environment (Marmot *et al.*, 2008). There

is a well-documented relationship between health and social determinants in the current literature (Raphael, 2006; Wilkinson & Marmot, 2003). According to the World Health Organisation (2017), the social determinants of health are the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life.

As noted earlier, differences are mentioned in the health literature regarding the way history and society have interpreted a variety of concepts of health (there are differences in terms of cultural views, age, sex, social class and nationality). The literacy level of parents differs, and the socioeconomic status also differs. Health literacy can be influenced by socioeconomic status, cultural background, age, the language we speak, our ability to communicate clearly and listen carefully, past experiences, cognitive abilities and mental health. These factors influence the way an individual communicates, responds to, and understands health information (U.S. Department of Health and Human Services, 2010).

1.10 Research Methodology

Using a qualitative approach, the aim of the study was to understand how parents of secondary-school learners perceive health and health promotion. A detailed discussion of the research methodology is given in Chapter 3, but I present a brief overview below.

1.10.1 Research Paradigm

I carried out this study according to an interpretive research paradigm. Johnson and Christensen (2008:33) indicated “that a paradigm is a perspective about research held by a community of researchers based on a set of shared assumptions, concepts, values and practices”. Interpretivism is regarded as an approach that emphasises the “importance of interpretation and observation in making sense of the social world” (Ritchie & Lewis, 2003:7).

Cohen *et al.* (2007:19) stated that the role of the researcher in the interpretivist paradigm is to “understand, explain and demystify social reality through the eyes of different participants”. The purpose of interpretive studies is to explain phenomena through the meanings that people assign to them (Cohen *et al.*, 2007:19). The aim of interpretivist research is to offer a viewpoint of a situation and “to analyse the situation under study to provide insight into how a particular group of people make sense of the phenomena they encounter” (Nieuwenhuis, 2007:60). Therefore, an interpretive paradigm was appropriate for this study because I aimed to gain an in-depth understanding of how parents understand and construct their health literacy.

1.10.2 Research Design

I followed an exploratory qualitative design for this study. According to Horn (2009), a qualitative design provides a source of possibilities to learn more about individuals and people. According to Mouton and Marais (1992:174), qualitative research is regarded as an in-depth study in which the researcher seeks to understand the essence and core of an unknown phenomenon. Since limited research had been done in South Africa on parents and health literacy, a qualitative research design made it possible for me to explore this phenomenon in greater depth.

1.10.3 Sampling

According to Maree and Pietersen (2007), sampling is done when a few people from a population are selected to be representative of the entire population. There are various ways to choose a sample (Nieuwenhuis, 2007:79) but, for this study, I used purposive sampling to obtain rich data about the phenomenon of health literacy among parents of secondary-school children.

I selected the two secondary schools that formed part of this study from the Dr. Kenneth Kaunda Education District surrounding Potchefstroom. I approached the schools in this district on the basis of logistics and their willingness to participate in the research project. In addition, the Department of Basic Education requested that the university's Faculty of Education assist in a developmental programme in schools in the Dr. Kenneth Kaunda Education District. These schools were situated in socially and economically challenged communities where multiple health risks were prevalent. I regarded this as an opportunity to learn about, and participate in, the development of schools in the North West Province.

I used purposive sampling to select the parents who participated in the study because I considered them to have relevant knowledge and accurate, appropriate and meaningful data, which I needed to answer the research questions (Maree & Pietersen, 2007:178; Nieuwenhuis, 2007:79). The site-based procedure entailed an initial visit to the two schools, identified in the Dr. Kenneth Kaunda Education District, to meet the principals officially. I used this opportunity to discuss the research project and to identify possible participants.

I asked the principal to choose a minimum of ten participants according to the following criteria:

- The participants were the biological parents and/or official caregivers of learners in the school;
- The participants were not part of the school governing body structure;
- The participants had a child in the school for more than two years; and

- The participants were able to speak and understand English.

I approached the mediator (principal), who made arrangements with participants to explain the procedure. The mediator explained the aims of the research study to the participants to determine whether they would be willing to participate in the study voluntarily. Ten parents agreed to take part.

1.10.4 Data collection methods

According to Leedy and Ormrod (2013:151), data collection techniques and procedures are planned according to the research design of the study. The qualitative researcher may use documents and materials as well as interviews to collect data to be able to answer the research question of a study. For this study, I chose to use focus group interviews as the main method of data collection.

1.10.4.1.1 Focus group interviews

According to Clifford *et al.* (2010), a focus group is a small group of participants who come together where a researcher gives a specific topic to the participants that they can share their knowledge and experience of a phenomenon under investigation (Clifford *et al.*, 2010). Focus group interviews provide a more detailed understanding (DiCicco-Bloom & Crabtree, 2006:314–321) and generate a more significant number of topics than individual interviews (Kitzinger, 1995). The strategy of focus group interviews is based on the possibility that group contact will be effective in widening the range of responses, activating forgotten details of experiences and releasing inhibitions, which might otherwise discourage participants from disclosing information (Nieuwenhuis, 2016). An advantage of focus group interviews is the opportunity they provide to observe a significant number of interactions on the research topic for a limited period of time, based on the researcher's ability to assemble and direct focus groups (Babbie *et al.*, 2001).

The questions asked by the researcher should be open-ended so that the participants can express themselves and be able to share their views (Maree, 2011). The role of the researcher is to facilitate the group discussion. Therefore, the researcher needs to act as the generator of the conversation (Bloor & Wood, 2006; Clifford *et al.*, 2010).

I conducted two structured focus group interviews for this study. The following questions were asked:

1. How do you perceive health?
2. How would you define promotion of health?

3. According to you, what *knowledge* do parents need to have about health and health promotion?
4. According to you, which *skills* do parents need to acquire in order to promote their children's health?
5. Which factors might contribute to parents' experience of barriers in the promotion of the health of their children?
6. What would you as a parent perceive as possible *solutions* to overcome the stated barriers to the promotion of health of your children?
7. In which ways do you think you can collaborate with the school to promote the health of your children?

1.10.4.1.2 Data analysis and interpretation

De Vos *et al.* (2005:333) defined data analysis as “the process of sifting through raw data, where the researcher aims to identify significant patterns and to construct a framework of what the data reveals”. Data analysis entails a progressive process of reading, re-reading and identifying themes and categories.

For this study, I used content analysis to analyse the data. Nieuwenhuis (2016) stated that content analysis is classified as an inductive process whereby the researcher compares the data generated from the participants. Data generated findings are based on the participant's knowledge, skills, capabilities and attitudes. For this study, I focused on parents' as participants' knowledge, skills and attitudes regarding the concepts of health and health promotion.

1.10.4.1.3 Role of the researcher

My role as the researcher was to integrate the theoretical application with the practical implementation of the study. I followed the suggestions of Nieuwenhuis (2010) to record all discussions and also to take notes during observation. I also ensured that all viewpoints were recorded/expressed and relevant to the research questions of the study, and I ensured that ethical standards, according to North-West University, were met.

1.10.4.1.4 Validity of the study

Validity and trustworthiness are two important aspects of research since they contribute to the credibility of the study (Merriam, 2009). It is important that the people who read the research

understand the foundation on which the research was based, the purpose of the research, the methods used in collecting data, and the processes involved.

To ensure trustworthiness in this research project, I consulted the work of Creswell (2005) and other qualitative researchers (Botma *et al.*, 2010:232–235; Lincoln & Guba, 1985; Nieuwenhuis, 2016). The following considerations were relevant to this study: credibility, transferability, dependability and confirmability, which I have discussed in detail in Chapter 3.

1.11 Ethical Considerations

Ethics are defined by O'Neil and Norris (2006:184) as rules or standards pre-determined by the proper conduct of participants in a profession. As the researcher, I was ethically responsible for protecting the rights and welfare of the parents who participated in this study. I obtained informed consent from all relevant institutions, and the confidentiality of the parents who participated in this study was protected (McMillan & Schumacher, 2010:117). I obtained permission to conduct the study from relevant stakeholders and also from the Research Ethics Committee of the Faculty of Education of North-West University.

According to Wiersma (2000:418), ethical considerations are central to ensuring the protection of the rights and welfare of participants. Therefore, I carried out this study in accordance with the following ethical considerations:

- Informed consent: the participants were approached in their private capacity to participate in the research voluntarily;
- Each participant was provided with oral and written information about the purpose of the research, as well as the expectations regarding their involvement;
- Participants could withdraw from the study at any time;
- Confidentiality and privacy were protected, and participants were referred to as “P1”, “P2”, etc.;
- The participants could request feedback on the project at any time; and
- The risk level of the parents as participants was low.

1.12 Chapter Summary

In this chapter, I have described the background of the study by focusing on the research problem, the aim, the rationale and the objectives. I have clarified concepts and explained the theoretical and practical relevance of the study. In the following chapter, I focus on presenting the theoretical framework, within which I have addressed health literacy and health promotion in schools, in

particular Bronfenbrenner's Ecological Systems Theory and the concept of the social determinants of health.

CHAPTER 2: A LITERATURE REVIEW OF THE CONCEPTS AND THEORIES GUIDING THIS STUDY

2.1 Introduction

In this chapter, I review relevant literature on health promotion and health literacy in schools. In the first part of the chapter, I explain health as a multi-pronged concept and then discuss health promotion from a global and South African perspective. Furthermore, I discuss the policies that guide health promotion and the problems that have been encountered in their implementation. In the second part of this chapter, I focus on the concept of health literacy and the role of parents in it. Finally, I explain the concept of Social Determinants of Health as it relates to this study and end with a discussion of how I used Bronfenbrenner's Ecological Systems Theory as a theoretical framework.

2.2 Health

Health is a concept that is open to multiple explanations. Depending on the context, health has been defined in different ways by various writers and researchers (Edelman & Mandle, 2002; Muslu, *et al.*, 2020). Differences in interpretations of health are influenced by cultural views, age, gender, social class and nationality (Naidoo & Wills, 2000:6,17-20; Muslu, *et al.*, 2020).

According to Naidoo and Wills (2004:20-23), the following are the main perspectives on health:

- Health as a commodity: This perspective leads to unrealistic expectations of health as something which can be purchased. By paying a higher price for health care, health cannot be guaranteed.
- Health as an ideal state: Health is holistic. This perspective is significant in showing the inter-relationship of different dimensions of health.
- Health as personal growth: From this perspective, health results from humanistic psychology and it is suggested that an individual can become healthy through self-actualisation and discovery (Maslow, 1970; Semela, 2010). This approach encourages individuals to define their health, but it neglects the influence of the environment on the health of the individual.

In this study, I followed a meta-approach which is a more comprehensive and holistic view of health and, thus, extends the bio-psycho-social-spiritual view to include the ecological and metaphysical contexts of health as well its determinants. According to Viljoen and Kirsten (2006:8) and Stoewen (2017), aspects of life, such as the physical, mental, spiritual, mental, social and intellectual, individual maximise an individual's potential and maximise an individual's potential (Stoewen, 2017). For example, to find an ideal state of health, no aspect should be emphasised at the expense of another.

In South Africa, high levels of poverty and inequity in socioeconomic status are experienced. The poor face many factors that are recognised as social determinants of poor health (Ataguba *et al.*, 2011). The parents of secondary school learners who participated in this study lived in a poor community with a high level of poverty and low levels of education. These environmental and social challenges in the environment might limit a parent's ability to create a healthy environment and pursue healthy lifestyles (Ataguba *et al.*, 2011). In South Africa, children of poor families are born into an unhealthy environment, where contaminated water, lack of suitable sanitation, polluted air, toxic hazards and degraded ecosystems are all important environmental risk factors (World Health Organisation, 2017). Basic needs are often not met, and this places them at a disadvantage. Thus, health promotion is vital to provide the added help necessary to overcome adverse circumstances.

2.3 Health Promotion

Health promotion is a concept that is used to describe activities that are intended to prevent diseases and ill-health as well as to increase wellbeing in the community. O'Donnell (2008:11) defines health promotion as, "the art and science of helping people discover the synergies between their core passions and optimal health, enhancing their motivation to strive for optimal health, and supporting them in changing their lifestyle to move toward a state of optimal health". Health promotion entails the provision of opportunities to "enhance awareness, increase motivation, and build skills to make positive health choices". The health promoting school approach was introduced in the 1970s. The first international conference took place in 1986, known as the Ottawa Charter (Turunen *et al.*, 2017).

It is important to follow the development of health promotion, and I have summarised the historical development of health promotion globally in Table 2-1.

Table 2-1: The historical development of health promotion globally

The Lalonde Report in Canada, 1974	The Lalonde report focused on promoting health and preventing diseases. The Lalonde Report was the first official report on health promotion (Edmondson & Keileher, 2000). This report has been seen as ground-breaking work in health promotion. It was suggested that health existed outside of the health care system and that social determinants of health influence health (Roux, 2013).
Alma Ata Declaration, 1986	The Alma Ata declaration aimed to protect and promote the people's health, with a specific focus on marginalised groups to promote equitable health outcomes (Tones & Tilford 2001). From this declaration, the WHO (1986) started to emphasise the pre-requisites for health, and this included aspects such as social and economic factors, conditions for good health, housing and work environment (Pike & Forster, 1997). This was a move towards health promotion rather than a curative approach.
1 st Global Conference on Health Promotion. The Ottawa Health Charter for Health Promotion, 1986	In the Ottawa Charter for Health Promotion, it was recognised that health occurs within the setting of a daily working life where individuals live, learn, work and play as human beings (Ntuli, 2000). Parents and schools thus have an essential role to play in the health promotion of children. In the Ottawa Charter for Health Promotion (WHO, 1986), it was emphasised that good health depends on significant resources for social, economic and personal development, and this is a crucial dimension of the quality of life of an individual. Specific factors such as political, social, cultural, environmental, behavioural and biological were seen as impacting on health. According to this Charter, the aim of health promotion action is to create optimal conditions in these areas through advocacy for health.
2 nd Global Conference on Health Promotion. The Adelaide Conference, 1988	Health as a fundamental human right and a sound social investment form the focus of the Adelaide Conference (Edmondson & Kelleher, 2000; Tones & Tilford 2001). At the conference, the link between a country's economy and the health of its population was emphasised.
3 rd Global Conference on Health Promotion. The Sundsvall Conference, 1991	In 1991, a clear link was given at the Sundsvall Conference between an individual's physical environment and health. The focus at the conference was on mainly spiritual, political and ideological dimensions of health (Tones & Tilford, 2001). At this conference, six specific areas were addressed, namely: i) education; ii) food and nutrition; iii) home and neighbourhood; iv) work and transport; v) support and vi) care (Tones & Tilford, 2001).

4 th Global Conference on Health Promotion. Jakarta Conference, 1997	At the Jakarta Conference, priorities for the 21st century were set out. The Ottawa Charter for Health Promotions was again emphasised at this conference. More focus was given on aspects of Public Health Promotion. Edmondson & Kelleher (2000) explain that this conference can be viewed as a catalyst for national, international, and global health promotion actions. It was evident that disparities were arising between rich and poor, leading to a double burden of diseases (Edmondson & Kelleher, 2000), with five priorities: i) promote social responsibility for health, ii) increase investments for health development, iii) expand partnerships for health promotion, iv) increase community capacity and v) empower the individual and secure infrastructure for health promotion.
5 th Global Conference on Health Promotion: Bridging the Equity Gap, Mexico 2000	At the Bridging the Equity Gap Conference on Health Promotion, the essential role that Ministers of Health and leaders play was recognised in promoting health as a fundamental priority in international, national and local, regional policies and programmes and the preparation of countrywide plans of action for health promotion.
6 th Global Conference for Health Promotion in a Globalised World, Policy and Partnership for Action: Addressing the Determinants of Health, Bangkok 2005.	In the Bangkok Charter for Health Promotion in a Globalised World, it was highlighted that civil societies and communities need to have the rights, opportunities and resources that lead to initiating, understanding and shaping health promotion. The private sector was acknowledged as playing a vital role in promoting health promotion within the workplace.
7 th Global Conference for Health Promotion, Promoting Health and Development: Closing the Implementation Gap, Nairobi 2009	At the Nairobi Global Conference on Health Promotion, key commitments of health promotion required to close the implementation gaps in health and development were identified.
WHO-AFRO's Strategy for Health Promotion in the African Region, 2012.	According to the WHO-AFRO's Strategy for health promotion in the African Region, all health systems and institutions need to integrate health promotion into clearly defined goals and objectives. The incorporation of health promotion into non-health institutions and sector interventions was highlighted.
8th Global Conference for Health Promotion. The Helsinki Statement on Health in All Policies, 2013.	In the Helsinki Statement on Health in all Policies Global Conference, it was outlined that all sectors need to take into account the health implications of decisions and strive for synergies to avoid harmful health impacts in order to promote health equity and population health.
9 th Global Conference on Health Promotion,	The Shanghai Declaration on promoting health provides guidance to the Member States on how to reflect responses to

promoting health, promoting sustainable development: Health for all, and all for health, Shanghai 2016.	promoting health in national Sustainable Development Goals (SDGs) and how to accelerate progress towards achieving SDG targets. In this declaration, national experiences were exchanged in strengthening good governance for health through action across government sectors, broadening and strengthening social mobilisation, and promoting health literacy. In this declaration, the health sector's changing role as the key advocate for promoting health was highlighted. In this declaration, the crucial role that cities – and municipal leaders, especially mayors – play was pointed out in promoting health (creating healthy cities) in the context of an increasingly urbanised global population.
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The Ottawa Charter of 1986 has been credited in the literature as the turning point on how health promotion has been defined (Roden, 2003). Different researchers refer to the five key areas of action in the Ottawa Charter that include: healthy public policy, strengthening community action, creating supportive environments, re-orienting the health services and developing personal skills (Mitchell, 2011). The focus of the more traditional approach to health education in schools was on gaining knowledge about diseases and healthy behaviour based on the narrow concept of health. However, the new paradigm, which provided a basis for a more health promoting school approach, encompassed health education and is regarded as any activity undertaken to protect and/or improve the health and wellbeing of learners, teachers, and other stakeholders (Turunen *et al.*, 2017)

Health promotion refers to a holistic activity (process) to assist, guide and empower someone to be able to take control of his/her health to attain a state of physical, mental and social wellbeing. To reach a state of complete mental, physical and social wellbeing, a group or an individual must be able to identify and realise objectives to satisfy needs and to cope with developments in the environment. Therefore, health promotion in schools should be regarded as a way of trying to address unhealthy lifestyle choices and improve the attainment of the relevant Sustainable Development Goals (SDG). It is thus the joint responsibility of parents, teachers and the community.

2.4 Health Promoting Schools

2.4.1 Health Promoting Schools Globally

A variety of factors affect the health and development of children globally, such as poverty and the environment in which children function, nutrition, HIV/AIDS, trauma, and violence (Coulson,

2000:1; Department of Health, 2003:5). Health problems have become critical reflections in the development of future packages for school health activities, such as the concept of Health Promoting Schools (HPS). HPS is part of a global school health initiative that offers a holistic approach, addressing the various factors that influence the health of young people (Kwan *et al.*, 2005:677; Lynagh *et al.*, 2002:300).

There has been a well-established link between the wellbeing and overall health of children and their capacity to benefit from educational opportunities and attain high levels of achievement (St. Leger & Nutbeam, 2000). Healthy children outperform academically; health affects children's ability to attend school (St. Leger & Nutbeam, 2000: 257). In addition, promoting healthy lifestyles can empower learners to contribute to their communities as adults (Coulson, 2000:1; Japanese International Co-Operation Agency (JICA), 2007:2).

Young children spend more than one-third of their day at school, and therefore the school can be seen as an important health promotion setting (Pearson *et al.*, 2015). Schools empower learners through knowledge, attitudes, values, skills, and services to be healthy and avoid essential health problems (St. Leger & Nutbeam, 2000:258). Thus, HPSs could be one of the most efficient ways to improve learners' lives (JICA, 2007:3). Schools are a complex social system where the functioning and the activities a school promote can influence the health of people who work within a school environment (Rowling & Rissel, 2000:249). In South Africa, the development of health promoting schools is a critical strategy to achieve educational goals to promote wellbeing and health in the school community that includes parents, learners, teachers and community members (Department of Basic Education, 2010).

2.4.2 Health Promoting Schools in South Africa

South Africa's first democratic election was held in 1994. As part of the transition from Apartheid to democracy in 1996, a permanent constitution was promulgated. The Constitutions of South Africa focus in Chapter 3 on the Bill of Rights that provide fundamental rights to all the people within the country. The Bill of Rights forms the cornerstone of democracy, protects all the people, and supports equality. The Bill further emphasises that the state needs to protect, and promote people's rights within the country (South African Constitution, 1996). In the Constitution of the Republic of South Africa (1996), it is stipulated under Section 24 that every person in the country has the right to an environment that is not harmful to health or wellbeing (Kwatubana & Nel, 2018).

In 1994 different ministries accepted a 'setting-based' approach to health promotion, and as a result, health promoting schools originated in South Africa (Struthers *et al.*, 2017; Waggie *et al.*, 2004: 303-312). However, as mentioned above, South Africa is a unique country with unique

obstacles. As a result of apartheid, thousands of children did not have the opportunity for high-quality education, and therefore, South Africa is still struggling to reform education and correct the legacy (Heaton, 2014).

The Integrated School Health Policy (2012) explains that being unhealthy can create barriers to learning. Such barriers are caused by poor nutrition; poverty; environmental factors, such as insufficient water and sanitation; illness and disease; and disabilities. According to the policy, these factors affect learner attendance and ability to concentrate in the classroom, resulting in an inability to perform well academically and leading to poor pass and retention rates for schools (Coovadia *et al.*, 2009:817-834).

According to the Integrated School Health Policy (2012), to address the issues mentioned above, it is necessary for schools to assist in the following ways:

- Carrying out physical health assessments of learners in Grade R (reception year), where it is attached to a school, and learners in Grade 1 who were not assessed in Grade R. This assessment includes assessing hearing, vision and speech, as well as a physical examination for gross locomotor dysfunction, oral health checks and an anthropometric assessment (to measure physical development against normal milestones). Additional assessments that might be provided should a need exist include identifying and responding to intentional injuries and child abuse and mental health assessments.
- Being involved in school health promotion and health education. This is done by assisting: schools with school health committees to establish a healthy school; school communities to develop self-sufficiency in promoting health; school health programmes initiated by the school community; the development of an infrastructure that can respond to injury and acute illness (sick rooms): setting up first-aid requirements including a first-aid box, and the development of a health guide resource booklet for teachers.
- Supporting Life Orientation teachers when dealing with topics including sexuality, sexually transmitted diseases, and sexual abuse. School nurses and health practitioners in health education should be involved here.

South Africa, just as other countries all over the world, has adopted the approach of health promotion based on the Ottawa Charter of Health (Kwatubana & Nel, 2018). The five areas identified by the Ottawa Charter (1986) are used as a framework for the HPS approach to promoting health in schools.

- Skills: Build the necessary skills of all members of the school community (KwaZulu-Natal Department of Health, 2001) to design and implement health promoting services and curricula.
- Policies: Develop non-complex, healthy policies that guide and direct activities. School-based policies should be developed and monitored to ensure that policies, such as the national health policies, are implemented in a manner relevant to a particular school.
- Environment: Create a healthy and safe environment for living, working and learning. An indication of a healthy school environment is the presence of certain physical features such as well-maintained school and classroom surroundings where learners feel physically and psychologically safe, running water for drinking and washing hands, well-kept sports grounds, a shady area where learners may sit during the break, and a clean kitchen with clean utensils for feeding schemes. A clean environment and an area where learners can play during breaks, perform physical activities or sit and relax are necessary, not only for the mental health but also for the physical health of learners (Terburg, 2015).
- Community: Strengthen interactions between the school and the surrounding community. The responsibility for health promotion is shared by the government, health professionals, community groups, health service institutions and individuals who are working together to establish health care systems that contribute to health. Health services must embrace and mandate systems that are sensitive and respect cultural needs. The mandate must support the community and individuals to live a healthier life by providing training and education with regard to health, promoting the interaction between the health sector and the social, economic, political and physical components of the environment (Integrated School Health Policy, 2012; KwaZulu-Natal Department of Health, 2001).
- Services: According to the Integrated School Health Policy, the strengthening of school health services is a key component of the health sector's efforts to re-engineer and reinforce primary health care delivery, whilst the provision of school health services is a key component of the Care and Support for Teaching and Learning (CSTL) Programme. The aim of the CSTL Programme is to realise the educational rights of all children, including those who are most vulnerable, through schools becoming inclusive centres of learning, care and support (Integrated School Health Policy, 2012).

It should be noted, however, that these guidelines refer mainly to physical and environmental health, to the detriment of other aspects, such as social and mental wellness.

2.5 Health Promoting Challenges in South Africa

Over the last decade, political changes have been made in the health sector that was intended to reduce inequities in the health services and, in the South African health care system, efforts were made to focus on primary health care (Chopra *et al.*, 2009:1023–31). There are many challenges to the quality of health care in South Africa (Maphumulo & Bhengu, 2019). Moreover, Statistics South Africa (2009) mentioned that since 1994 specific health goals have been insufficient. Tremendous obstacles were experienced after Apartheid, such as wealth and unemployment (Delobelle, 2013). South Africa has one of the highest unemployment rates in the world (Statistics South Africa, 2009; 2020). Since 1994, the HPS policy implementation has been affected severely by a lack of knowledge and skills, lack of coordination between stakeholders and the lack of coordination between the Department of Basic Education, Department of Health, and Department of Social Development. Some of these challenges are discussed below.

2.5.1 Lack of Knowledge and Skills of Teachers and School Leaders

Health promotion faces severe obstacles in South Africa. One of the obstacles is the lack of skills and poor knowledge (Gugglberger & Dur, 2010:37-43; Macnab, 2014; Tossavainen *et al.*, 2004:33-44; Wood & Jewkes, 2006:109-180). According to a study conducted by Mohammadi *et al.* (2010), school staff lacked a shared understanding of the term HPS. Previous research showed that there is a lack of common understanding regarding health promoting schools as well as confusion among school leaders regarding the implications of HPS for school management (Mohammadi *et al.*, 2010). At schools, staff members are one of the key role players in promoting health programmes at school and that their perception of health promotion is essential (Mohammadi *et al.*, 2010). Verhaeghe *et al.* (2013:1569–1578) added that knowledge about health promotion could help an individual to live a healthy lifestyle, the teacher's perceptions of health and health promotion may influence participation in health promoting initiatives (Tjomsland *et al.*, 2009:89-102).

The World Health Organisation (1986) emphasize that stakeholders such as health and education should have a continuous discussion about the significance and purpose of health promoting schools. Consequently, schools would have a better understanding of the priorities of the public health sector, and the understanding of health promoting schools would be more transparent (Mohammadi *et al.*, 2010). However, this is not always done as the complexity of the HPS approach and the discourse differences between health and education make coordination between stakeholders difficult.

2.5.2 Lack of Coordination between Stakeholders

Stakeholders need to obtain a common understanding for a diverse, realistic and practical involvement in health promotion. One of the major barriers to the implementation of health promotion strategies was identified as the lack of understanding between the stakeholders (Gugglberger & Dur, 2010:37-43; Mohammadi *et al.*, 2010; St. Leger & Nutbeam, 2000; World Health Organisation, 1996:5).

The different pace and degree of implementation of HPS's revealed challenges in the coordination between sectors in the health programme. The programme was not initiated in some settings because of the lack of cooperation and coordination between the Department of Health and the Department of Basic Education, complicated further by problems in the education system such as over-crowded classes, and dysfunctionality in schools in many areas (ISHP, 2012).

The phased approach that was outlined in the 2003 School Health Policy, which was focused on district-level implementation, did not translate into adequate provision at sub-district, school and learner levels (ISHP, 2012).

The aim of the 2003 National School Health Policy was to:

- “address the prevailing inequities in the provision of health services at schools;
- integrate the vertical, school health service into primary health care services, in keeping with national policy to move towards comprehensive, integrated service provision at the district level;
- create a uniform school health service; and
- develop norms and standards for the provision of good-quality school health service” (NSHP, 2003).

The following factors contributed to the failure of the 2003 policy implementation:

- “Systemic factors such as the immaturity of the district health system, general nursing staff shortages and relative lack of referral services;
- School health-specific factors such as poor relationships between key stakeholders, in particular, the Departments of Health and Education; poor relationships between parallel health initiatives aimed at schools, namely that between health promoting schools and school health; a lack of transport for this community-based outreach

service; and poor managerial understanding of, and support for, the school health service” (Shung-King *et al.*, 2014).

The integration of school health into the managerial and service delivery structures at the district level was the only objective in this policy that was achieved successfully (Shung-King *et al.*, 2014).

In the Integrated School Health Policy of 2012, it was recognised that collaboration was necessary between the National and Provincial Department of Health (DoH), Department of Basic Education (DBE) and Department of Social Development and all parties taking part in the programme (Spotlight, 2013).

2.5.3 Lack of resources

According to Gugglberger and Dur (2010), schools need resources such as human, financial information and knowledge management to apply school health policies effectively. Networking forms a vital role in the success of health promotion at schools. In addition, schools can benefit from networking such as health promotion services, cooperating with other schools and parents. It is clear from research done in the last twenty years that a gap exists in Health Promoting Schools in South Africa and globally. It is recommended to achieve health within the international community; these communities need to devise by allocating additional resources and strategies to achieve health across the globe (Bruce & Klein, 2012:411-417; Marks, 2011:340-346; Sharp *et al.*, 1999; St. Leger & Nutbeam, 2000; Stewart *et al.*, 2000). Due to the relative failure of the National School Health Policy (2003), the Integrated School Health Policy was introduced in 2012.

2.6 The Integrated School Health Policy (ISHP)

The ISHP is seen as the primary policy that supports the promotion of health at school and builds and strengthens the existing health services at schools (ISHP, 2012), but with some changes linked to the 2003 School Health Policy (SHP). The focus of the phased approach (as presented in the 2003 School Health Policy) was on implementation at the district level, but it lacked adequate provision at sub-district, school and learner levels. Although the ISHP targeted the most disadvantaged schools initially, the aim of sequenced plans for progressive implementation was to ensure that all learners were reached.

The initial aims of the Integrated School Health Policy (2012) were to:

- Strengthen the collaboration between the Department of Health (DoH), Department of Basic Education (DBE) and the Department of Social Development (DSD) to serve all learners in all schools;

- That learners at all phases of schooling will be provided with school health services.
- A more comprehensive school health service package, will be provided that will not only focus on barriers.
- Place more emphasis on the provision of health services (as opposed to screening and referral) in schools, with an obligation to expand the variety of services provided over time.
- Provide mechanisms to ensure that learners who needed additional services received these services and that they were available.
- A more systematic approach will be implemented at disadvantaged schools.
- To implement the policy within the Care and Support for Teaching and Learning Framework as utilised by the DBE.

It was indicated in the Integrated School Health Policy (2012) that the focus was on children of school-going age where parents and caregivers, teachers, school management, auxiliary staff and school administrations were intended to receive benefits from the program. Table 2-2., taken from Shung-King (2013), outlines the main improvements this policy made as compared to the previous policy.

Table 2-2: Key differences between the 2003 and 2012 National School Health Policies

	2003 National Policy	2012 National Policy
Political support	At the political level, school support and resources are limited for school health Minimal media attention.	Strong support as the school policy was launched in October 2012. Support by the Minister of Health and Basic Education. Support national education, school and union bodies at the launch of the National Policy in 2012. Much media publicity, especially on sexual and reproductive health aspects.

Context	Not the only child-health policies develop before 1994. Low priority compares to other child-health issues. Fledgling district health system with many challenges.	In this health policy, school health is seen as a priority. Department of Education set framework and policies that can promote school learners health.
Relationships		
Between sectors	Only the Department of Health is an active member of the Tri-sectoral policy task team.	Health and education department and Social Development Department are part of the Tri-sectoral policy task team. However, the Department of Social Development is less involved.
Between health programmes	Inadequate coordination, in particular between school health and health promoting schools.	Coordination between health programmes is not yet optimal.
Leadership capacity	For the last five years of implementation, national and provincial school health coordination positions were vacant.	Designated national, provincial and district, school health personnel in Health and Education largely in place.
Health service package		
Health assessment	Mainly for Grades 1 and R; approximately one million learners per year. Stated that disadvantaged schools must be prioritised but not done in a structured way.	Expanded to one year in each educational phase, Grades R/1, 4, 8 and 10. Close to four million learners per year. Initial emphasis on schools classified socioeconomically into Quintiles 1 and 2, representing the most disadvantaged learners. Anaemia and TB screening added.
Health promotion	Across all grades, but primarily in primary schools.	Across all grades. A new focus on sexual and reproductive health and risk behaviour in secondary schools. The provision of sexual and reproductive health services in schools requires the explicit permission of individual school governing bodies.
Prevention and clinical care	Deworming. A Tetanus and Diptheria (tD) vaccine, introduced after six years	Deworming and the tD vaccination. Contestation of the provision of

	into the implementation period for 6- to 12-year-olds.	contraception in schools. The HPV vaccine for 9-year-old girls commenced in 2014.
Psycho-social and mental health	Mental health assessments to be introduced only if provinces had the necessary capacity.	Psycho-social and mental health assessments now a requirement.
Chronic diseases	Mentioned, but no specific direction for implementation given.	Identification and support of children with chronic diseases a required part of the service.
Interaction with school community, educators, parents and caregivers	Left to individual nurses and school-health teams to negotiate this with schools, with mostly poor coordination between school health teams and schools. Multi-partner teams to be established at district level for coordinated planning of school-based interventions.	This is now more structured between Health and Education. Community-based implementation teams in health and school-based teams required to work together. Multi-partner teams to be established at district level for coordinated planning of school-based interventions.
Key resources		
Staff	Districts had to fund school health posts entirely out of existing budgets.	National grants have been made available to support the recruitment of additional nurses for school health.

Adapted from Shung-King (2013)

2.7 Parents' Knowledge, Skills and Attitudes regarding Involvement in Health Promoting Schools

More recent work by Fernández *et al.* (2020) emphasises that parents' beliefs about health behaviours and attitudes can address gaps and lead to support child health behaviour and management. Parents are positioned to influence a child's health behaviour in a positive way (Jurkowski *et al.*, 2014). According to Rowling and Samdal (2013), parents, staff and learners' involvement in health promotions empower them and also equips them with ownership, practice and decisions making by using their existing abilities and strengths. Walton *et al.* (2010) explained that, even if school policies concerning healthy nutrition were more accessible, the involvement of parents is necessary for socioeconomically deprived schools, and the lack of parental involvement compromised opportunity for longer-term impact. Hornby and Witte (2010) found that

parents with low socioeconomic background, education level and training were less likely to become involved in health promotion activities at school than their more affluent counterparts. Research done by Mohamed (2015) discovered that socioeconomic factors such as poverty, unemployment, malnutrition, lack of supportive family structures, alcohol abuse, dysfunctional families and low level literacy could cause a lack of parent involvement in the health promotion of their children (Pieterse, 2010; Munje, 2018).

The 2016 Shanghai Declaration on promoting health (9th Global Conference on Health Promotion) recognised that health literacy is a critical determinant of health that empowers individuals and makes it possible for them to engage in collective action to promote health. Therefore, it is important to understand health literacy, as emphasised by Nutbeam *et al.* (2018).

2.8 The Global Movement of Health Literacy

The importance of health literacy has been recognised globally. The World Health Organisation has positioned health literacy as having a critical influence on promoting health (Nutbeam, 2000), and the U.S. Agency for International Development (2001) recognised health literacy as an essential contributor to the move towards a healthier society.

During the 1980s, the concept of health literacy in schools was introduced internationally in countries such as Canada, the United Kingdom and various countries in Europe. For example, as part of a global movement to integrate health literacy in schools, the Coordinated School Health Programme is implemented in America by determining the health and safety levels of its learners, employees, environment, parents and the community at large (Stanhope & Lancaster, 2010:583; Clark, 2008: 633; Gross, 2004:796).

Since 1995, Austria has been a member of the European Network of Health Promoting Schools and has been implementing health promoting schools with the aim of furthering health literacy. Austria works towards health promoting schools that are focused not only on health literacy among children but also the teachers and the community. Instead of health literacy being taught in just one subject, it is integrated across the curriculum (Flaschberger, 2012:216-231).

In Australia, health promoting schools are grounded in a social-ecological approach. This approach recognises the relevance of the psychological world, referring to the motivation for each child and parent's actions, the family environment, the school context, and their social context (Williams & Lawson, 2013:126). To date, Canada is the only country with health literacy comparable to Australia's (Pleasant, 2012).

2.8.1 Health literacy in South Africa

Various researchers and authors have mentioned that children who grow up in the circumstances of unsupported families are subjected to mental, physical and emotional abuse, which might lead to diseases (e.g. HIV/AIDS, sexually transmitted diseases), teenage pregnancies and substance abuse. These factors all have a direct impact on poor school achievement and an increasing drop-out rate (UNICEF, 2011:31; Sines *et al.*, 2009:172; de Klerk, 2013). The Department of Basic Education's figures in South Africa indicated that 1,100,877 learners were enrolled for Grade 10 in 2014, but only 610,178 were enrolled for Grade 12 in 2016. Reasons for dropping out of school, as indicated by adolescents, were poverty, inability to pay school fees, the need to get a job to sustain a family, and teenage pregnancies (Panday *et al.*, 2009:38)

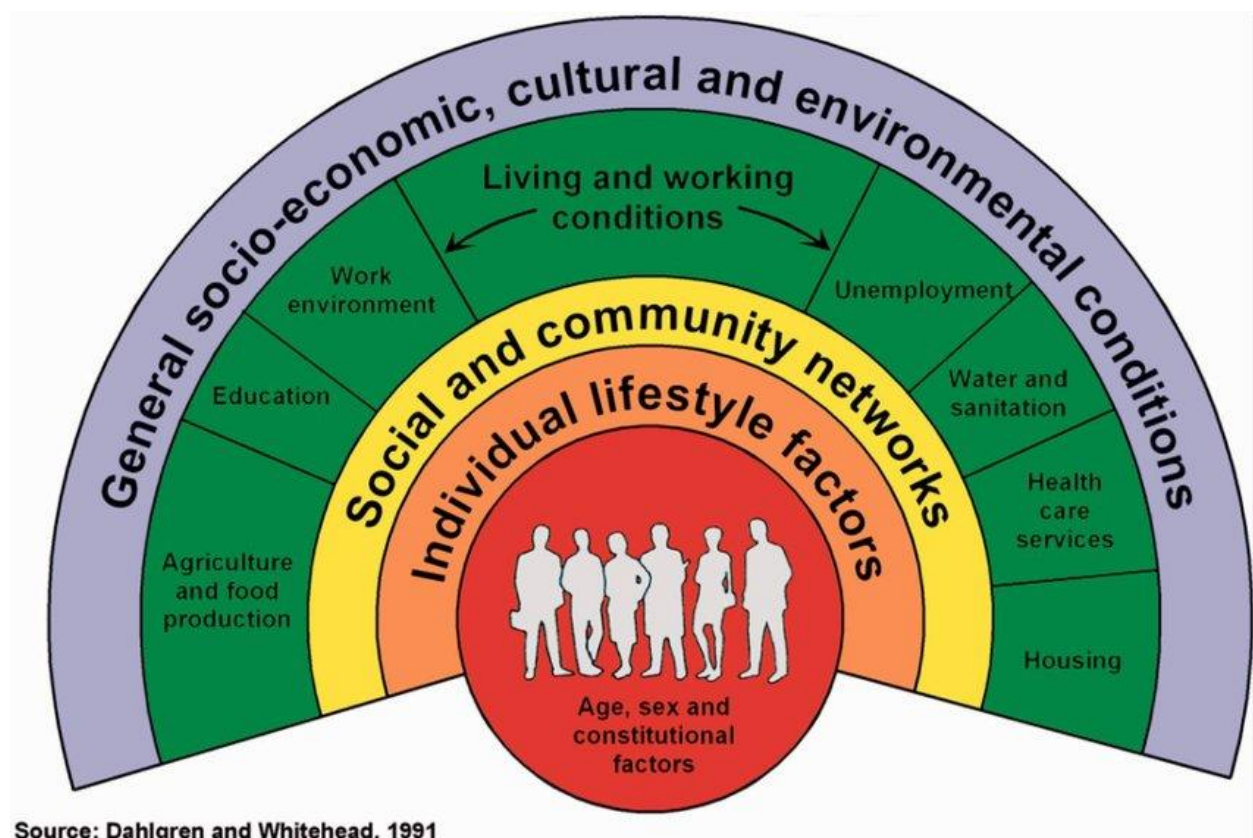
According to Yin *et al.* (2009), parental health literacy matters can be linked directly to children's health. Therefore, efforts should be made to address the literacy demands on parents as they seek to address the health needs of their children. Dossey *et al.* (2005) stated that the focus should be not only on pre- and primary-school health promotion but also on health promotion of secondary-school learners. Parents might not be able to promote health care to their children because they might lack the knowledge and skills to do so effectively (Fleary *et al.*, 2013).

Ratzan (2001) linked health literacy in the community to the concept of social capital, arguing that health-literate people live longer and have more substantial incentives to invest in developing their own and their children's knowledge and skills. Healthier populations tend to have higher labour market productivity contributing to, rather than withdrawing from, pension schemes. Fine and Hicks (2008) explored the role of health programming, seeking to identify practices that were effective in supporting the services needed to promote healthy development for children and parents. When a collaborative relationship is built between parents and teachers, the wellness concepts taught at schools are reinforced by parents at home, and parents are more involved in their children's education. The relationship serves as an invitation for parents to be involved in the process of their children's education at school, and it provides a mechanism for parents to inform teachers about how families can help to promote health literacy. Communication and role-modelling are essential elements of this collaboration (Sorte *et al.*, 2011).

2.9 Social determinants of health

Social determinants have been defined as “life-enhancing resources, such as food supply, housing, economic and social relationships, transportation, education, and health care, whose distribution across populations effectively determines length and quality of life” (Brenna Ramirez *et al.*, 2008:6). Different authors mention that determinants of health are life-enhancing factors and include factors that can influence an individual negatively or positively. A model of determinants was developed in 1991 by Dahlgren and Whitehead. This model is also known as the “rainbow model”, as this model illustrates the multiple determinants of health through different layers (Keleher & MacDougall, 2011); this commonly cited model illustrates the multiple determinants of health in the form of expanding layers (Jackson, 2007) (see Figure 2-1).

Figure 2-1: Dahlgren and Whitehead’s (1991) model of determinants of health



Individual sex, age and inherited factors form the centre of the diagram and are known as the unmodifiable determinants. The second layer is the predominantly modifiable determinants that

consist of an individual lifestyle and behavioural factors. The third layer is the social factors, and the fourth layer is known as the community networks.

It is clear that a number of factors may influence an individual's health literacy. These factors must be acknowledged in a diverse country such as South Africa. When seeking to understand the determinants of health, it can be useful to group together similar types of determinants of health using principles from the social-ecological model for health promotion (Mcleroy *et al.*, 1988). Accordingly, determinants of health can be distinguished as those influences on behaviour change resulting from intrapersonal factors (parent characteristics), those resulting from interpersonal factors (social networks, such as friends and family) and those resulting from broader environmental factors (the community) (Jarvis *et al.*, 2017).

Individual and lifestyle factors in a growing, multi-cultural society such as South Africa, diverse family structures, high prevalence of drug/alcohol abuse, food insecurity and poverty are factors that need to be understood by parents and teachers, so that classroom approaches that are utilised are relevant to the needs of the young learners (Sorte *et al.*, 2011). Personal characteristics that influence health literacy are predicted by: race, age, gender and cultural backgrounds (Manganello, 2008); competencies such as vision, hearing, verbal ability, memory and reasoning (Paasche-Orlow & Wolf, 2007); physical abilities; social skills; and the meta-cognitive skills associated with reading, comprehension, and numeracy (Manganello, 2008). The health literacy of adolescents can be influenced by their parents.

Education in health literacy for learners is crucial because they can be infected with HIV and AIDS, for instance, as a result of mother-to-child transmission during pregnancy, at birth or through breastfeeding (Kassa, 2018). According to the Department of Health (2012), one of the highest causes of death in South Africa is HIV and AIDS. The disease resulted in a growing trend of children being orphaned in South Africa (Department of Health, 2012), which in itself causes psychological trauma, unmet needs for love and security and school dropout, among other negative consequences (Maqoko & Dreyer, 2007). Programmes to increase health literacy need to empower individuals to gain control over their lives (Askheim, 2007; Crondahl & Karlsson, 2016). According to Crondahl and Karlsson (2016), empowerment entails facilitating self-control, improving knowledge and skills, strengthening self-esteem and self-image. Empowerment cannot be given from one person to another, it must emerge from within (Laverack, 2007). Rappaport (1985) described empowerment in terms of psychological empowerment, encompassing the individual's beliefs in his or her competence, efficacy, and involvement in activities aimed at gaining environmental, political, and societal control.

Kickbusch (2001) argued that it is essential to clarify the issue of power in the health literacy debate so that the promotion of health literacy is not focused just on compliance barriers. Health literacy empowers individuals and enables them to engage in collective action to promote health (Shanghai, 2016). It has been suggested that a lack of concern with empowerment has been one of the reasons why literacy efforts around the world have failed (Kickbush, 2001). Parents have a critical role to play in the wellbeing of their children, and this includes improving their health literacy. Therefore, empowered parents are able to promote health and health literacy.

The social and community network is supported by the surrounding living and working conditions such as education, work environment, agriculture and food production, unemployment, water and sanitation, health care services and housing (Mitchell, 2011). Parents with low health literacy share their concerns more with parents from the same community. Parents who have overcome challenges within a certain community can be seen as role models for parents with low health literacy. Social support and actions by the health system can mitigate limited health literacy in communities where it occurs (De walt *et al.*, 2010; Lee *et al.*, 2004: 58, 1309-1321).

According to Edwards *et al.* (2013), social networking is one of the broader factors that influences health literacy, leading to contribute to health care processes and, subsequently, to a changed health outcome. The benefit of the positive relationship between health literacy and social networking is that the resources and support in individuals' social networks can improve their ability to acquire and understand health literacy (Lee *et al.*, 2004). According to Lee *et al.* (2004), there are two types of social networking (structural and functional) that interact with health literacy. Structural social networking refers to an individual's location within their social structure and their participation in the community. Functional social networking refers to communication and support that serves informational, emotional and tangible needs. Functional social networking interacts with health literacy in defining an individual's knowledge and skills relating to health services (Lee *et al.*, 2004; Edwards *et al.*, 2013). It is clear that social factors impact on health literacy.

Different authors refer to demographic/biographical, cultural factors and proximal factors such as general literacy, prior experience of illness, individual characteristics and health care system. These authors further mention that demographic and social factors impact health literacy such as socioeconomic status, occupation, employment, income, social support, culture and language (Paasche-Orlow, Wolf, 2007), environmental and political forces (Freedman *et al.*, 2009), and media use (Manganello, 2008).

Sorte *et al.* (2011) state that families are the primary teachers of their children, and the parents have a significant influence on a child's wellbeing. They furthermore mention that the traditional

family structure is changing continuously. Family arrangements include various combinations of adults caring for children: Children are being raised by teenage mothers or single fathers, grandparents who are the child's legal guardians, children with same-sex parents or time spent with divorced parents, and children who live temporarily in foster care placement. It is essential to notice, as mentioned by Sorte *et al.* (2011), that family structures are changing. Within this changing structure, another crucial aspect to take into consideration is the number of families with two working parents is increasing as more mothers' join the workforce (Sorte *et al.*, 2011).

It is clearly stated by Nyama (2010:87) for teachers to strengthen positive relations with learners' parents, and teachers need to have background knowledge about their learners, their family environment and the community values and norms. His research agrees with the findings of Donald *et al.* (2002) and Sorte *et al.* (2011) that the gap between the school and the communities in more affluent and more deprived areas of the country widens. Being poor does not cause poor health outcomes. Still, it is a contributory factor to children living in poverty because they are more prone to health risks associated with malnutrition, disease, infection, and injury than those who are not poor (Donald *et al.*, 2002; Sorte *et al.*, 2011).

Therefore, Bronfenbrenner's model (1994) is essential for health promotion in that these complex interactions between an individual, their social interactions, as well as environmental and cultural influences, affect behaviour in either a positive or negative way (DiClemente, Salszar & Crosby, 2013).

2.10 Bronfenbrenner's Ecological Systems Theory, 1979

To understand the complex issues affecting the health literacy of parents, a systemic approach is needed. In the Ecological Systems Theory, the importance of the environment in understanding the learner is emphasised (Addison, 1992). Children do not develop and grow up in isolation. Instead, children's wellness is influenced by the context in which they develop, including the environment and conditions that surround the children and affect their experience.

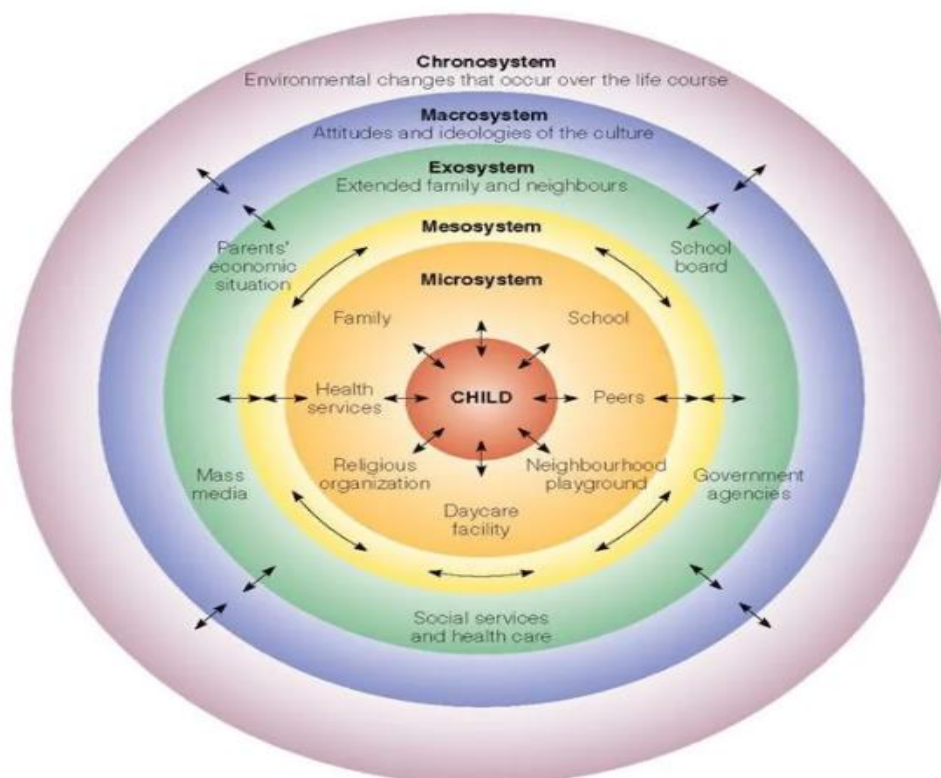
The health and education of a child's family, poverty, cultural beliefs, and many other factors interact and contribute to a child's development in positive and negative ways. In the Ecological Systems Theory, Bronfenbrenner (1994) described and explained the processes and spheres of influence as a way to reinforce the importance of viewing a child's health and wellbeing within the context of the environment. In this theory, a child is depicted as developing within a nested series of surrounding social systems and structures that connect and interact with one another (Brewer, 2007).

The theoretical framework must be understood in terms of accepting that what happens at all system levels, directly and indirectly, affects the role of parents in promoting health and health literacy (Mashau, 2019). This understanding of the direct and indirect effect of the role of parents was relevant and essential to the current study.

In the Ecological Systems Theory, five types of environmental systems that surround a child are identified, namely: the micro-system, meso-system, eco-system, macro-system and chrono-system (Addison, 1992). The dynamic system view is that a child's mind and body, and physical and social worlds, form an integrated whole that influences the development of new skills and knowledge (Brewer, 2007). The ecological systems theory can help to understand interpersonal factors (knowledge and skills), interpersonal factors (social support and influence) and the community (health policy and a community and parent's ability to promote health) (Higgins *et al.*, 2009).

Bronfenbrenner's theory provides a theoretical framework regarding building stronger parental involvement in health promotion. Figure 2-2 presents an overview of the theory, which I explain in the sections that follow.

Figure 2-2: Bronfenbrenner's Ecological Systems Theory



(Guy-Evans, 2020)

2.10.1 The Micro-System

The direct environment in which a child is intimately involved and learns about the world is referred to as the micro-system. A home and a school are thus the micro-system of the child. Within this micro-system, the child experience a feeling of security and trust are developing with certain people within the system. Furthermore, in this micro-system, a child can create a healthy life and personality (Swick & Williams, 2006). Safe and nurturing surroundings affect children's health and wellbeing positively (Sorte *et al.*, 2011). According to Stack (2005), barriers that can affect a child's holistic health in the micro-system include the stress of parents going through divorce, poverty and unemployment.

2.10.2 The Meso-System

The meso-system represents the relationships between settings that revolve around a child (Stacks, 2005). This system involves interaction with people in the micro-system (Clampett, 2016) as what takes place in the micro-system influences what happens at school and vice-versa (Clampett, 2016). Shumba, Rembe and Pumla (2014) emphasised that the interactive relationship between parents and teachers will result in the influence of the meso-system. If an effective, communicative relationship exists, then a child will experience a safe environment within the meso-system.

Communication plays an essential role as the quality of communication between stakeholders such as the parent, school and community, and the social interaction between the stakeholders form an important aspect of a learner's development (Mashau, 2019). The family system, peer group, school and community interact with other micro-systems and influence each other (see Sections 2.7 and 2.9.3). This layer provides a connection with the structures of a child's micro-system (Berk, 2000).

For this study, I focused on the micro-system and meso-system as these systems have the most significant influence involving parents (see Sections 2.7 and 2.9). The family structure is changing because of urbanisation and, where both parents work in the city, often grandparents look after the children. In child-headed homes, children look after children. The diversity in family structure, teenage pregnancies, unemployment and poverty have significant effects on parenting and the collaboration between parents and other role-players. From the situations described above, it is clear that the parent's health literacy would influence health promotion and the health literacy levels of a child.

2.10.3 The Exo-System

The exo-system influences a learner's development as this system forms part of the structure where decisions are taken (Bronfenbrenner, 1994). This system includes the parents' workplace, extended family members, policies from the Department of Health and the Department of Basic Education such as the Integrated School Health Policy (ISHP, 2012) and the School Health Policy (SHP, 2003). A child does not interact directly with these departments; the involvement of the departments affects and influences children's development (Chinhara, 2016).

The exo-system will be beneficial if the community has enough resources available for the promotion of health development of children. However, if parents are at work and grandparents or guardians are not available to look after the children, the experience is the same as a child-headed home. Parents status at work demand them to work long hours, and they come exhausted at home and are not always able to attend critical parent's meetings at schools (Swick & Williams, 2006).

2.10.4 The Macro-System

Bronfenbrenner (1994) explained that the macro-system is the larger and broader context that is furthest from the child. More importantly, decisions taken within this structure affect learner development. All systems function within the macro-system. Furthermore, the macro-system embodies the morals, beliefs, values, and traditions shared among people and the laws and policies developed by the national departments (Onchwari *et al.*, 2008). The macro-system involves socioeconomic structures, social determinants of health as well as ideas and values that might be influenced by the other levels of the system. The learner's health and wellbeing are influenced and threatened during the economic depression when a decreases an experience in health care (Sorte *et al.*, 2011). The decentralised power of provincial and districts can slow down the implementation of health promotions policies as they operate at a different level and pace than school's bodies (Wildeman & Nomdo, 2007).

2.10.5 The Chrono-System

The chrono-system represents environmental changes over time (Bronfenbrenner, 1994). As mentioned by Hosek *et al.* (2008), the changes that occur over time within one of the layers of the exo-system can affect learner development. The chrono-system encompasses the changes when a child leaves home to attend school. Swick and Williams (2006) explained that the chrono-system also includes transitions such as chronic illness (cancer, HIV/AIDS, diabetes), death or divorce (see Section 2.10.5).

The above explanations about the relationship between systems indicate the effects that these systems can have on the health and development of a child. Research has shown a relationship between school achievement and family factors (Manganello, 2008).

2.11 Chapter Summary

In this chapter, I have reported the findings of a review of literature about health promotion and health literacy in schools. I discussed the concept of health promotion from a global and South African perspective before moving to the policies that guide health promotion and the problems that have been encountered in their implementation. In the second part of this chapter, I discussed the concept of health literacy and the parent's role in it. Lastly, I discussed the social determinants of health and the Ecological Systems Theory that informed this study. In the next chapter, I provide a theoretical discussion of the methodology that I followed in this study.

CHAPTER 3: RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction

The chapter focus on the overview of the methodology used in this research by focusing on the method and design, population and sampling, the role of the researcher, data collection methods, data analysis and elements that contribute to the trustworthiness of this study. This chapter also focuses on the ethical considerations regarding qualitative research.

3.2 Research Aims and Objectives re-examined

I used the following questions to guide this study. The primary research question was:

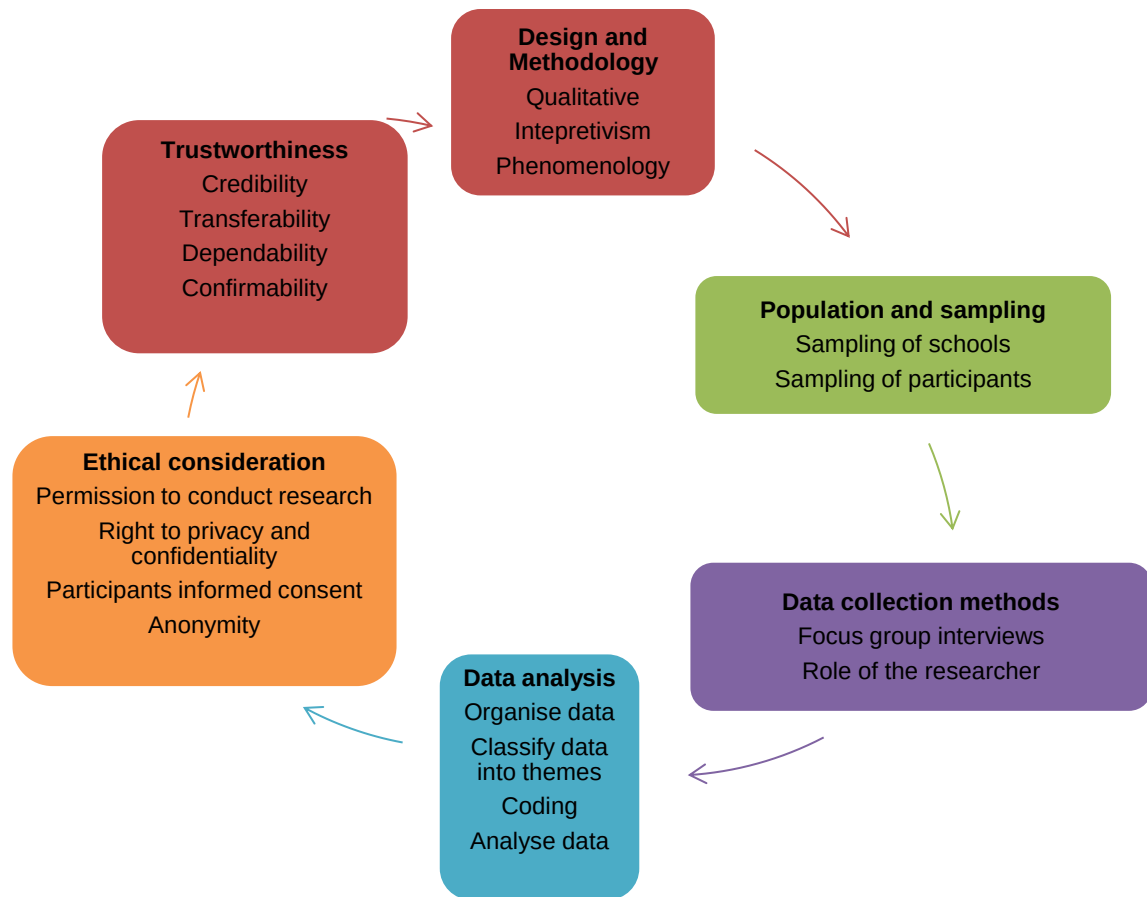
- How do parents of secondary-school learners perceive and construct their health literacy?

I formulated the following secondary research questions in order to explore the primary question systematically:

- What knowledge, skills and attitudes do parents possess about the concepts of health and health promotion?
- What factors are perceived as barriers to supporting health promotion activities in the school?
- What suggestions do parents have for overcoming the stated barriers to support the health of their children in secondary schools?

Figure 3-1 illustrates how this study was executed.

Figure 3-1: Qualitative study



Source: Adapted from (Mashau, 2019).

3.3 Research Methodology

Research methodology is based on the paradigm according to which a study is carried out and includes the methods used, such as the recruitment of participants, data generation and strategies for data analysis (Nieuwenhuis 2007:70).

3.3.1 Research Paradigm

Lichtman (2010) defines a paradigm as the way we view the world. A paradigm of an individual is related to his world assumptions, philosophy about life and one's role in it. Johnson and Christensen (2008:33) indicate that a paradigm is a perspective about research held by a community of researchers based on a set of shared assumptions, concepts, values and practices. Interpretivism is seen as an approach that emphasises the importance of interpretation and observation in making sense of the social world (Bryman, 2012).

Cohen *et al.* (2007:19) stated that the role of the researcher in the interpretivist paradigm is to “understand, explain and demystify social reality through the eyes of different participants”. In Interpretive studies, an attempt is made to explain phenomena through the meanings that people assign to them (Cohen *et al.*, 2007:19). The aim of interpretivist research is to offer a viewpoint of a situation and “to analyse the situation under study to provide insight into how a particular group of people makes sense of the phenomena they encounter” (Nieuwenhuis, 2016:60).

According to Nieuwenhuis (2016:61), an interpretive paradigm is based on the following epistemological and ontological assumptions:

- Human life can only be understood from within: how people interpret and interact within their social environment.
- Social life is a distinctively human product: observing people in their social contexts is important to understand and interpret the meanings constructed.
The human mind is the purposive source or origin of meaning: insight is gained into the meanings communicated and thereby improves our comprehension of the whole through uncovering how meanings are constructed.
- Human behaviour is affected by knowledge of the social world: realities can differ across time and place.

The social world does not exist independently of human knowledge: Our own knowledge and understanding of phenomena constantly influence us. To conceive the world, therefore, as external and independent from the researcher’s own knowledge and understanding is to ignore the subjectivity of the researcher’s actions (Nieuwenhuis, 2016:61).

The aim of this interpretive research for this study was to offer a perspective on a situation and to analyse the situation, to provide insight into the way in which parents of secondary-school learners understand and construct their health literacy.

3.3.2 Research Design

I followed an exploratory design for this study, using qualitative methods. According to Horn (2009), a qualitative approach provides a source of possibilities to learn more about individuals and people. According to Aspers and Corte (2019), qualitative research is an in-depth study where the researcher aims to understand the essence and core of an unknown phenomenon. Qualitative research is context-bound, which implies that the phenomenon is investigated in the context in which it occurs. Louw (2003) stated that qualitative research begins with anticipated problems, which can be re-defined during the fieldwork stage. Such problems are usually common questions

about whom, why and how things happen. Since limited research had been done in South Africa about parents and health literacy, a qualitative research method enabled me to explore this phenomenon in greater depth.

Creswell (2014) suggested four assumptions of qualitative research:

- The researcher focuses on the process rather than the product of the research.
- Qualitative research aims to discover the meaning that a person gives to his/her experience.
- The researcher is the primary tool when it comes to collecting and processing data because the majority of the data collection is dependent on their involvement in the research (Flick, 2009:106).
- Qualitative research is inductive, which implies that the researcher comes to certain conclusions, insights and hypotheses during the process. This suggests that the researcher must be open and receptive to new information, insights and perspectives.

The aim of this study entailed exploring the experiences, perceptions and understanding that parents have about health and health promotion in schools to determine their health literacy. I adopted a qualitative research method to help me understand the phenomenon from the parents' point of view.

3.4 Sampling

Depending on the scope of a study, including an entire population is impossible (Maree & Pietersen, 2007:172). Therefore, a researcher makes use of sampling. According to Maree and Pietersen (2007), sampling entails selecting a few people from a population to represent the entire population. A sample for a study can be chosen in various ways, and in the current study, purposive sampling was utilised (Nieuwenhuis, 2016). Purposive sampling entails choosing members of a sample for the purpose of representing a critical criterion about a group phenomenon (Henning *et al.*, 2011). I used purposive, intensity sampling to provide rich information about the phenomenon of health literacy among parents with secondary-school children.

3.4.1 Sampling of Schools

I selected the secondary schools for this study from the Dr. Kenneth Kaunda Education District surrounding Potchefstroom. The Department of Education requested the Faculty of Education to assist in a developmental programme in schools in the Dr. Kenneth Kaunda District. Various meetings were held where school principals, and members of the Dr. Kenneth Kaunda Education

District collaboratively voiced their need to assist and develop schools. These schools were situated in socially and economically challenged communities where multiple health risks were prevalent. I viewed this as an opportunity to assist, learn and participate in the development of schools in the North West Province. I received permission from the District Manager to go to the designated schools and visit them to conduct the interviews. Two schools were willing to participate in the study. After this consent, I went to the two relevant principals and the school governing bodies to obtain written consent from them.

Purposive sampling was used in order to select the participants. I considered them to have the relevant knowledge and accurate, appropriate and meaningful information that I needed to answer the research questions (Nieuwenhuis, 2016).

The site-based procedure entailed an initial visit to meet the principals of the two schools selected in the Dr. Kenneth Kaunda District. I used this visit as an opportunity to discuss the research project and to identify possible participants. I gave the following criteria to the principals, as mediators, to ensure that the participants comply with the following criteria:

- The participants should be the biological parents and/or official caregivers of the learners at a secondary school;
- The participants must have had a child in the school for more than two years; and
- The participants must speak and understand English.

I approached the school principals (mediators), who made arrangements with the participants to explain the procedure. Ten parents from each school volunteered and met the criteria. I then built a rapport with the parents who participated in the study by introducing myself and providing them with a detailed explanation of the research. After the participants gave consent to be part of the study, I commenced with the data collection process. Table 3.1 gives the biographical data of the participants.

Table 3-1: Participant demographic information

Participant	Position	Gender	Race	Home language	Grade of learner	Social-economic class
School A						
P1	Parent	Female	White	Afrikaans	10	Middle
P2	Parent	Female	White	Afrikaans	10	Middle
P3	Parent	Male	White	Afrikaans	10	Middle

P4	Parent	Female	White	Afrikaans	10	Middle
P5	Parent	Female	White	English	10	Middle
School B						
P1	Parent	Female	Black	Setswana	10	Low
P2	Parent	Female	Black	Setswana	10	Low
P3	Parent	Female	Black	Setswana	10	Low
P4	Parent	Female	Black	Setswana	10	Low
P5	Parent	Female	Black	Setswana	10	Low

For the sake of confidentiality, pseudonyms were used, and the participants were referred to as P1, P2 and so on.

3.5 The Role of the Researcher and the Researcher as an Instrument

As the researcher, I formed an integral part of the research process and, more specifically, the data collection. Furthermore, my role as the researcher was to integrate the theoretical and practical application of the study. During the research process, my role was to develop dialogical processes and practices to create opportunities to explore and understand how parents perceive and construct their health literacy. I combined oral data with observation as a data-gathering technique during the focus group interviews (Nieuwenhuis, 2016). Furthermore, I ensured that all viewpoints expressed were recorded and aligned with the research questions of this study. During qualitative research, the researcher is the primary instrument for collecting and analysing the data. It is necessary for the researcher to be interpretive (Terre Blanche *et al.*, 2006).

3.6 Data Collection Methods

The research field is entered by the researcher the moment when data collection take place with the purpose of collecting information that will give answers to the studies research questions (Creswell, 2014).

Various methods of data collection existed, but when utilising qualitative data collection, it involves interviews with participants, document analysis, and observations. When dealing with this method, it includes historical analyses, surveys and case studies (Savenye & Robinson, 2004). In this study, I use the following data collection methods: focus group interview, observation and document analysis.

3.6.1 Focus Group Interviews

According to Clifford *et al.* (2010), a focus groups interview is seen as a group of individuals who gather within an informal environment where a researcher discusses a specific topic with the group and shares their knowledge and experience regarding the topic. A focus group strategy is based on the possibility that group contact will be productive in widening the range of responses, activating forgotten details of experience and releasing inhibitions that might otherwise discourage participants from disclosing information (Nieuwenhuis, 2016). An advantage of focus group interviews is that there is an opportunity to observe a significant amount of interaction about the research topic for a limited period of time and are based on the researcher's ability to assemble and direct focus groups (Mishra, 2016). Nieuwenhuis (2016) stated that the researcher must bear in mind the size of the groups. There must be sufficient groups and participants that will participate in preventing the focus group from collapsing if participants choose to remain silent. On the other hand, large groups require higher participation and skills.

Furthermore, focus group interviews are conducted informally and consist of small homogeneous groups (Maree, 2011). Open-ended questions should be asked to allow the participants to express themselves and give their views on the topic (Maree, 2011). The role of the researcher is to facilitate the process and also act as a generator for the conversation (Bloor & Wood, 2006:88-89; Brotherson, 1994:101-118; Calderon *et al.*, 2000:91-95; Clifford *et al.*, 2010).

An interview guide was compiled informed by the themes identified in the literature review. Merriam (1998) explained that interview guides are part of qualitative research, and they are focused on several specific questions and open-ended questions that allow the researcher to follow up with enquiries (see annexure 5 interview questions).

3.7 Data Analysis

Qualitative data analysis is seen as the process where meaning is obtained from the data gathered during a researcher collection phase (Bryman, 2012). According to McMillan and Schumacher (2001), data analysis is used to transform data, collected through interviews, observations and document analysis, into information with which to answer the primary research question. Qualitative data analysis required me to organise, place and prepare the data methodically in writing and to classify the data into themes and sub-themes (Creswell, 2014).

In order to analyse the data, I had to engage in more reading, using the field notes I collected during the focus group, and I made use of colour codes by highlighting corresponding responses

in certain colours. In order to develop themes and sub-themes, the similarities and differences, as well as unique findings, were identified (Creswell, 2014).

Creswell (2014) outlined six data analysis steps as follows:

- Bracket the researcher's own experiences for the purpose of taking a fresh approach to the data;
- Through reading the transcripts, you become more familiar with the data;
- Identify significant statements which indicate the experience of participants about the phenomenon;
- Develop themes and sub-themes from the statements;
- Write verbatim descriptions of what the participants experienced; and
- Write about the crux, which describes the common experiences of participants.

I determined different themes and sub-themes on how do parents of secondary school students perceive and construct their health literacy. Additionally, data were checked against the literature to regulate the trustworthiness of my study.

3.8 Trustworthiness

Validity and trustworthiness are two critical aspects of research since they contribute to the credibility of the results (Merriam 2009). To assure the trustworthiness of this research project, I applied the work of Creswell (2005) and other qualitative researchers (Botma *et al.*, 2010:232-235; Nieuwenhuis, 2007; Lincoln & Guba, 1985). The following aspects were relevant to this study: credibility, transferability, dependability and confirmability, as summarised in Table 3-2.

Table 3-2: Measures are taken to ensure the trustworthiness of the project

Epistemological standards	Strategies for trustworthiness	Researcher's application in the study
Truth value	Credibility • How congruent are the findings with reality? • How will I ensure that the reader will believe the findings?	• Used interview schedule to pursue all information possibilities. • Adhered to ethical requirements.

		• Clarified understanding throughout focus group interviews to ensure accuracy and fullness of data. • Made general field notes.
Applicability	Transferability • Can the outcome be applied to other cases?	• The context was described clearly and combined with specific demographic information of each school. • The sample consisted of knowledgeable representatives of the population. • Transferability refers to making detailed and rich descriptions of the setting, the process of data generation, analysis, and the use of bracketing to keep the participants' viewpoints separate from my own.
Consistency	Dependability • Focus on methodological rigour and consistency.	• To ensure that there is dependability, there was a clear chain of evidence. • Recorded and described data accurately.
Neutrality	Confirmability • Concerns about my preference and influence on the study	• Verbatim accounts were used to ensure that confirmability took place. • Full disclosure of the research process included limitations of the study and ethical considerations throughout the study.

Source: Adapted from (Creswell, 2005; Botma et al., 2010:232-235; Nieuwenhuis, 2007; Lincoln & Guba, 1985).

3.9 Ethical Considerations

Ethics are defined by O'Neil and Norris (2006:184) as the pre-determined rules or standards for the proper conduct of participants in a profession. Therefore, possible ethical conflicts exist regarding how a researcher gains access to a community group and the effect the researcher might have on the participants.

Given the above statement, I followed the correct ethical procedures to obtain consent to conduct this research.

3.9.1 Permission to Conduct Research

Firstly, the District Manager of the Dr. Kenneth Kaunda District provided permission to conduct the research project at schools in the district. The District Manager approved documents relevant to the research (see Annexure 1). Additionally, this research project was conducted according to the ethical requirements of the Research Ethics Committee of the North-West University. The committee approved all relevant documents and provided an ethics certificate, number: NWU-00779-18-S2 (see Annexure 2). I did obtain informed consent from the participants as required for all research where identifiable participants are part of a research project, especially given the probing nature of qualitative research (Richards & Schwartz, 2002:135-139). Orb et al. (2001:93-96) mentioned that an important ethical principle closely associated with research is beneficence, doing good and preventing harm to others. Based on these principles, participants received an information sheet that explained the aims and objectives of the research and the procedures followed in conducting the research (see Annexure 3). All the aspects of the research were explained by the researcher to the participants beforehand. This was done to ensure that participants were fully informed and completely understood what the research entailed. Together with the information sheet provided to the participants, the participants received a consent form and were completed it on the day of the interview (see Annexure 4).

3.9.2 Right to Privacy and Confidentiality

In line with the ethical principles of educational research, I obtained written consent from all the participants before conducting the focus group interviews, as well as consent for the interviews to be recorded and notes to be taken. In order to secure the privacy of the participants, I took extra care to make sure that the participants were comfortable with my taking notes.

Although participants might not be completely anonymous, their identity was protected by not mentioning their names during the interview, in the findings or in the final report.

To ensure confidentiality, I implemented appropriate measures to prevent disclosure of information that might identify the participant either during the research or afterwards, e.g. by making data anonymous or pooling results. Only I had access to the respondents' personal information while collecting or analysing the data, and this information will not be shared in a way that would identify individuals. Privacy is limited in a focus group, but data were reported anonymously. No names were used whatsoever. The participants were informed about anonymity and that there would be no way to identify any participant from the information provided. This was done by separating the personal information from the survey response. If some of the participants used personal names or identification of some kind, these were removed from the data.

3.9.3 Participants' Informed Consent

I went to the relevant schools' principals and the school governing bodies and obtained oral and written permission from them. Following this permission, the principal (mediator) I pointed out ten parents who met the requirements as previously mentioned. Before the interviews, confidentiality was guaranteed by ensuring that the participant gave informed verbal and written consent after the participant was fully informed about the scope of the study. Privacy was limited in a focus group, but the data were handled confidentially. The participant's identity was protected by not mentioning his/her name, the school's name or any other names that were mentioned during the interviews or in the findings and the final dissertation.

The participation was voluntary, and the participant may withdraw at any time without giving reasons to do so, and the withdrawal from the project was not held against the participants. Before the interviews, confidentiality was discussed, and the researcher ensured that the participant gave informed verbal and written consent after the participant was fully informed about the scope of the study.

3.9.4 Participants' Protection from Harm

This study involved minimal risks. It was possible that participants might share their personal experiences with me. Thus, the name and information of the school or sensitive parties might be shared. This reliable information about the opinions that the participants might have shared could have resulted in them being admonished by the board members of the school. The case also might occur where sensitive information from parents is shared.

3.9.5 Benefits for Participants

The participants' knowledge about health, health promotion and health literacy could be broadened by the information that they receive from this research, making them aware of what

health entails and what their role is in the school system. Parents can act as leaders in the community in terms of health promotion and so affect other role-players in the community. The findings could make the Department of Basic Education aware of parents' knowledge and skills regarding health literacy. Furthermore, any reader who comes into contact with this research will be made aware of the status of health promotion in South African schools. The skills and knowledge of the school and the parents of the learners could be broadened and improved in terms of health, health promotion and health literacy. The school could then serve as a health promoting school in their society, thus improving their environment and serving as an example for other schools.

3.10 Chapter Summary

The research process that I used was explained in this chapter. I explained the research design and methodology, population and sampling, the role of the researcher, data collection methods, data analysis, ethical considerations and trustworthiness. In Chapter 4, I present a critical discussion of the findings.

CHAPTER 4: DISCUSSION OF FINDINGS

4.1 Introduction

The main purpose of this research was to explore and understand how parents, as key role-players in schools, perceive and construct their health literacy. In chapter 3, I presented an overview of the research process that I followed during this study.

The purpose of this chapter was to report on the findings of this qualitative study. I used focus group interviews to collect data about the experiences of ten participants from two secondary schools in the Dr. Kenneth Kuanda Education District surrounding Potchefstroom, representing how parents, as key-role players in schools, perceived and constructed their health literacy.

4.2 Analysis and Reporting

I gathered data to achieve the objective of this research study which was to improve health promotion in schools through a better understanding of how parents, as key role-players in schools, perceive and construct their health literacy.

4.3 Discussion of Themes

The data reflected on four main themes and each theme are explained with supporting evidence by referring to the data and justified by theoretical support.

The following themes emerged:

4.3.1 Theme 1: how parents perceive health and define health promotion

The first two questions (refer to Annexure 5) were aimed to understand how parents of secondary school learners perceive health and health promotion.

The first question on the open-ended questionnaire was: How do you perceive health?

The definition is differently interpreted by the participants. From my point of view, I perceive *health* holistically and, thus, extend the bio-psycho-social-spiritual view to include the ecological and metaphysical contexts of health as well as its determinants. It is important to include the following aspects when perceiving health: physical, mental and social-emotional health and interventions to keep a person physically, mentally, socially and emotionally well.

All participants (ten participants) had different interpretations of the term health. Six participants perceive health as holistic, and four perceive health as the absence of disease. The participants perceive health as a basic responsibility concerning and affecting the care, welfare and proper development of their children.

It is important to acknowledge the social determinants of health in a diverse country such as South Africa. It is clear that a number of factors such as general socioeconomic, cultural and environmental conditions, social and community networks and individual lifestyle factors may influence an individual's health literacy.

The participants had different ways that they perceived health, stemming from their own experiences. This is highlighted from the responses quoted below:

P1: *“On a person’s physical, mental, social, emotional and how to maintain it.”*

P2: *“Health is to be healthy.”*

P3: *“State of wellbeing of the whole self includes hygiene, nutrition, exercise, mental wellbeing, body functions a state of being free of illness or injury.”*

As mentioned in Chapter 2 (paragraph 2.2), health is a concept that is open to multiple explanations. Differences in interpretations of health are influenced by cultural views, age, gender, social class and nationality (Naidoo & Wills, 2000:6,17-20). Naidoo and Wills (2000:6–7) argued that a definition of health should be holistic in nature and should include physical, social, emotional, mental, spiritual, societal and environmental dimensions and aspects of the self.

Question 2 asked participants to define promotion of health

With regard to *health promotion* in this study, the holistic approach of Naidoo and Wills (2000:6–7) has informed my thinking about health, as well as the notion that health promotion is controlled by, and is thus the responsibility of, individuals such as parents. Health promotion describes an individual's activities to prevent ill-health and diseases and increase the community's wellbeing.

According to the participants, health promotion is the responsibility of different stakeholders such as parents, school (P1 & P2), teachers and community. The participants' focus was on the role the school must play towards improving health promotion.

P1: *“learners must be taught about the important of exercising.”*

P2: *“They should also be taught about hygiene, healthy eating and the importance of health.”*

As explained in Chapter 2, schools play a vital role in health promotion settings as young learners spend more than one-third of their day at schools (Pearson *et al.*, 2015). At schools, learners can gain knowledge, skills, and values to be healthy and avoid health problems (St. Leger & Nutbeam, 2000:258). Health Promotion Schools can help learners improve their lives (JICA, 2007:3). Schools are a complex social system that can influence the activities and how they function to promote the health of those who work with the school (Rowling & Rissel, 2000:249). In South Africa, the development of health promoting schools is a critical strategy to achieve educational goals to promote wellbeing and health in the school community that includes parents, learners, teachers and community members (Department of Basic Education, 2010).

For Participant 2 (P2) and Participant 4 (P4), health promotion is to have informed up to date knowledge about health to make an informed decision.

P2: *“Promotion of health is for me to improve constantly your own ideas and knowledge about health because everything is changing. What we thought ten years ago is healthy is now all of a sudden not healthy we need to drink other stuff and do other stuff, and I think that promotion of health is to improve everyone’s health but to start at yourself and your knowledge of your own body.”*

“so the promotion of health for me is keeping my own knowledge updated, and so everyone around your health promotes through that information the disseminate between the people.”

P4: *“Knowledge, you need to be informed. You need to have enough knowledge to know if you are making good or bad decisions.”*

Health promotion refers to a holistic activity (process) to assist, guide and empower someone to be able to take control of his/her health to attain a state of physical, mental and social wellbeing. To reach a state of complete mental, physical and social wellbeing, a group or an individual must be able to identify and realise objectives to satisfy needs and to cope with developments in the environment. Therefore, health promotion in schools should be regarded as a way of trying to address unhealthy lifestyle choices and improve the attainment of the relevant Sustainable Development Goals (SDG). It is thus the joint responsibility of parents, teachers and the community.

It can be concluded from the current study that social determinants of health and, according to Bronfenbrenner, wellbeing and health of children are strongly influenced by *the* knowledge about the promotion of health and behaviours of their parents that set the example of health promotion.

4.3.2 Theme 2: the nature and scope of the knowledge and of parents concerning health promotion

Question 3 (refer to Annexure 5) was aimed at what knowledge parents need to have about health and health promotion.

During the focus group interviews with the participating parents, I explained the terms “knowledge” and “skills” with examples, but the parents were still unsure and struggled to answer this question.

Judging from the answers the participants gave to the question, the literacy levels of parents could be a barrier to health promotion because the parents lacked the necessary health knowledge, skills, attitudes and practices.

Participant 1 (P1) implies that parents have an important part to play in the health and health promotion of their children.

P1: *“Parents must know how to build a healthy relationship in order to enforce a balanced meal and healthy activities for their child.”*

For Participant 3, knowledge is more about wellness. As discussed in Chapter 1, wellness is established on the building blocks of health, nutrition and safety. For this participant, nutrition knowledge is very important.

P3: *“Skills so your child can stay healthy it will be like nutrition.”*

According to Participant 5, the decision-making skills and health knowledge of their child are important. The degree to how the parent can obtain processing and understanding of the basic health information and services, a parent need to make appropriate health decisions and how they can apply this knowledge in raising their children.

P5: *“Parents need to identify when their child is sick. They also need to be able to identify warning signs of health or mental issues in order to keep their children safe and to get them the help that they might need. Parents need to be aware of health options that are available and preventative health options. Parents need to have access to health information that can create awareness that leads to good wise decisions.”*

Parents’ knowledge is multi-dimensional (Winter *et al.*, 2012) and can be described as parents understanding of a child developing milestones as well as the process and phases of child development and how a parent need to care for their children during their developing (Benasich & Brooks-Gunn, 1996:1187). Therefore, parents are seen as key role players during the different

developing phases of their children. Parents need to take care of their children so that a child be able to reach milestones during each process.

P2: *"I think it is all about the basics. In general, the wellbeing of your kid so that when there is something troubling him or her, you will be able to spot that. And they should also be taught the basics of first aid so that when any learner experiences any problem, they would be able to help."*

Parents need basic health knowledge to make informed decisions to prevent risks regarding their children's health. To conclude, if you don't have basic health knowledge, you put your child at risk.

Question 3 (refer to Annexure 5) asked participants: According to you, which skills do parents need to acquire in order to promote their children's health?

Parents' skills are a significant factor that guides children into health education as they inform children's negative and positive behaviours with regard to health and health promotion.

Participant 2 (P2) and Participant 3 (P3) stated that parents should have communication skills:

P2: *"I think the important part is communication. Parents need communication skills."*

P3: *"Skills what a person need is to listen. You need to communicate with the person like your child, and you need to listen and understand what your child is saying and see the signs."*

As emphasised by (Mashau, 2019), the quality of communication between the parent, schools and the community (after-care centre, church and library) and social interaction with peers play a role in developing a learner. The family system, peer group, school and community interact with other micro-systems and influence each other (see Sections 2.7 and 2.9.3). This layer provides a connection with the structures of a child's micro-system (Berk, 2000).

Fine and Hicks (2008) explored the role of health programming, seeking to identify effective practices and services required to support the promotion of healthy development for children and families. Collaboration between the teachers and parents increase the wellness concept that teachers at school teachers and families will reinforce these concepts at home. Such a relationship serves as an invitation for families/parents to be involved in the process of their child's education at school. The relationship provides a mechanism for parents to inform teachers about how families can help to promote the communication of health literacy, of which role modelling is an essential element (Sorte *et al.*, 2011).

P1: *“that the skill that the parents need is to be able to show the kid what has to be done. Like washing your hands, cleaning your house, so that it can be much easier for kids to adapt from their parents.”*

P3: *“You must show them what to do. A parent should lead by example”*

P5: *“Parenting skills are important, we need to be able to create routine and exercise, and boundaries and then in self-control is also very important if we don’t have healthy habits if we do bad things it is the first place our kids see it. Self-control and parenting skills I think it is your child’s first exceptions on how they perceive the world and realistic expectations.”*

From the answers above, the participant has a holistic view regarding health promoting skills. From the preliminary literature review that I carried out for this study, it was clear that it was necessary to focus research on how parents perceive and construct their health literacy. Such research can provide valuable insight into enhancing parents’ health literacy to communicate information about health effects to their children and to support healthy behaviour development through role modelling. Empowerment entails facilitating self-control, improving knowledge and skills, strengthening self-esteem and self-image.

4.3.3 Theme 3: possible barriers that the parents are encountering in their health promoting activities and possible solutions by parents to overcome the stated barriers.

This theme focused on factors that might contribute to parents’ experience of barriers in the promotion of the health of their children. It is important to understand the experiences and barriers parents have and that intervention steps, communication and training can be provided for parents to help understand health and health literacy and how to overcome barriers that might exist. As seen in Chapter 2, possible barriers are poor nutrition; poverty; environmental factors, such as insufficient water and sanitation; illness and disease; and disabilities. The five areas identified by the Ottawa Charter (1986), skills, policies, environment, community and service, are used as a framework for possible solutions to overcome the stated barriers.

Question 5 asked which factors might contribute to parents’ experience of barriers in the promotion of the health of their children.

P1: *“parents lack of time and parental presence.”*

P3: *“The relationship between parents and but mostly for me it is time you know our lives are so chased as I can say it works it is back home there are some times they still busy with the school you don’t see them that much. Time for me, it is a big barrier.”*

P4: *“Barrier is time in our rushed life we don’t have time.”*

According to Participant 1, Participant 3 and Participant 4, the relationship between their children and not having enough time is a barrier in their health promoting activities. If parents are at work and grandparents or guardians are not available to look after the children, the experience is the same as a child-headed home. Parents status at work demand them to work long hours, and they come exhausted at home and are not always able to attend critical parent’s meetings at schools this is influenced by the eco-system (Swick & Williams, 2006). This has direct involvement in the micro-system of Bronfenbrenner’s ecological systems theory. This is the direct environment in which a child is intimately involved and learns about the world. A home and a school are thus the micro-system of the child. The microsystem for the learner is the school and home and the context where the learner feels job security and trust. A learner learns how to create a healthy life (Swick & Williams, 2006). Safe and nurturing surroundings affect children’s health and wellbeing positively (Sorte *et al.*, 2011). According to Stack (2005), barriers that can affect a child’s holistic health in the micro-system include the stress of parents going through divorce, poverty and unemployment.

As discussed in Chapter 2, Dahlgren and Wheatheadd (1991) model identified determinants of health and these determinants could be implemented and utilised at schools and home. Sorte *et al.* (2011) stated that families are the primary teachers of their children, and the parents have a significant influence on a child’s wellbeing. They furthermore mention that the traditional family structure is changing continuously. Within this changing structure, another crucial aspect to take into consideration is the number of families with two working parents is increasing as more mothers’ joins the workforce (Sorte *et al.*, 2011).

P5: *“Barriers come from the environment the lack of community involvement and support structure lack of access to schools, doctor’s, clinics, hospitals, information and knowledge.”*

The environment, the lack of community involvement, support structure and the lack of access, information and knowledge is seen as a barrier in health promoting activities by Participant 5. The social challenges in the environment might limit a parent’s ability to create a healthy environment and pursue healthy lifestyles (Ataguba *et al.*, 2011). In South Africa, children of poor families are born into an unhealthy environment, where contaminated water, lack of suitable sanitation,

polluted air, toxic hazards and degraded ecosystems are all important environmental risk factors (World Health Organisation, 2017). Basic needs are often not met, and this places them at a disadvantage.

According to Bronfenbrenner's theory, the meso-system represents the relationships between settings that revolve around a child (Stacks, 2005). This system involves interaction with people in the micro-system (Clampett, 2016) as what takes place in the micro-system influences what happens at school and vice-versa (Clampett, 2016). Shumba, Rembe and Pumla (2014) emphasised that the interactive relationship between parents and teachers will result in the influence of the meso-system. If an effective, communicative relationship exists, then a child will experience a safe environment within the meso-system.

Question 6 asked what would you as a parent perceive as possible solutions to overcome stated barriers to the promotion of health of your children

The way that parents want to solve the barriers and solve problems regarding the health promotion of their children are important. Possible solutions to the barriers may have a positive or negative influence on their children if a parent or both parents together choose the incorrect process of solving barriers of health and health promotions of their children. To overcome the barriers, parents need to apply a holistic approach. To be able to apply a holistic approach, parents need to be more educated regarding health promotion and the positive and negative consequences of their decision-making with regard to the health promotion of their children.

Parents act as role models for their children, and their decisions regard to physical and mental actions influence their children's decisions.

P2: *"Make a greater effort to set an example."*

Participant 2 emphasized to overcome the stated barrier, role modelling by parents is important.

P3: *"I would say to overcome barriers is involvement. If a barrier is time to make food, involve your children in helping with the dinner."*

Participant 3 mentioned being more involved in your child's life, for example, involving the child with how to make a healthy meal.

P5: *"For me, you need to create a healthy environment. If you are in a bad environment, only you can try and improve that. Only you can make discussions to fix it when you need help."*

You need to reach out for help, and if you are experiencing a specific problem with your child, you need to research information in order to make informed decisions.”

According to Participant 5, a healthy environment is important; you can improve your environment by making informed decisions. If you cannot make informed decisions, you need to get help, improve your knowledge to make informed decisions. According to Crondahl and Karlsson (2016), empowerment entails facilitating self-control, improving knowledge and skills, strengthening self-esteem and self-image.

- P1:** *“Some parents are not assisting teachers with the school management with anything. You will find that at some point, the school is requesting the parents to come and check on their kids’ school books or anything other things that might be related to the curriculum. Parents don’t even bother to come. Parents don’t attend meetings that they are being called by the school. So the solution is when the parents can participate and be hands-on, on their kids’ curriculum or anything that might include school.”*
- P2:** *“Teachers, learners and parents must form a pyramid whereby this unity among the stakeholders, so that there can be a better relationship and connection between the three stakeholders.”*
- P3:** *“There must be unity between parents, learners and teachers and there must be a moment where these three stakeholders sit down and come up with ideas that can help us as the school and even kids should be given a platform whereby they come with their grievances so that those grievances can be solved.”*

According to Participant 1, Participant 2 and Participant 3, possible solutions to overcome the stated barriers to the promotion of health of their children is for all the role players (stakeholders) to be involved. Developing a common understanding among stakeholders is essential for a more diverse, realistic and practical intervention for health promotion. Stakeholders must develop a common shared understanding of a diverse, practical and realistic intervention for health promotion. If this common understanding is lacking between the stakeholders, it becomes a barrier to the successful implementation of strategies for health promotion (Gugglberger & Dur, 2010: 37-43; Mohammadi *et al.*, 2010; St. Leger and Nutbeam, 2000; World Health Organisation, 1996:5).

4.3.4 Theme 4: how can parents collaborate with the school to promote the health of their children.

From the theory, there are different ways how to involve/collaborate stakeholders in health promotion, but as mentioned in Chapter 1, research to date fails to explain how parents can be collaborating with schools to promote their children's health. From my point of view, I see health education starting at home as children's first experience is at home with their family, their second experience is within the community and later on at school as seen from the Ecological theory. It is important that communication take place between the relevant parties regarding the education of children and their health.

Question 7 (refer to Addendum) asked participants in which ways do they think they can collaborate with the school to promote the health of their children.

P1: *"Make positive connections with other parents of your school. Communicate with the school on a regular basis about your child's health and attend school events."*

Participant 1 emphasised parental involvement in the school and communication with the school.

P2: *"To make sure that you are involved at the school is very important."*

Like Participant 1, Participant 2 also states parental involvement can help the school to promote the health of their children. Fine and Hicks (2008) explored the role of health programming, seeking to identify effective practices and services required to support the promotion of healthy development for children and families. Collaboration between teachers and school increases and reinforces wellness taught at schools and home. In addition, this collaboration between parents/families serves as an invitation to their child health education at school and can be utilised as a mechanism for a parent to inform teachers on how families can promote communication of health literacy (Sorte et al., 2011).

P3: *"Communication is important between you as a parent and the school so that they know what problems your child is facing, if it is mentally or if your child is slow to listen to the teacher must know about it."*

P5: *"Firstly it is our responsibility to make sure the information comes from us first secondly we need to provide the school with the right information making sure that we report incidents that we tell the teachers about conditions our kids might have obviously they cannot provide support if they do not know unfortunately weather they provide support or not it is not really up to us that is them, and then we need to also try to take part when*

something is offered I am guilty of it any time anything is offered from the school health-wise it is a no unless it is an eye test.”

Participants 3 and 5 said that communication between the different role-players is important. It is clearly stated by Nyama (2010:87) teachers need to know learners' backgrounds, the norms and values of the family and community to create a positive relationship with parents of learners.

P1: *“I think personally the school and me it would be being involved in matters that involve health, for example, being on the committees that can influence the type of food/nutrition that is the food that the kids get to buy at the tuck shops this is just an example, or it could be in sports activities where it is not just physical activities the kids will be exposed to but the kids will also might get an opportunity that there to know to lead a healthy balanced lifestyle where they can maybe the couches or whoever is assisting them will also give them a typical example will be what to eat as an athlete and what food not to eat and so on so being involved with platforms that do existed that involve parents and the school and I think from the community side as well weather it is churches, or any other organisation that one is involved in that could also be a part from that can be used to be part of participating.”*

P2: *“Not all the parents know exactly what is happening in our children lives when they are at school, so I think if we as parents can make time and just give our time back to the school and just get involved in whatever is happening in the schools that you would be able to know what exactly is happening.”*

P3: *“I would also say to get involved more with the projects with the school, more products to get out about health and safety for the children for the grownups for everybody just to learn more to get more involved with there is schools that with a lot of projects so if the parents can involve themselves get some time out with the school with the children to enjoy this these projects.”*

According to Participants 1, 2 and 3, parental involvement is how parents can collaborate with the school to promote the health of their children. While parental involvement in schools is desirable (Conner, 2000), it is not always achievable, but parents can be motivated to participate and support health activities.

As Rowling and Samdal (2013) mentioned, parents' involvement at schools empowers parents, staff, and the learner to utilise existing abilities and strengths but provides parents with a feeling of ownership in the process of decision and practices arising from their involvement with the

school. Walton *et al.* (2010) reported that school policies regarding healthy nutrition are more accessible to implement in socioeconomically disadvantaged schools as a lack of parent involvement exists and may influence long-term impact and gaps concerning parent's involvement. Hornby and Witte (2010:504) found that "the most notable gaps" concerning schools taking the initiative to involve parents "were the lack of specific ideas (on how) to involve parents from diverse backgrounds, the limited focus on parent education, and the minimal training for teachers on working with parents".

4.4 Chapter Summary

In this chapter, I reported on the findings and used verbatim quotations to support them. The aim was to use the findings to answer the research questions of the study, which have been concluded in Chapter 5. A total of ten participants from two secondary schools in the Dr. Kenneth Kuanda Education District surrounding Potchefstroom participated in the focus group interviews. The analysis led to the grouping of sub-themes, and, based on this grouping, four main themes were identified.

In Chapter 5, I have discussed the findings, conclusions and recommendations for further studies.

CHAPTER 5: FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

The purpose of the study was to gain an understanding of how parents of secondary-school learners perceive and construct their health literacy. In this chapter, I present the conclusions and recommendations based on the findings of the qualitative study, as explained in Chapter 4. I have used the findings to address the three secondary research questions of the study that were context-specific. I based the findings on the qualitative evidence from the focus group interviews, as well as evidence from the literature review that was embedded in a theoretical framework that encompassed, firstly, Bronfenbrenner's Ecological Systems Theory (1979) and the adapted version of Bronfenbrenner's work by Addison (1992) and, secondly, the social determinants of health defined by Dahlgren and Whitehead (1991). The literacy level of parents differs, and the socioeconomic status also differs. Health literacy can be influenced by socioeconomic status, cultural background, age, the language we speak, our ability to communicate clearly and listen carefully, past experiences, cognitive abilities and mental health. These factors influence the way an individual communicates, responds to, and understands health information (U.S. Department of Health and Human Services, 2010).

In this chapter, I have presented the conclusions drawn from the primary and secondary research questions, and then I have discussed the recommendations based on these conclusions. The secondary research questions were:

- What knowledge, skills and attitudes do parents possess about the concepts of health and health promotion?
- What factors are perceived as barriers to supporting health promotion activities in the school?
- What suggestions do parents have for overcoming the stated barriers to support the health of their children in secondary schools?

Before providing the recommendations for parents, relevant school stakeholders and the community, I have provided a summary of Chapters 1 to 4.

5.2 Summary of Chapters

I have presented a summary of the coverage of each of the chapters of this study in the sub-section below.

5.2.1 Chapter 1: Introduction and Background

This chapter served to provide the rationale and the problem statement to orientate this study. The research questions and aims for the study were determined from the problem statement and rationale. In this chapter, I outlined the aim of the research as being to explore and understand how parents, as key role players in schools, perceive and construct their health literacy. I stated the research paradigm and theoretical framework that underpinned this study as well. This chapter also contained a short overview of the research design and methodology that were followed and the critical ethical measures that I took during the course of the study.

5.2.2 Chapter 2: A Literature Review

This chapter contained a review of literature about health promotion and health literacy in schools. In this chapter, I presented multiple explanations of health followed by a discussion of the concept of health promotion from a global and South African perspective. Furthermore, in the first part of this chapter, I discussed the policies that guide health promotion and the problems that have been encountered in their implementation. The focus in the second part of this chapter was on the concept of health literacy and the role of parents in it. In this chapter, I presented the Theory of Ecological Systems that informed this study.

5.2.3 Chapter 3: Research Design and Methodology

In this chapter, I explained in detail the data collection methods and the analysis procedures that I used. I explained the scope and limitations of the study as well as the ethical measures I took while conducting interviews with parents.

5.2.4 Chapter 4: Discussion of Findings

In this chapter, I reported on the findings of this study, concluding with an analysis of the findings. The following four themes emerged from these findings:

- how parents perceive health and define health promotion.
- The nature and scope of the knowledge and skills of parents concerning health promotion.
- Possible barriers that the parents are encountering in their health promoting activities and possible solutions by parents to overcome the stated barriers.
- How parents can collaborate with the school to promote the health of their children.

I discussed and justified each of these findings with supporting evidence from literature and empirical research.

5.2.5 The Research Questions Revisited

In this research study, my aim was to answer the research questions. I have presented my conclusions on each of the research questions that I used to guide this study in the following sub-sections.

5.2.5.1 Sub-question 1: What knowledge, skills and attitudes do parents possess about the concepts of health and health promotion?

It is clear from the interview answers that parents, in general, feel that they do not have adequate knowledge and skills to make informed decisions with regard to their children's health and health promotion. They lack different skills such as decision-making skills and basic health knowledge to communicate effectively with their children with regard to health and health promotion.

With regard to **health**, the participants believed that knowledge, how to apply knowledge on health and decision-making skills of their child's health is a multi-dimensional concept as they understand that they need to be familiar with caregiving skills and wellness of their children by providing nutritious food that their children stay healthy. Parents need skills to identify warning signs of health and mental issues of their child, skills to make preventative health decisions and use the information to improve their children's health.

The findings indicated that parents' knowledge about health is important as, without knowledge, they cannot make informed decisions and cannot communicate with their children about basic health information. Basic knowledge prevents parents from putting their child health at risk.

With regard to **health promotion**, the participants have a more holistic approach. The participants believed that health promotion skills would include parental support of behaviour to participate in physical/exercising activities. Parents need skills to communicate with their children about health promotion and listening skills to identify what their children are saying. Self-control is important for healthy habits. The right diet, enough sleep and drinking enough water are important. Parents need to be a role model by practising positive, healthy lifestyles by doing exercises and eating healthy, nutritious food.

5.2.5.2 Sub-question 2: What factors are perceived as barriers to supporting health promotion activities in the school?

During the focus group interviews, the participating parents listed the following factors as barriers to promoting health in school:

- Parents lack time and parental presence with their children. This barrier is a result of a rushed lifestyle. Working hours prevent parents from spending time with their children. As mentioned in Chapter 2, paragraph 2.10.3, according to Bronfenbrenner Ecological Systems Theory in the exo-system, the status of parents' work can influence the development of children in terms of assisting and helping them with their schoolwork because parents arrive home late and are already exhausted. Furthermore, this can have an effect when parents cannot attend critical parents' meetings when called by the school.
- The environment and social challenges the children live in can be seen as a barrier. These social challenges limit parents' ability to create a healthy environment and lifestyle. According to Bronfenbrenner Ecological Systems Theory, the chronosystem represents the environment in which a child is growing up.
- The lack of community involvement, support structures and lack of communication (see paragraph 4.3.3). The meso-system represents the relationships between settings that revolve around a child. The quality of communication between parents and the school, parents and community institutions (church, after-care centre, and library), as well as social interaction with peers, play a role in the development of a learner. The family system, peer group, school and community interact with other micro-systems and influence each other (see paragraphs 2.7 and 2.9.3).
- Lack of access to information and knowledge is seen as a barrier in health promoting activities. As mentioned in chapter 4 (see paragraph 4.3.3), a healthy environment is important; you can improve your environment by making informed decisions. If you cannot make informed decisions, you need to get help, improve your knowledge to make informed decisions.

5.2.5.3 Sub-question 3: What suggestions do parents have for overcoming the stated barriers to supporting the health of their children in secondary schools?

Parents can do the following:

- Parents need to be more involved with their children. They can take more interest in what happens in their child's life and what they are doing to support a healthy lifestyle.
- Parents need to set an example by acting as a role model for their children on healthy behaviour.
- Help their children with health problems by getting information through research and making more informed decisions.
- Spending more time and making time available with their children every day.
- Parents need to be more involved in schools to overcome barriers.

According to the parents, the school can do the following:

- Information sharing. Platforms where parents, friends, family or people that relate can share information. The community, such as the schools, churches, after-care centres, libraries and society, can help address barriers by giving professional information and advice. Social interaction with peers is important for the development of children.
- Building the necessary skills of all members of the school community empowers people to learn to prepare themselves for all stages of life, and it is essential that they are able to cope with chronic illness and injuries. This has to be facilitated in school, home, work and community settings. The responsibility for promoting health is shared by the government, health professionals, community groups, health service institutions and individuals who work together to establish health care systems. Health services must embrace and mandate systems that are sensitive and respect cultural needs. The mandate must support the community and individuals in seeking a healthier life by providing training and education in health and promoting the interaction between the health sector and the social, economic, political, and physical environments.
- Schools need several resources to implement school health policies effectively. Schools need human and financial resources and information and knowledge management. These resources will provide a school with a firm basis on which to implement health promoting strategies.

5.2.6 Answering the Primary Research Question

I used the following primary research question to guide this study:

How do parents of secondary-school learners perceive and construct their health literacy?

I have used the discussion of participant responses above that I generated from the findings to answer this question. In the following section, I have made recommendations based on the findings of this study.

5.3 Recommendations

From my interpretation of the findings that emerged during this study, I have made recommendations for parents and relevant stakeholders and for further studies in the following sub-sections.

5.3.1 Recommendations for Parents and Relevant Stakeholders

- Schools can do a survey first to find out what the parents' needs for health literacy information are.
- It was clear from the study that parents need more training through workshops, group discussions or large group interventions with regards to the discussion in health promotion. This can be done by schools sending pamphlets to parents or presenting information sessions for parents and involvement groups (parents that are nurses) about health literacy.
- Local and provincial governments should prepare programmes to develop the health literacy of parents.
- To get parents more involved in health promotion. The involvement of parents in health promotion not only empowers parents, staff, and learners to use their strengths and existing abilities but also equips parents with a sense of ownership of the process as well as the decisions and practices arising from it. Even if school policies concerning healthy nutrition were more accessible, the involvement of parents is necessary for socioeconomically deprived schools, and the lack of parental involvement compromised opportunity for longer-term impact.
- The health promoting school's framework should require that all parents and relevant stakeholders have the knowledge, skills and behaviour models that promote health better within schools.

5.3.2 Recommendations for Further Studies

With regard to further research, I recommend that the following topics should be explored:

- Participatory research into the development of community projects which include education in health literacy for parents;
- Education programmes for parents, which are facilitated by parents and the Department of Education. These programmes should make use of technology to deliver education to parents in communities in hard-to-reach areas;
- Monitoring and evaluation of health literacy programmes for parents in order to measure the effect and impact of these programmes.

If programmes were developed to educate parents more in health literacy, it would lead to the empowerment of parents. Empowerment entails improving knowledge and skills. Health literacy empowers parents and enables them to engage in collective action to promote health.

5.4 Limitations and Contribution of this Study

I used an exploratory design for this study and focused on determining how parents of secondary-school learners perceive and construct their health literacy. No research is without limitations, and this study is no exception. The possible limitations of this study could include the following:

This method of study tends to work with a relatively small number of parents, and as explained by Silverman (2000), I was prepared to sacrifice scope for detail.

I took measures to ensure that the findings were of high quality and trustworthy. The data that were generated in this study were based on the experience of parents from two schools who participated in how they perceived and constructed their health literacy. Not all the participants arrived for the interviews. Parents in this community live in a diverse economic status community.

Through this study, I aimed to contribute to assisting parents to make informed decisions and to improve the level of parents' literacy that plays an important role in influencing the education of their children in health literacy.

5.5 Concluding Remarks

The goal of health promotion is to strive towards a holistic, all-encompassing state of wellbeing, which includes optimal psychological, physical, social and spiritual health. To attain this state, parents must be able to identify and actualise their potential and aspirations, adapt to changes, satisfy needs and cope with the environment. The ultimate aim of this endeavour is a better quality of life (WHO, 2009). However, the lack of research about the health literacy of parents is a gap in the field and is an area that could be researched further, specifically the development of programmes to educate parents more on health literacy for themselves and their children. Training material, such as pamphlets provided to parents by the Department of Education, would help to broaden their knowledge, skills and perception with regard to health literacy.

In the South African context, it is necessary to remember that cultural environments play a crucial role. I engaged with poor and unemployed communities in certain areas. In this regard, the ecological family system, as viewed by Bronfenbrenner, has an influence on a child's development. It is easier and healthier for a child to grow when the environment is empowering. Bronfenbrenner's (1979) perspective provides valuable insights into the influence of the ecological environments and the role of all the relevant stakeholders on parents and their health literacy. Community support within the ecological system is also beneficial to the family system.

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ANNEXURES

Annexure 1: Permission to conduct research schools in the Dr. Kenneth Kaunda district

 education Lefapha la Thuto la Bokone Bophirima Noord-Wes Onderwys Departement North West Education Department NORTH WEST PROVINCE	Seemake Building, B.O.P., Tambo Street, Potchefstroom Private Bag 21255, Potchefstroom 2020 Tel: (018) 299-8264 / Fax: 294-8254 e-mail: potchefstroom@nwpg.gov.za Office Manager: Linda Molson - Tel: (018) 299-8264 or mail: LindaMolson@nwpg.gov.za
OFFICE OF THE DISTRICT DIRECTOR Dr KENNETH KAUNDA DISTRICT	
Enquiry: P Tyatya; 018 299 8264/082 317 4656	Tel: (018) 299 8264 / e-mail : ptyatya@nwpg.gov.za
To: North West University Potchefstroom Campus	01 March 2021
Attention: Mrs Joleen Keyser (Researcher) 082 902 0590	
From: Mr. B. Monale District Director	
PERMISSION TO CONDUCT RESEARCH STUDY IN [REDACTED] AND [REDACTED]	
Reference is made to your emailed correspondence regarding your request to conduct research in [REDACTED] [REDACTED] and [REDACTED]	
Your request is noted and accordingly, approval is hereby granted to you to undertake the research study.	
Please take note that the envisaged research must conform to the following provisions:	
• That the onus to contact your target schools and or relevant persons remains with you. • That participation in the project will remain voluntary for its entire duration. • That should need to arise to go to any school for this purpose during working hours, the general functionality of schools should not be compromised by research itself, considering that your research will involve Educators/and or Learners. • That the outcomes of your research will be shared with the NW Department of Education, or its proxy, upon request. • That the principle of confidentiality will be observed in its strictest terms in relation to information sourced from the research. • That all researchers take reasonable steps to comply with COVID 19 safety and preventative measures in the course of you undertaking the research project.	
With Our Best Wishes	
	
Mr. B. Monale District Director: Dr. Kenneth Kaunda District	
Cc: Ms. N. Seokolo: Acting Sub-district Manager (Matlosana)	
	

Annexure 2: Certificate of Proofreading

Olivier Language Practitioner
Editing and Translation Service

Date: 22 November 2021

Letter of confirmation of professional proofreading

Title: Health promotion in secondary schools: a qualitative exploration into the health literacy of parents

Author: J.M. Keyser
Editor: Willemien Olivier

*This paper was proofread
by
a proofreader*

LETTER OF CONFIRMATION OF ENGLISH EDITING

This is to confirm that the paper with the provisional title, *Health promotion in secondary schools: a qualitative exploration into the health literacy of parents*, to be submitted by Joleen Keyser of North-West University, has been edited for language by Olivier Language Practitioner, Willemien Olivier. The document needed only a few amendments. Neither the research content nor the author's intentions were altered in any way during the editing process.

The editor guarantees the quality of English language in this paper, provided the editor's changes are accepted and further changes made to the paper are checked by the editor.

Willemien Olivier

Honours Degree Translation Studies (2017) UNISA
Editing and Translation Service: Olivier Language Practitioner since 2008
Proud member of Professional Editor's Group (PIG) since 2012
South African Translators' Institute (SATI) since 2012 - Member no. 1802587

Willemien Olivier
Olivier Language Practitioner
Translation, proofreading and editing service
Cell phone: 075 379 0807
Email address: willemienol@gmail.com

Annexure 3: Ethics Certificate



Private Bag X1290, Potchefstroom
South Africa 2520

Tel: 018 299-1111/2222
Fax: 018 299-4910
Web: <http://www.nwu.ac.za>

Senate Committee for Research Ethics
Tel: 018 299-4849
Email: nkosinathi.machina@nwu.ac.za

ETHICS APPROVAL LETTER OF STUDY

Based on approval by the **Faculty of Education Research Ethics Committee (EduREC)** on 19/07/2020, this committee hereby **approves** your study as indicated below. This implies that the North-West University Senate Committee for Research Ethics (NWU-SCRE) 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: Health promotion in secondary schools: A qualitative exploration into the health literacy of parents			
Study Leader/Supervisor (Principal Investigator)/Researcher: Prof L Wood			
Student / Team: JM Keyser (MED student - 23593539)			
Ethics number:			
N	W	U	- 0 0 7 7 9 - 1 8 - A 2
Institution	Study Number		Year
Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation			
Application Type: Project			
Commencement date: 24/03/2020		Risk:	Low
Expiry date: 24/03/2021			
Approval of the study is initially provided for a year, after which continuation of the study is dependent on receipt and review of the annual (or as otherwise stipulated) monitoring report and the concomitant issuing of a letter of continuation.			

Special in process conditions of the research for approval (if applicable):

General conditions: While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, the following general terms and conditions will apply: • The study leader/supervisor/principal investigator/researcher must report in the prescribed format to the EduREC: - annually (or as otherwise requested) on the monitoring of the study, whereby a letter of continuation will be provided, and upon completion of the study; and - without any delay in case of any adverse event or incident (or any matter that interrupts sound ethical principles) during the course of the study. • The approval applies strictly to the proposal as stipulated in the application form. Should any amendments to the proposal be deemed necessary during the course of the study, the study leader/researcher must apply for approval of these amendments at the EduREC, prior to implementation. Should there be any deviations from the study proposal without the necessary approval of such amendments, the ethics approval is immediately and automatically forfeited. • Annually a number of studies may be randomly selected for an external audit. • The date of approval indicates the first date that the study may be started. • In the interest of ethical responsibility, the NWU-SCRE and EduREC reserves 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 study are revealed or suspected;
 - it becomes apparent that any relevant information was withheld from the EduREC or that information has been false or misrepresented;
 - submission of the annual (or otherwise stipulated) monitoring report, the required amendments, or reporting of adverse events or incidents was not done in a timely manner and accurately; and / or
 - new institutional rules, national legislation or international conventions deem it necessary.

The EduREC would like to remain at your service as scientist and researcher, and wishes you well with your study. Please do not hesitate to contact the EduREC or the NWU-SCRE for any further enquiries or requests for assistance.

Yours sincerely



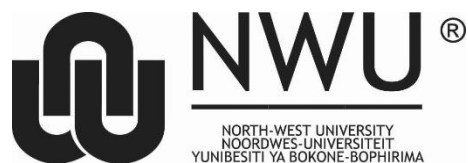
Prof JAK Olivier
Chairperson NWU Faculty of Education Research Ethics Committee

Original details: (22351930) C:\Users\22351930\Desktop\ETHICS APPROVAL LETTER OF STUDY.docm
8 November 2018

Current details: (22351930) M:\DSS\18533\Monitoring and Reporting Cluster\Ethics\Certificates\Templates\Research Ethics Approval Letters\9.1.5.4.1 ES-REC Ethical Approval Letter.docm
5 December 2018

File reference: 9.1.5.4.2

Annexure 4: Consent Letters



PrivateBagX6001, Potchefstroom
South Africa 2520

Tel: 018 299-1111/2222
Web: <http://www.nwu.ac.za>

Faculty of Education
COMBER

Tel: 018 299 4770
Email: Lesley.Wood@nwu.ac.za

Date

PERMISSION LETTER: SCHOOL PRINCIPAL/OTHER RELEVANT PERSON

I herewith wish to request your permission as the school principal (as a mediator) to conduct this research, which involves parents of secondary school learners from the Dr. Kenneth Kuanda District. Prior to granting permission, please acquaint yourself with the information below.

The details of the research are as follows:

TITLE OF THE RESEARCH PROJECT:

Health promotion in secondary schools: a qualitative exploration into the health literacy of parents

ETHICS APPLICATION NUMBER

NWU-00779-18-A2

PROJECT SUPERVISOR: Prof Lesley Wood

CONTACT NUMBER: 018 299 4770

MEMBER OF PROJECT TEAM: MEd-Student JM Keyser

CONTACT NUMBER: 082 902 0590

FACULTY OF EDUCATION RESEARCH ETHICS COMMITTEE

Contact person: Ms Erna Greyling, e-mail: Erna.Greyling@nwu.ac.za, tel. (018) 299 4656

The conducting of this study has been approved by the Research Ethics Committee of the Faculty of Education of the North-West University and it will be conducted according to the ethical guidelines of this committee. Permission was also obtained from the provincial Department of Basic Education/other relevant bodies.

What is this research about?

The aims of this research are:

- to understand how parents perceive health and health promotion;
- to investigate the nature and scope of the knowledge (understanding) and skills (ability) of parents concerning health promotion (the terms knowledge and expertise will be explained to the participants/parents before the focus group commences);
- to examine the various ways in which health promoters (parents) are contributing towards health promotion;
- to investigate the possible barriers that the health promoters (parents) are encountering in their health-promoting activities;
- to develop a possible *solution* by parents to overcome the stated barriers to the promotion of the health of their children and to develop workable strategies to overcome these barriers.

Participants

- parents of secondary school learners

What is expected of the participants?

To share their knowledge of health, health promotion and health literacy.

Benefits to the participants

The participants will possibly learn more about health, health promotion and health literacy.

Risks involved for participants

The participants will have to reveal information about their personal experiences.

Safety protocols will be observed to protect individuals/participants against transmission of the Corona virus, by wearing masks and keeping a distance of more than 1,5m between individuals. In addition, any equipment used in the research process will be thoroughly sanitised and hand sanitiser (with at least 70% alcohol content) will be available during the data collection period. The number of individuals involved in the data collection process will be no more than ten individuals.

Confidentiality and protection of privacy

Informing participants about the study purpose would result in trustworthiness being better ensured. In line with ethical principles of educational research, written consent will be obtained from all the participants before conducting the focus group, and the participants will also give consent to the recording process of the interviews and the fact that notes will be taken. In order to secure the privacy of the participants, extra care will be taken to ensure that the participants are comfortable with the researcher taking notes. Permission will be asked in this regard.

Therefore, it is important that all research participants will give informed written consent before they participate. Although participants may not be completely anonymous, their identity will still be protected by not mentioning their names during the interview, in the findings or in the final report.

To obtain confidentiality, *appropriate measures* will be implemented to *prevent disclosure of information* that might identify the participants either during the research or afterwards, e.g. anonymising data or pooling results. Only the researcher collecting or analysing the data have access to the respondents' personal information, and this information will not be shared in any way that would identify individuals. Privacy is limited in a focus group, but data will be reported anonymously. No names will be used whatsoever. The participants will be informed about anonymity, as there will be no way to identify any participant from the information provided; this will be done by separating the personal information from the survey response. If some of the participants are going to use personal names or identification of some kind, it will be removed from the data.

Dissemination of findings

Unpublished dissertation

If you have any further questions or enquiries regarding your participation in this research, please contact the researchers for more information.

DECLARATION BY THE PRINCIPAL/OTHER RELEVANT PERSON:

By signing below, I agree to give permission for the research to take place with the identified participants in the study entitled:

Health promotion in secondary schools: a qualitative exploration into the health literacy of parents

I declare that:

- I have read this information and consent form and understand what is expected of the participants in the research.
- I have had a chance to ask questions to the researcher and all my questions have been adequately answered.
- I understand that taking part in this study is voluntary and participants will not be pressurised to take part.
- Participants may choose to leave the study at any time and will not be penalised or prejudiced against in any way.
- Participants may be asked to leave the research process before it is completed if the researcher feels it is in their best interest, or if they do not follow the research procedures agreed to.

Signed at (place) _____ on (date) ____ / ____ /20 ____

Signature of School Principal/Relevant person



PrivateBagX6001,
Potchefstroom South
Africa 2520

Tel: 018 299-1111/2222

Web: <http://www.nwu.ac.za>

Faculty of
Education
COMBER

Tel: 018 299 4770

Email: Lesley.Wood@nwu.ac.za

Date

GOODWILL PERMISSION: SCHOOL GOVERNING BODY/OTHER RELEVANT BODY

I herewith wish to request your permission as the school governing body to conduct this research, which involves parents of secondary school learners from the Dr. Kenneth Kaunda District. Prior to granting permission, please acquaint yourself with the information below.

I herewith wish to request your permission as the school principal (as a mediator) to conduct this research, which involves parents of secondary school learners from the Dr. Kenneth Kaunda District. Prior to granting permission, please acquaint yourself with the information below.

The details of the research are as follows:

Health promotion in secondary schools: a qualitative exploration into the health literacy of parents

ETHICS APPLICATION NUMBER

NWU-00779-18-A2

PROJECT SUPERVISOR: Prof Lesley Wood

CONTACT NUMBER: 018 299 4770

MEMBER OF PROJECT TEAM: MEd-Student JM Keyser

CONTACT NUMBER: 082 902 0590

FACULTY OF EDUCATION RESEARCH ETHICS COMMITTEE

Contact person: Ms Erna Greyling, e-mail: Erna.Greyling@nwu.ac.za, tel. (018) 299 4656

The conducting of this study has been approved by the Research Ethics Committee of the Faculty of Education of the North-West University and it will be conducted according to the ethical guidelines of this committee. Permission was also obtained from the provincial Department of Basic Education/other relevant bodies.

The aims of this research are:

- to understand how parents perceive health and health promotion;
- to investigate the nature and scope of the knowledge (understanding) and skills (ability) of parents concerning health promotion (the terms knowledge and skill will be explained to the participants/parents before the focus group commences);
- to examine the various ways in which health promoters (parents) are contributing towards health promotion;
- to investigate the possible barriers that the health promoters (parents) are encountering in their health-promoting activities;
- to develop a possible *solution* by parents in order to overcome the stated barriers to the promotion of the health of their children and to develop workable strategies to overcome these barriers.

Participants

- parents of secondary school learners

What is expected of the participants?

To share their knowledge of health, health promotion and health literacy.

Benefits to the participants

The participants will possibly learn more about health, health promotion and health literacy.

Benefits to the participants

The participants will possibly learn more about health, health promotion and health literacy.

Risks involved for participants

The participants will have to reveal information about their personal experiences.

Safety protocols will be observed to protect individuals/participants against transmission of the Corona virus, by wearing masks and keeping a distance of more than 1,5m between individuals. In addition, any equipment used in the research process will be thoroughly sanitised and hand sanitiser (with at least 70% alcohol content) will be available during the data collection period. The number of individuals involved in the data collection process will be no more than ten individuals.

Confidentiality and protection of privacy

Informing participants about the study purpose would result in trustworthiness being better ensured. In line with ethical principles of educational research, written consent will be obtained from all the participants before conducting the focus group, and the participants will also give consent to the recording process of the interviews and the fact that notes will be taken. In order to secure the privacy

of the participants, extra care will be taken to ensure that the participants are comfortable with the researcher taking notes. Permission will be asked in this regard.

Therefore, it is important that all research participants will give informed written consent before they participate. Although participants may not be completely anonymous, their identity will still be protected by not mentioning their names during the interview, in the findings or in the final report.

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Dissemination of findings

Unpublished dissertation

If you have any further questions or enquiries regarding your participation in this research, please contact the researchers for more information.

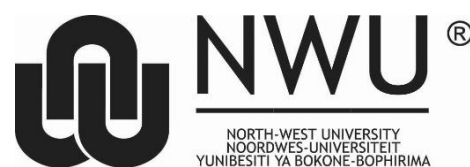
DECLARATION BY THE SGB CHAIRPERSON/RELEVANT RESPONSIBLE PERSON:

By signing below, I agree to give permission for the research to take place with the identified participants in the study entitled:

I declare that:

- I have read this information and consent form and understand what is expected of the participants in the research.
- I have had a chance to ask questions to the researcher and all my questions have been adequately answered.
- I understand that taking part in this study is voluntary and participants will not be pressurised to take part.
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Signed at (place)_____on (date)_____/_____/20



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Faculty of Education
COMBER

Tel: 018 299 4770

Email: Lesley.Wood@nwu.ac.za

Date

PARTICIPANT INFORMATION AND CONSENT FORM

I herewith wish to request your consent to participate in this research, which involves parents of secondary school learners from the Dr. Kenneth Kaunda District. Prior to granting consent, please acquaint yourself with the information below.

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Dissemination of findings

Unpublished dissertation

If you have any further questions or enquiries regarding your participation in this research, please contact the researchers for more information.

Yours sincerely
(JM Keyser)

Annexure 5: Example of Transcriptions

1. How do you perceive health?
2. How would you define the promotion of health?
3. According to you, what *knowledge* do parents need to have about health and health promotion?
4. According to you, which *skills* do parents need to acquire in order to promote their children's health?
5. Which factors might contribute to parents' experience of barriers in the promotion of the health of their children?
6. What would you as a parent perceive as possible *solutions* to overcome the stated barriers to the promotion of health of your children?
7. In which ways do you think you can collaborate with the school to promote the health of your children?

Transcription of feedback session with Participants of school B

Speakers	Responses	Coding comments
Researcher	As a parent, how do you view the role of the school in the society/community?	
Participant 1	My school is (name of school). The role of the school in the community is to give all learners an opportunity to get education and develop people.	Education & development Give learners opportunity – education and development

Participant 2	It is to prepare our learners for future in terms of writing, reading, counting and so forth, but we should not only focus on academic stuff and various aspects of life, like religion, health and social matters.	Education Prepare learners for the future Focus on academic – aspect of life (health & social matters)
Participant 3	It is to assist kids with the self-esteem, their ego, to be able to stand up for themselves, to differentiate between right and wrong and also assist learners in taking the right decisions for their rights.	Personal choices and decisions Self-esteem & ego Right & wrong Decision-making
Participant 1	Okay the role of the school is to build a strong relationship between the learners and teachers but not only that, there must also be a strong relationship between the school as it is, and the community so that learners can also acknowledge the fact that teachers are also their parents, because they spent most of their time here with the teachers.	Relationship between stakeholder parties Strong relationship between learners & teachers & community Teachers are also seen a parent – time they spend with children
	The role of the school, the role that the school must play in assisting your community is to help the kids with their mental stability and also teach learners	

	about the unity, for example if there are a lot of different learners in our school, there must be sort of unity, the learners must learn to accept the differences they will get from other learners and also learn from them.	
Researcher	What do you as parents understand about the term health?	
Participant	there must be a connection between learners and teachers so that learners feel to confront teachers if there is something wrong and also it is the duty of the parents to inform teachers about certain problems that learners experience.	Identify health issues/problems/Communication Inform teachers children experience problems
Participant 2	To me health it is all about the wealth, either psychology	Wealth – socio economic status Health is about wealth - psychology
Participant 3	the term health is that there must be some sort of a mental stability and guide, how, what are you supposed to eat and clothes.	Nutrition and mental health Mental stability, eat, clothes (Wealth and socio-economic status)

Participant 3	teachers and learners must be taught about the importance of guide, with some cases learners are not even aware that there is a certain type of, their well-being, the matter of weight, of increase of weight in a bad way, so that learners must be informed of type of food that they are typing and which type of food they should not eat.	Nutrition education
Participant 4	Learners must be told more often that they should avoid eating sweets, because you will find that in the morning the would eat sweet or sweets self and when it is lunch time, most of them they prefer bunny chow and contains a lot of fat, so learners need to be taught what type of food they must eat and also be encouraged to exercise more and also to drink more water.	Nutrition & exercise
Participant 5	exercise doesn't only mean you must be physical, kids can exercise while using a box, critical thinking and also form part of debating.	
Researcher	According to you as parents, what <i>knowledge</i> do parents	

	need to have about health and health promotion?	
Participant 3	that as a parent it is very important to know what type of a person your child.	Parent role
Participant 2	I think it is all about the basics. In <i>general well-being</i> of your kid so that when there is something troubling him or her, you will be able to spot that. And they should also be taught the basics of <i>first aid</i> , so that when any learner experiences any problem, they would be able to help.	Child well-being Hygiene & self-help injuries
Participant 1	parents should know more about drugs, they think that drugs are not only that they sniff, it can also be alcohol, it is also a drug, a cigarette is also a drug. They must also teach their kids that drugs are very, very dangerous for them.	Mental health issues
Participant 3	Parents should emphasise more about the issue of respect to their kids and also teach the learners that drug abuse so that learners can be able to take whatever they've been taught at home, to school so that they can promote respect more and also be aware	

	of the type of drugs that can hamper your bodies.	
Participant 4	Okay, some kids don't have father figures at home, so they only have mothers. So as single parent especially when you are a mother, you must be aware of the type of friends that your kids have, you must be aware his or her surroundings, everything that he or she does you must be aware of.	Parent role Single parent Influence & Friendship with other children Environment / living
Researcher	According to you as parents, what <i>skills</i> do parents need to have to promote their children's health?	
Participant 3	that the skill that the parents need is to be able to show the kid what has to be done. Like washing your hands, cleaning your house, so that it can be much more easier for kids to adapt from their parents.	Personal hygiene Washing hands/cleaning house Parent role – example – washing hands
Participant 1	You must show them what to do. A parent should lead by example, they shall create from scraps where the kids can follow, whether sometimes kids don't do as their parents does but it is parents' duty to show the kids what it is about, things that are	Parent role – example for children

	supposed to be done so that they can be able to follow.	
Participant 2	Should have communication skills, sometimes our kids don't what to be taught what to do. So sometimes when you relay maybe an incident that so and so took some drugs and the after effects. At a later stage they will say I do this and this to help me or you can maybe read articles about what the likes of drugs, alcohol does to the body, or maybe watch programmes on TV that discuss such issues.	Education & mental health issues / communication via media (Television)
Participant 5	Parents should make sure that they teach their kids about respect at an early stage, they shouldn't wait until their kids are at a certain age and then even though there are a lot of things that may influence the behaviour of kids, maybe friends, the parents try by all means to make sure that they show their kids the right way.	Respect / Type of friends
Researcher	What could be viewed as possible <i>barriers</i> by parents in the promotion of the health of their children?	

Participant	The problem is the fact that kids are brain taught a lot of things, kids are being told a lot of things but there is no implementation for example if you are a great teacher, you must teach them about the importance of farming, but it must not only end there, you must go outside, pick any piece and implement that garden so the learners can develop some passion and take care of this garden of love so that they can see the importance and the need of gardens in our schools. So whatever we say to kids, must not only end there, there must be sort of an implementation so that learners can understand what is it that the parents or teachers are talking about.	Education
Participant 1	the kids needs to know and understand that vegetables are very important for their health.	Nutrition
Participant 2	I am of the opinion that health issues should be incorporated into ... I don't know if it is done now but maybe it is done to a certain extent. Learners should be taught about health aspects	Education – health aspects

	because when they get to high schools, it is late you know. You must teach them about health and they would be adopting bad manners from other learners. Now to learn them from an early age, it is going to be second nature them. Children must know from the early stage from the primary when they come to the secondary they must know what to do, what they must do.	
Participant 5	one of the mistakes that parents do, is to believe of think that it only the teacher's responsibility to take care of their children. Parents needs to play a major role in the wellbeing of their kids even at schools. The curriculum the extra-murals and each and everything that their kids are involved. Parents need to be part of.	All stakeholders responsibilities – wellbeing of children
Researcher	What could be perceived as possible <i>solutions</i> by parents in overcoming the stated barriers to the promotion of health of their children?	

Participant	There must be unity between parents, learners and teachers and there must a moment where these three stakeholders sit down and come up with ideas that can help us as the school and even kids should be given a platform whereby they come with their grievances so that those grievances can be solved.	Co-operation between relevant stakeholders
Participant	teachers, learners and parents must form a pyramid whereby this unity among the stakeholders. And when kids come up with ideas or complaints, they must be given a moment, a platform whereby they come up with ideas, they come up with their complaints and they should not be done by teachers or parents, they should be given a platform whereby everybody listen to whatever the kids are saying, so that there can be a better relationship and connection between three stakeholders.	Co-operation between relevant stakeholders – solving problems – teachers and parents
Participant	the issue of the meetings that are being held by the school whereby the parents are requested to come and attend these meetings and also come with their kids. So	School management/Teachers

	that the SMT, the school management can be aware of the problems that the kids are encountering at school and also I think that some kids are bullying others, so other kids are, they even feel it hard to come to school because they are being bullied and teachers or the school management is not even aware, so this platform of school meetings is used to solve that kind of problems.	
Participant 2	I think what can also be done, because of some of the learners they prefer to ... unclear maybe once in a while a session should be held where a professional like yourself distribute questions regarding, then by so doing they will be able to identify areas where a child should be attended to.	Community involvement/independent - researchers
Participant 1	Some parents are not assisting teachers with the school management with anything. You will find that at some point, the school is requesting the parents to come and check on their kids' school books or anything other thing that might be related to the	Non-co-operation by parents/lack of parent commitment and involvement

	curriculum. Parents don't even bother to come. Parents don't attend meetings that they are being called by the school. So the solution is when the parents can participate and be hands on, on their kids' curriculum or anything that might include school.	
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