

**Life Orientation in the health promoting school:
conceptualisation and practical implication**

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**Thesis submitted for the degree Philosophiae Doctor in Educational
Psychology in the Faculty of Educational Sciences, North-West University
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May 2013

DEDICATION

This work is dedicated to my darling daughter Liana. You are an inspiration and a loving and caring human being.

ACKNOWLEDGEMENTS

To all the people who, through their support and encouragement, helped to ensure the completion of this study, thank you. In particular, I would like to mention the following people who proved to be invaluable to me throughout the study:

- My promoter doctor Charles Viljoen for the time he spent with me, offering insights, guidance and most of all encouragement and motivation throughout the research process. Thank you for understanding my situation.
- My family, husband and two children who supported me and encouraged me to complete the study.
- To the personnel of the primary schools for their co-operation and feedback which enhanced to make the study meaningful.
- Dr Patricia Banda, Deputy Director Health Promotion: Department of Health for her assistance.
- Dr Annette Lyons, Advisor for Health Skills and Citizenship in Devon, United Kingdom for assisting me during my visits to the Devon Health Promoting schools.
- Mr Klaus Klein for proof reading my thesis and his advice.

ABSTRACT

KEY WORDS: Life Orientation / Life skills / health promotion / health promoting schools

Globally there is a serious need to equip children and young people with knowledge, attitudes, skills and values to assist them in making healthy lifestyle choices. Life skills education is possibly among the most important answers to the problems and challenges many young people are faced with. Life skills programs are being developed to address the alarming increase in high risk health behaviours among adolescents. According to international research, Health promotion is a critical life skill to acquire, since health impacts on almost every facet of a person and their society.

The South African Department of Education introduced Life Orientation as a Learning Area as part of Outcomes Based Education. The paramount role of Life Orientation within the context of the Health Promoting School is increasingly being recognised by educational planners, policy makers, school managers, teachers, parents and even learners themselves. Health promotion as part of Life Orientation aspires to promote a healthy lifestyle and equip learners with the knowledge and skills to attain and maintain a healthy lifestyle. It further aims to reduce risk behaviours and equip learners with social skills.

Empirical research was done in the Gauteng Province of South Africa. In order to give voice to teachers and health co-ordinators in terms of their views and comments on Life Orientation, questionnaires and focus group interviews were utilised. Based on the evidence gathered in questionnaires, discussions and observations in the selected Health Promoting Schools, it emerged that Life Orientation has a major role to play in instilling knowledge and skills to promote health and well-being.

However, even though Health promotion is included in the Life Orientation curriculum, there seems to be a lack of energy and motivation to progress to Health Promoting Schools. It emerged that Life Orientation teachers viewed a healthy lifestyle as the link between Life Orientation and Health promotion, which is a positive indication that schools are making progress towards becoming Health Promoting Schools. Furthermore, the quantitative research revealed key issues that need be dealt with, especially proper water and sanitation, policies on tobacco and substance use, the enhancement of physical well-being of the learners and an integrated nutrition program. Schools need an effective safety and security plan to ensure a safe school environment conducive to teaching-and-learning. Learners should receive basic health screening with appropriate referrals from school nurses. Also, trained health promoters should oversee and manage the health promoting program in the Health Promoting School.

The qualitative research indicated that healthy lifestyles are promoted, with particular focus on balanced diets, clean and hygienic environments and adequate physical activity. It emerged that stakeholders play an important role, including the community, school nurses, private companies and governmental departments. Community involvement is particularly important, since community members assist the school by cleaning, cooking, gardening and participating in health promoting awareness.

It can be concluded that Life Orientation has a prominent role to play in the Health Promoting School. A successful initiative requires the involvement of the entire school, changes to the schools' psychosocial environment and participation from the parents and wider community.

OPSOMMING

Sleutelwoorde: Lewensoriëntering / Lewensvaardighede / gesondheidsbevordering / gesondheidbevorderende skole

Wêreldwyd bestaan daar 'n dringende behoefte om kinders en jong mense met kennis, houdings, vaardighede en waardes toe te rus om hulle te help om gesonde leefstylkeuses te maak. Lewensvaardighede is moontlik een van die belangrikste oplossings vir die probleme en uitdagings waarmee jongmense gekonfronteer word. Lewensvaardighedsprogramme is ontwikkel om die kommerwekkende styging in hoë risikogedrag onder adolessente aan te spreek. Volgens internasionale navorsing is Gesondheidsbevordering 'n kritiese lewensvaardigheid wat verwerf moet word omdat gesondheid 'n impak het op byna elke faset van 'n mens en sy/haar samelewing.

Die Suid-Afrikaanse Onderwysdepartement het die leerarea Lewensoriëntering as deel van Uitkomsgebaseerde Onderwys geïmplementeer. Die kernrol van Lewensoriëntering binne die konteks van die gesondheidsbevorderende skool word toenemend deur opvoedkundige beplanners, beleidmakers, skoolbesture, opvoeders, ouers en self die leerders erken. Gesondheidsbevordering as deel van Lewensoriëntering strewe daarna om 'n gesonde leefstyl te bevorder en om leerders toe te rus met kennis en vaardighede om 'n gesonde leefstyl te verkry en te handhaaf. Dit het verder ten doel om risikogedrag te verminder en om leerders met sosiale vaardighede toe te rus.

Empiriese navorsing is uitgevoer in die Gauteng provinsie van Suid-Afrika. Vraelyste asook fokusgroeponderhoude is gebruik om 'n stem te verleen aan onderwysers en gesondheidskoördineerders aangaande hul siening en kommentaar oor

Lewensoriëntering. Uit die inligting wat ingesamel is deur middel van vraelyste, besprekings en waarnemings in die geselekteerde gesondheidsbevorderende skole, het dit geblyk dat Lewensoriëntering 'n betekenisvolle rol speel om kennis en vaardighede te vestig sodat gesondheid en welstand in die skole bevorder kan word.

Alhoewel Gesondheidsbevordering ingesluit is in die Lewensoriënteringkurrikulum, blyk dit dat daar 'n gebrek aan energie en motivering bestaan om tot gesondheidsbevorderende skole oor te gaan. In aansluiting hierby het dit verder geblyk dat Lewensoriëntering onderwysers 'n gesonde leefstyl as 'n skakel tussen Lewensoriëntering en gesondheidsbevordering beskou, wat 'n positiewe aanduiding is dat skole vordering maak om gesondheidsbevorderende skole te word.

Die kwantitatiewe navorsing het sleutelkwessies aangetoon wat aangespreek behoort te word, soos voldoende water en sanitasie, beleid rondom tabak en dwelmmiddels, die bevordering van die fisieke welstand van die leerders asook 'n geïntegreerde voedingsprogram. Skole toon 'n behoefte aan effektiewe veiligheids- en sekuriteitsplanne om veilige skoolomgewings te verseker sodat onderrig en leer behoorlik kan plaasvind. Leerders behoort basiese gesondheidsondersoeke te ontvang, met behoorlike verwysings deur skoolverpleegsters en opgeleide gesondheidskoördineerders sodat die gesondheidsbevorderende plan bestuur kan word.

Kwalitatiewe navorsing het getoon dat gesonde leefstyle bevorder kan word met spesifieke fokus op 'n gebalanseerde dieet, skoon en higiëniese omgewings en voldoende fisieke aktiwiteite. Vaardighede verwant aan gesondheidsbevordering sluit in 'n gesonde leefstyl, 'n gesonde voedselkeuse asook die ontwikkeling van persoonlike vaardighede. Dit blyk dat aandeelhouers asook die gemeenskap, skoolverpleegsters, private maatskappye en die regeringsdepartemente 'n belangrike

rol speel. Gemeenskapsbetrokkenheid is veral belangrik aangesien gemeenskapslede die skool bystaan met skoonmaak, kook, tuinmaak en deelname aan gesondheidsbevorderende bewusmaking.

Lewensoriëntering het dus 'n prominente rol om te speel in die Gesondheidsbevorderende skool. Om 'n suksesvolle inisiatief deur te kan voer, word die betrokkenheid van die hele skool asook die veranderinge aan die skool se psigososiale omgewing en deelname deur die ouers en wyer gemeenskap benodig.

LIST OF ABBREVIATIONS AND ACRONYMS

ABS	Australian Bureau of Statistics
ADHD	Attention Deficit Hyperactivity Disorder
AHPSA	Australian Health Promotion Association
AIDS	Acquired Immune Deficiency Syndrome
BEE	Black Economic Empowerment
CAPS	National Curriculum and Assessment Policy Statement
CELP	Centre of Education Law and Policies
DoBE	Department of Basic Education
DoE	Department of Education
DoH	Department of Health
DWAF	Department of Water Affairs and Forestry
EFA	Education for All
FET	Further Education and Training
ENHPS	European Network of Health Promoting Schools
FRESH	Focusing Resources on Effective School Health
HIV	Human Immunodeficiency Virus
HPS	Health Promoting School
HSRC	Human Sciences Research Council of South Africa

JICA	Japanese International Co-Operation Agency
MDG	Millennium Development Goals
MRC	Medical Research Council
MTSF	Medium Term Strategic Framework
NEIMS	National Education Infrastructure Management System
NEPI	National Education Policy Investigation
NFCS-FB	National Food Consumption Survey-Fortification Baseline
NGO's	Non-Governmental Organisations
NQF	National Qualification Framework
NSNP	National School Nutrition Program
NYRB	National Youth Risk Behavior Survey
OBE	Outcomes Based Education
OVSA	One Voice South Africa
PAHO	Pan African Health Organisation
PDHPE	Personal Development, Health and Physical Education
RDP	National Reconstruction and Development Program
SAHRC	South African Human Rights Council
SBST	School Based Support Teams
SGB	School Governing Body

TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/Aids
UNESCO	United Nations Educational Scientific and Cultural Organisation
UNICEF	United Nations International Children’s Fund
USAID	United States Agency for International Development
WCED	Western Cape Education Department (South Africa)
WHO	World Health Organisation

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CHAPTER 1

INTRODUCTION AND ORIENTATION TOWARDS THE RESEARCH PROBLEM

1.1 INTRODUCTION

The paramount role of Life Orientation within the context of the health promoting school is increasingly being recognised by educational planners, policy makers, school managers, educators, parents, and even learners themselves.

The aim of this research project was to explore and describe how Life Orientation is currently conceptualised within the context of the health promoting school; and also to investigate how Life Orientation is practically implemented in the health promoting school setting. The research endeavour was done in the Gauteng Province of South Africa. This study was conducted in two main stages. The first stage dealt with a comprehensive literature survey on Life skills, Life Orientation, Health promotion and the health promoting school. In the second stage various health promoting schools were empirically studied in order to explore the various ways in which Life Orientation was practically implemented.

This chapter will highlight the statement of the research problem and justify the study by an initial engagement with a review of relevant literature. Lastly, a concise clarification of basic terms and concepts will be given as well as an outline of the research study.

1.2 ORIENTATION TOWARDS THE RESEARCH PROBLEM

The needs of South African learners in terms of their health, the challenges they encounter, the curriculum transformation context and the potential of Life Orientation to respond to these issues, combine to shape the context of this study.

Life Orientation includes Health promotion, wellness and well-being as core to its Learning Outcomes and Assessment Standards (Department of Education, 2002:9; Department of Education, 2003a:9; Department of Education, 2011:2). The aim of Life Orientation is to guide and prepare learners for life and its possibilities (self-in-society). It equips them for meaningful and successful living in a rapidly changing and transforming society. Life Orientation in South Africa directly includes aspects of leading international charters like the Ottawa Health Charter (WHO, 1986) and organisations like the World Health Organisation (WHO) (1996) and the Guidelines for health promoting schools (Department of Health, 2002). The core of these aspects include: the development of personal health skills and the promotion of learners' self-esteem. Life skills, self-efficacy and emotional literacy, all pertinent to health promotion, are inherent in Life Orientation's learning and teaching.

Thus, Life Orientation is uniquely positioned to prepare learners to follow lifelong healthy lifestyles, reduce risk behaviour and attain optimal well-being. Learners are enabled to do so as they are equipped with the necessary knowledge, skills and values, to apply problem solving methods and make informed and responsible decisions about their health (Prinsloo, 2007:159; Department of Education, 2008b:7).

Health promotion within the context of Life Orientation is developmental, promotive and preventative. It focuses on wellness, rather than merely on disease. For optimal well-being, long-term maintenance of health behaviour is necessary (Hoelscher, Feldman, Johnson, Lytle, Osganian, Parcel, Kelder, Stone and Nader, 2004:599; Van Deventer,

2009:131). This means that the focus is on a preventative approach to help learners avoid problems, instead of waiting until problems occur. Life Skills/Life Orientation as a school subject takes cognisance of this focus by being compulsory from grade R to 12 (schools) as well as at National Qualification Framework (NQF) levels 2-4 (Further Education and Training Colleges). The NQF has been built on the principles of relevant, appropriate standards and quality that is national benchmarked and internationally comparable. The objectives of the NQF are designed to contribute to the full personal development and well-being of each learner and the social and economic development of the nation at large (NQF, 2012).

The teaching of Life Orientation (Life skills) is very prominent in national as well as international educational debate. Increasing effort is currently being devoted to the development of life skills programmes especially in view of the disturbing level of risk behaviours displayed by young children and adolescents (Magnani, MacIntyre, Karim, Brown and Hutchinson, 2005:289) and the increasing number of adolescents who struggle to find meaning in life (Francis, 2007:1).

International studies indicate the universality of youth needs, summarised by the WHO (2010:8) as a swiftly changing career and job sector, violence evidenced in home, school and community, familial disintegration and divorce, teenage suicide, substance abuse, sexual experimentation and other risk behaviours. Further, the demands of modern life, poor parenting, changing family structures, dysfunctional relationships, new understanding of learners' needs, decline of religion and rapid socio-cultural changes are some of the reasons why life skills are necessary for primary prevention (WHO, 1999:12). Adolescence is a time of risk taking and experimentation, with leading causes of morbidity and mortality behaviourally mediated (Ka He, Kramer, Houser, Chomitz and Hacker, 2004:27-28). Increased rates of drug and alcohol experimentation, sexual

activity, delinquency, suicide attempts, anti-social activities, physical aggression and fighting further characterise adolescence (USAID, 2010).

Learners' needs are similarly identified by South African research. In a comprehensive national research project on youth risk behaviour in South Africa, the Medical Research Council (2008) identified health needs and investigated core facets such as intentional and unintentional injury for instance violence, traffic safety and suicide-related actions; substance abuse such as tobacco, alcohol and drug usage; sexual behaviour; nutrition and dietary behaviour; physical inactivity; and hygiene. Added to these risks are the Children's Institute's (2012) findings that the most significant challenges facing children in South Africa are poverty, child abuse and violence, HIV and a lack of access to services, as well as the fragmentation of the family unit, the loss of caregivers and an unsafe environment.

OneVoice South Africa (OVSA) (2012) is a unique non-governmental organisation (NGO), which uses innovative and creative ways of actively engaging with young people on HIV and AIDS and TB. Their goal is to promote meaningful participation of young people in making informed decisions about health and lifestyle, including sexual and reproductive health and rights within communities; as well as expand target audience knowledge on TB and TB/HIV co-infection, and promote early detection. On a provincial level, the schools programs have successfully being implemented with Grade 8 learners in 74 schools in KwaZulu-Natal, Eastern Cape and Western Cape in the past. The Department of Health and co-workers are currently focusing on 15 schools in KwaZulu-Natal as the terrible reality of HIV and TB co-infection and the outbreak of extremely drug resistant TB in rural areas of KwaZulu-Natal in particular, have hit this province especially hard (OVSA, 2012).

As stipulated by *The National Guidelines for the Development of the Health Promoting schools in South Africa* (Motlatla, 2007:3), schools have a special value as key settings in the community. These include the following:

- young people attend school at an important stage of their lives, through childhood and adolescence. This is when behavioural patterns relating to health and concepts of health are established;
- the length of time learners attend school varies in different countries, however by 18 years, most young people in South Africa have completed secondary school education. This period allows schools to plan long term, coherent and progressive programmes of health education, which take account of the needs of conceptual development of young people as appropriate to their stage of development;
- health and education are inextricably linked and schools provide universal settings for achieving both;
- schools provide a setting for actively involving parents and using parents as a resource to promote the health of their children. Active parental involvement has been shown to increase the effectiveness of school health promotion activities, and
- a school is a community where the health of all staff and learners can be promoted, if positive and caring ethos is created and actively natured. Schools have the potential to be the focus for health promotion activities for the wider community surrounding the school.

In accordance with the new National Curriculum and Assessment Policy Statements (CAPS, 2011) the formulated *National Guidelines for the Development of Health Promoting Schools/sites in South Africa* (Department of Health, 2000), advocated the creation of a culture of effective teaching and learning through the holistic development

of schools and other learning sites, which will promote the optimal well-being of all members of the teaching and learning community. According to leading theorists Donald, Lazarus and Lolwana (1997:24) as well as the World Health Organisation (1996) health promotion includes, but means more than, promoting physical health. It means promoting all those dimensions of development, which together contribute to positive, competent and confident persons. It therefore includes all the physical, cognitive, emotional, social, moral and spiritual aspects of development and environmental aspects of health. If health promotion is to occur, people must be concerned about the whole context and environment in which learning occurs. This includes the classroom environment and the school as an organisation.

The *Health Promoting Schools Initiative* provides a comprehensive vision, and multidisciplinary approach that considers people in the context of their daily life, in the family, community and society (Maree and Ebersöhn, 2002:334-233; Van Niekerk and Prins, 2001:244-264). The health promoting schools ideal focuses on the development of knowledge, and skills to assist people to take care of their own health and that of others and to prevent risk behaviours that may impact negatively on the health ideal (Kirsten and Viljoen, 2000:7-8; Ward, Lombard and Gwebushe, 2006:228).

According to the WHO (1996), a health promoting school is a place where all members of the school community work together to provide students with integrated and positive experiences and structures that promote and protect their health. This includes both the formal and informal curricula of health, the creation of a safe and healthy school environment, the provision of appropriate health services and the involvement of the family and wider community in efforts to promote health. Furthermore, health promotion is the process that enables people to gain control over and improve their health. This process requires supportive settings and the acquisition of individual skills (Lindström and Nilsson, 1998; Van Niekerk and Prins, 2001:244; Rooth, 2005:9).

A key challenge in providing an integrated and coordinated approach to developing effective schools is to incorporate the five components of health promoting schools/sites. The *National Guidelines for the development of Health Promoting schools/sites in South Africa* (Department of Health, 2000:21-24) describe these five components as building education and school policies that support well-being, creating supportive teaching and learning environments, strengthening community action and participation within the education context, providing access to and re-orientating of support services and developing personal skills within the education context.

The challenges of developing personal skills within the context of the schools include (Motlatla, 2007:23):

- the development of compulsory implementation of health and life skills education (Life Orientation) for learners within the context of the curriculum;
- the development of the capacity of the educators and other members of staff to promote their own, and the learners', health and well-being (for example stress management programs, HIV/AIDS management within the context of sexuality education, establishing and maintaining discipline in the schools/site and classroom, etc.);
- peer education (child-to-child training) to learners to support and implement health promotion and prevention strategies;
- capacity development for parents and the broader community to promote the well-being of the family and community; and
- capacity building for service providers to provide a relevant health promotion and life skills education support to sites of learning.

It could be argued that health is inextricably linked to educational achievement, quality of life and economic productivity (Nakajima, 1997:1). By acquiring health-related knowledge, values, skills and practises, children can be empowered to pursue a healthy life and to work as agents of change for the health of their communities.

Apart from the various advantages of the health promoting schools (e.g. a holistic model of health that includes the inter-relationships between the physical, mental, social, spiritual and environmental aspects of health; an opportunity for families to take part in the development of health skills and knowledge of their children; recognising the importance of the social ethos of the school in supporting a positive learning environment, one in which healthy relationships and the emotional well-being of learners are strengthened; enabling the school and the local community to collaborate in health initiatives which benefit learners, their families and community members, etc.), much emphasis is being put on the development of arrange of life-long health-related skills and knowledge. This life-long health related skills and knowledge is of paramount importance towards the total life orientation of learners (WHO, 1996; WHO, 1999).

1.3 RATIONALE AND MOTIVATION

The rationale or the significance of a study justifies the reasons for the researcher's choice of a particular problem (McMillan and Schumacher, 2006:67). A research problem is of significance if it provides knowledge about an enduring practice, increases generalisability, extends empirical understanding and focuses on current issues (McMillan and Schumacher, 2006:68).

The researcher chose the research problem as an educational psychologist interested in the ways Life Orientation is conceptualised in the Health Promoting School as well as its practical implication. Put bluntly, how do the school community (read: school leadership, educators, parents, etc.) perceive Life Orientation within the Health Promoting School?

On gaining more knowledge and information on the issues of health promotion within the Life Orientation Learning Area, the researcher became aware of the shortcomings in addressing the health promoting needs of learners in schools. In addition, as a former Life Orientation teacher, the researcher was motivated by the experiences encountered through working with learners. Schools as key settings of learning and platforms for the developmental changes of children should aim at providing the learners with life skills that will carry them through the dynamic challenges of life. Therefore the researcher investigated the practical implication of health promotion in the Life Orientation Learning Area (Prinsloo, 2007:160).

The curriculum transformation in South Africa provides a theoretical framework within which the interconnected components of Life Orientation and health promotion are introduced. The rationale of the study is configured from an overview of Life Orientation as a Learning Area (the newly formulation is National Curriculum and Assessment Policy Statement – CAPS, 2011) in the health promoting school, how Life Orientation teachers perceive health promotion as part of the Life Orientation learning area and the challenges they encounter.

According to literature surveys, health promoting schools are being recognized as an effective way to improve students' health as well as their ability to learn. The health challenges facing school-going children are complex. These challenges can be addressed through collaboration between the education, health and a number of other sectors (Motlatla, 2007:5).

As a core aspect of the health promoting school approach, Life Orientation as a subject is being promoted as fundamental in empowering learners to live meaningful lives in a society that demands rapid transformation. In this study special attention is given to the needs that have to be addressed in Life Orientation in the health promoting schools, as

well as the content and structuring of health promotion as part of Life Orientation curriculum.

1.4 PROBLEM STATEMENT

Literature surveys revealed that the learning potential of a significant number of children and young people globally is compromised by conditions and behaviours that undermine the physical and emotional well-being which makes learning possible. Hunger, malnutrition, micronutrient deficiencies, parasite infections, drug and alcohol abuse, violence and injury, early and unintended pregnancy, HIV infection and sexually transmitted infections, threaten the health and lives of children and youth (International Youth Foundation, 2000; UNESCO, 2001; Statistics South Africa, 2011:2; Department of Education, 2010:51).

These factors can be addressed, reduced or prevented through acquiring the knowledge, attitudes and skills that promote healthy lives. Such knowledge and skills can lead to behaviours that can prevent disease and injury, foster healthy relationships, and enable young people to play leadership roles in creating healthy environments (Donald, Lazarus and Lolwana, 2002:201). From pre-school to young adulthood, the developing young person can actively engage in learning experiences that will enable him/her, for example, to practise basic hygiene and sanitation; practise abstinence or safe sex; listen and communicate effectively in relationships; or advocate for a tobacco free school or community (WHO, 2002:5).

Ensuring that children are healthy, and able to learn, is an essential component of an effective education system. Beside individual factors, it is equally important to address improvements in structures and conditions of the learning environment. Children cannot attend school or concentrate if they are emotionally upset or in fear of violence. On the other hand, children who complete more years of schooling also tend to enjoy better

health and other opportunities in life. Equipping young people with knowledge, attitudes and skills through education is similar to a vaccination, providing a degree of protection against health threats, both behavioural and environmental. Educating young people about health is an important component of any education and public health programme, complementing and supporting various policies, services, and environmental changes (WHO, 2002:6).

It is therefore clear that Life skills education fulfils a vital role in increasing the awareness among the youth about various social problems and how to eradicate social skills in society. Life skills education further helps the individual to improve decision making skills, enable them to take everything in the right sense and improve their contributions to the society.

The WHO (1996) defines life skills as the abilities for adaptive and positive behaviour that enable an individual to deal successfully with demands and challenges of everyday life. It further encompasses thinking, social and negotiation skills. It ultimately equips young people with the ability to develop and grow into well behaved adults. Therefore the link between the learner's health and their education is a powerful one, since education and health are inseparable. Good health will always support successful learning and successful learning supports health. Healthy children will learn better than unhealthy ones. The schools and other learning sites are the settings where learners and educators spend a great portion of their time. There are instances where education and health programs can have their greatest impact on development, particularly during childhood and youth.

Life skills education can delay the onset of drug usage, prevent high-risk sexual behaviour, teach anger management, improve academic performance and promote beneficial social adjustment (Mangrulkar, Whitman and Posner, 2001). It is necessary to

focus on ways to support existing health behaviours (Kinzie, 2004). For example, learners who do not smoke when they enter their adolescent years need support to continue exhibiting tobacco free behaviour. To impact behaviour effectively, learners need to apply their skills to a particular topic, for example a relevant health issue (WHO, 2003). Botvin (2000), and Whitehead and Russel (2004) explain how life skills can be made specific to relevant health issues. For example, the health topic of substance abuse can be addressed through the following life skills: communication and interpersonal skills, advocacy, negotiation and refusal skills, decision making, critical thinking skills and stress management. As health education cannot be taught without associated life skills education, the relationship is one of reciprocity (WHO, 2003:3).

Health education cannot be taught as a separate and alone-standing entity. Hence Health promotion forms an integral part of Life Orientation, and links with all its foci.

The central research question which guided this research was:

- What is the role of Life Orientation in the health promoting school?

Forthcoming from this basic question, the following sub-questions also guided this research:

- What does the current scenario concerning Life Orientation in the health promoting school entail?
- What is the nature of the link between health, health promotion and the health promoting school, and how can the health promoting school be constructed?
- How can Life Orientation practically be implemented in the health promoting school context?

1.5 RESEARCH OBJECTIVES

1.5.1 General objective

The general aim of the research study was to investigate the role of Life Orientation in the health promoting school.

1.5.2 Secondary objectives

The research study was also guided by the following secondary aims:

- To investigate the current scenario concerning Life Orientation in the health promoting school;
- To explore and describe the nature of the link between health, health promotion and the health promoting school, and how the health promoting school can be constructed, and
- To examine how Life Orientation can be practically implemented in the health promoting school context.

1.6 CLARIFICATIONS OF TERMS

Key terms and concepts that are used in research report are briefly defined and described.

1.6.1 Life Orientation

Life Orientation guides and prepares learners for life and for its responsibilities and possibilities. It does this by equipping learners to interact on a personal, psychological, cognitive, motor, physical, moral, spiritual, cultural and socio-economic level. It

introduces learners to their constitutional rights and responsibilities, to the rights of others and to issues of diversity, health and well-being (Department of Education, 2011).

In the new CAPS document LO is described as (Department of Basic Education, 2011:8):

“central to the holistic development of learners. It addresses skills, knowledge and values for the personal, social, intellectual, emotional and physical growth of learners, and is concerned with the way in which these facets are interrelated. Life Orientation guides and prepares learners for life and its possibilities and equips them for meaningful and successful living in a rapidly changing and transforming society. The focus of Life Orientation is the development of self-in-society. It promotes self-motivation and teaches learners how to apply goal-setting, problem-solving and decision-making strategies. These serve to facilitate individual growth as part of an effort to create a democratic society, a productive economy and an improved quality of life. Learners are guided to develop their full potential and are provided with opportunities to make informed choices regarding personal and environmental health, study opportunities and future careers”.

One of the main changes in terminology is that the “Learning outcomes” and “Assessment standards” will not be used anymore. A Learning Area is now referred to as a Subject.

1.6.2 Life Skills

According to the World Health Organisation (WHO, 2003) life skills are abilities for adaptive and positive behaviour that enable individuals to deal successfully with the demands and challenges of everyday life. It represents the psycho-social skills that determine positive behaviour and include reflective skills such as problem-solving and critical thinking as well as personal skills such as self-awareness and interpersonal skills.

The Life Skills subject is aimed at guiding and preparing learners for life and its possibilities, including equipping learners for meaningful and successful living in a rapidly changing and transforming society. The Life Skills subject is central to the holistic development of learners. It is concerned with the social, personal, intellectual, emotional and physical growth of learners and with the way in which these are integrated (Department of Basic Education, 2011:6).

1.6.3 Life skills education

The primary aim of life skills education is to provide knowledge, attitudes, values and skills needed to empower learners to deal with the demands and challenges of everyday situations, and to promote and protect their own health and well-being (Department of Health, 2000:8). Life skills education is broadly denoted as promoting the practice and reinforcement of psychological skills that contribute to personal and social development and the prevention of health and social problems, as well as the protection of human rights (WHO, 1999:4).

1.6.4 Conceptualisation

According to the MacMillan English Dictionary (MacMillan Education, 2007) the word "conceptualise" is defined as "*to form an idea about what something is like or how it should work.*" Conceptualisation thus refers to contriving and constructing an idea or explanation and formulating it mentally.

1.6.5 Health promoting schools

A health promoting school is a school that constantly strengthens its capacity as a health setting for learning and working. The WHO (1997b:5) sets out the following broad definition of health promoting schools, which is still relevant today:

“A health promoting school is one in which all members of the school community work together to provide pupils with integrated and positive experiences and structures, which promote and protect their health. This includes both the formal and informal curriculum in health, the creation of a safe and healthy school environment, the provision of appropriate health services and the involvement of the family and wider community in efforts to promote health.”

The schools that were part of the research project are all health promoting schools in the Gauteng Province of South Africa. The study has been conducted in schools previously identified as health promoting schools. These schools are currently developed to become full fledged health promoting schools.

1.6.6 Health promotion

The Ottawa Health Charter (WHO, 1986) defines health promotion as *“a process of enabling people to increase control over, and improve their health”*. It is concerned with helping people to gain and maintain good health. This is achieved by promoting a combination of educational and environmental supports, which influence people’s actions and living conditions.

Health promotion entails a positive strive towards a holistic all-encompassing state of well-being. To reach this state of complete physical, psychological, social and spiritual health, an individual, group, school or community must be able to identify and to actualize potential and aspirations, satisfy needs, and change or cope with the environment. In this endeavor a better quality of life is the ultimate aim.

Some researchers are convinced that the pathogenic view (illnesses) of society and salutogenesis can be viewed as the two opposing positions on the illness/wellness continuum. One assumption is then, that the learner, educator, school or community is functioning between the two poles of being either dysfunctional/toxic and being

healthy. Other researchers argue that it is a more encompassing problem than only referring to the factors that influence health and that it should be broadened to include sources of strengths (fortigenesis) as well (Antonofsky, 1996; Eriksson and Lindström, 2005; Becker, Glascoff and Felts, 2010).

Although health promotion through education is taking cognisance of the un-healthy pathological state/condition of the individual, school or community, the central focus is on a better understanding of the growth, strengths, enablement, empowerment, prevention, protection and enhancement of the individual, school and community. It is to this ideal that the project on health promotion through education is strategically focussed on.

1.6.7 Implication

The Oxford Dictionary (2000) defines "implication" as "*a possible effect or result of an action or a decision*". Your Dictionary (2013) describes an implication as "*something implied, from which an inference may be drawn*".

For the purpose of this research project, implication will refer to the result or practical ways in which LO in the HPS is conceptualised and implemented in the actual school setting.

1.7 STRUCTURE OF THE RESEARCH STUDY

The research report is structured in the following way:

CHAPTER 1: Introduction and orientation towards the research problem

CHAPTER 2: Life Orientation in South Africa: the current scenario

CHAPTER 3: The health promoting school

CHAPTER 4: Research design and methodology

CHAPTER 5: Life Orientation in the health promoting school (HPS): The Gauteng Province of South Africa

CHAPTER 6: Findings, conclusions, limitations and recommendations.

1.8 TIMELINE OF THE RESEARCH STUDY

In this paragraph the development of the research study is provided. The various phase and steps are indicated.

Phase 1: Step 1: Introduction and problem statement
Step 2: Literature review
Step 3: Selection of methodology

Phase 2: Step 1: Initial quantitative survey – JICA
Step 2: Qualitative data collection

Phase 3: Step 1: Data analysis – Quantitative data
Step 2: Data analysis – Qualitative data
Step 3: Discussion and literature control

Phase 4: Step 1: Findings
Step 2: Conclusions
Step 3: Recommendations

1.9 CONCLUSION

This chapter introduces the subject of Life Orientation within the context of the health promoting school. It provides outline of the focus and what can be expected of the study. The chapter concluded with working definitions of the terms and concepts that will be used throughout this thesis. It also provides an outline of the various chapters. A timeline of the study is also provided. The next chapter is the first of the literature reviews and will focus on the current scenario of Life Orientation in South Africa.

CHAPTER 2

LIFE ORIENTATION IN SOUTH AFRICA: THE CURRENT SCENARIO

2.1 INTRODUCTION

The purpose of this chapter is to explore the current scenario concerning Life Orientation in South Africa. The chapter will present a concise overview of Life Orientation within a global context, focus on the need for Life Skills and Life Orientation and attempt to define Life Skills Education as well as Life Orientation. In this chapter these two terms will be used interchangeably. The scope and assessment of the learning outcomes of Life Orientation will be presented. Lastly, Health promotion as a component of Life Orientation will be considered.

2.2 LIFE ORIENTATION IN A GLOBAL CONTEXT

2.2.1 Introduction

The challenges that facing children growing up in the 21st century, especially the poorest and most disadvantage children living in low-income countries, are greater than ever (World Bank, 2011a:1). Some of the challenges mentioned are poor nutrition, infectious diseases, inadequate access to clean water and sanitation, violence and substance abuse. The World Bank (2011a:1) further states that children and young people need to be equipped with the knowledge, attitudes, values and skills that will help them face these challenges and assist them in making healthy life-style choices as they grow. This reference gives an indication of the reality of the world today – young people face many challenges from within and without and often do not have people or resources to rely

on for guidance and support (Theron and Dalzell, 2006; South African Institute for Distance Education, 2009:14).

These needs and challenges that the youth face offer both problems and possibilities for successfully living and learning in the 21st Century. The concepts of Life Skills/Life Orientation being taught at school is becoming important as a possible answer to the various problems and challenges facing young people (Pan American Health Organisation (PAHO), 2001:5; Karstens, 2010:65). In the new political dispensation in South Africa Life Skills/Life Orientation has been introduced as a compulsory curriculum subjects which learners must complete from Grade R to Grade 12, and which is intended to teach learners social and emotional skills as well as cognitive skills (Department of Education, 2002; Department of Education, 2011; PAHO, 2001:6).

It can be stated that the aim of Life Skills/Life Orientation is to provide learners with strategies on how to make healthy choices that contribute to a meaningful life. Life Skills/Life Orientation can be viewed as competencies that promote mental well being and ensure the capability of young people to effectively face the realities of life and ensure socialisation of the self-in-society. It helps young people to take positive actions to protect themselves and to promote health and meaningful social relationships (Department of Education, 2003b:9).

Studies have shown that educating children and adolescents can instil positive health behaviours in the early years and prevent risk and premature death (Francis, 2007). It can also produce informed citizens who are able to seek services and advocate for policies and environments that affect their health (WHO, 2003:6). Therefore, Life Skills/Life Orientation is aimed also at facilitating the development of psychosocial skills that are required to deal with the demands and challenges of everyday life. It includes the application of life skills in the context of specific risk situations and in situations

where children and adolescents need to be empowered to promote and protect their rights (Department of Education, 2002:4; Department of Education, 2011).

In some communities, people have limited opportunities for acquiring life skills. It might be that their parents cannot even read or write. That is why it is so important that Life Skills/Life Orientation must be included in the formal curriculum in the classroom. The practice and use of life skills must be recognized and highly regarded in the educational system (PAHO, 2001:11). According to the World Health Organisation (2003), life skills had already been taught in many schools around the world. Some initiatives were in use in just a few schools, whilst in other countries, life skills programs had been introduced in a large proportion of schools, and for different age groups. Several important life skills initiatives had been undertaken in some countries, originating in different groups in the country, for example, non-governmental organizations, education authorities and religious groups (WHO, 2003).

2.2.2 Life Skills/Life Orientation in some developed and developing countries: an overview

The literature concerning the development life skills is imprecise and vague but there are leading international organisations, conferences that outlined milestones in terms of Life Skills/Life Orientation and resolutions at these conferences with which one can establish the initiation of Life Skills/Life Orientation in most of the countries.

To illustrate the development of Life Skills/Life Orientation, a few developed and developing countries were arbitrarily chosen to discuss their changing curricula during the past decades. These countries include the USA, the Baltic and Scandinavian countries, Ireland, Lithuania, Australia, United Kingdom and African countries.

- **United States of America: from moral and character education to life skills**

In America, life skills education was earlier referred to as 'moral' or 'character' education. These latter terms have to an extent fallen out of favour in many educational and psychological discourses (Karstens, 2010). Wringe (2007:17) added that the term 'values education' was also used. According to Greenwalt (in Whitley, 2007) the first challenge to character education that would ultimately lead to its demise as an integrated component in the classroom, was the Character Education Inquiry initiated in the 1920's. This report showed that teaching morals and values in the classroom as prescribed by the old school of thinking, did not necessarily foster good character traits or the manifestations of good character in the classroom (Greenwalt, in Whitley 2007).

In 1992, the National Council for the Social Studies (NCSS) set a goal to develop character and citizenship, which it views as linked with all facets of social studies curricula (Hoge, 2002:104). According to Whitley (2007:15) character education, or the attempt to instill morals and values in students, is making a turn to the American classroom. Increased violence and a general lack of respect and manners among students are cited as reasons for this sudden interest in what is actually an old movement.

The violence seen in America's public schools in the 1990's have made many aware of the serious problems that face educators today, problems that have been intrinsically linked to a perceived decline in morals and values among the youth of America. Many see this "degeneration of personal virtue among the world's societies" as the biggest problem confronting the world today (Elliott, 2004:274). With this in mind, many teachers and administrators are now implementing programs in their schools to promote good morals and values that they feel are no longer being taught in the home.

These character education programs seek to restore what many feel is the lack of moral education in the home.

The American education system is unlike that of most countries. Education is primarily the responsibility of state and local government, and so there is little standardization in the curriculum, for example. It is left to the Education Departments of each individual state to formulate structure and implement their specific education system and policies. In the curriculum framework, health education and physical education are presented as complementary disciplines.

- **Baltic and Scandinavia: life skills for proactive prevention**

A report on curriculum change and social inclusion of the Baltic and Scandinavian countries (UNESCO: 2002), described the need for increasing focus on the generic curricula area of life skills as the expression of an essentially preventative and proactive perspective. They stated that life skills include skills related to communication, decision-making, critical thinking, empathy and coping with stress (Tawil in UNESCO, 2002:7). At an International Conference of Education held in September 2001, the Ministers of Education referred to it as the necessary 'paradigm shift'. They perceived this as a shift towards learning, rather than teaching, and towards competence-based – rather than subject-based – curricula, which combines knowledge with the development of personal qualities and social skills. The involvement of the family and wider community within the schooling process was also considered to be an essential principle of effective integration (Tawil in UNESCO, 2002:9). Finally, they placed importance on the inclusion of teacher training as part of counselling and professional orientation to promote the skills required by students to make proper career choices and better prepare for their integration into the labour market. Commonly accepted skills frameworks in different

countries often include personal, interpersonal, physical, learning skills, as well as those related to the use of new information and communication technologies.

In Denmark, there is a long tradition that the aim of the school is not only to focus on basic knowledge, but also on the individual learner's all-round personal development. Schools also aim at transmitting central values about the outlook on man and society, and at supporting learners in becoming responsible citizens in a democratic society (Ipsen and Jørgen in UNESCO, 2002:64). In 1993, the Danish Parliament adopted a new act on the Folkeskole, which has led to a reform of the school.

- **Ireland: comprehensive life skills education**

In Northern Ireland, where people have been directly involved in communal conflict since 1968, schools were seen as safe havens, a protected environment where the violence and communal conflict were excluded (Arlow in UNESCO, 2002:38). The Northern Ireland Curriculum was introduced in 1990 (Arlow in UNESCO 2002:39). It contained proposals for new aims, objectives, values and skills framework as well as for specific programmes for personal education, education for employability and citizenship.

- **Lithuania: comprehensive life skills education**

Systematic educational reform became a focus when the Law on Education was adopted in Lithuania from 1991 (Budiene in UNESCO, 2002:45). The new curriculum for basic school introduced not only the new broad guidelines for subject teaching, but also new subjects, for example, civic education, moral education etc. One of the goals of the comprehensive school curriculum reform was to develop learners' life skills. The emphasis was on personal, interpersonal, vocational, learning, communication, problem-solving and critical-thinking skills (Budiene in UNESCO, 2002:62).

- **Australia: life skills and the development of the whole person**

The department of education in Australia has recognised the importance of teaching skills, values and knowledge in order to facilitate learners to adopt a responsible and productive role in society (Board of Studies, 2007:5). One of the six key learning areas in the primary school curriculum is "Personal Development, Health and Physical Education (PDHPE)". The syllabus is designed to directly contribute to the development of a learner as a whole person; and is based on the concept that health encompasses all aspects of an individual's well-being i.e. includes social, mental, physical and spiritual health (Board of Studies, 2007:5).

Wyn (2009:1) stated that digital technologies have enhanced the capacity to access information and have created the expectation that individuals will learn how to use successive waves of new application and forms of new technologies in personal life and in work settings in Australia. In developing the PDHPE syllabus, the policy makers took note of the development of technology, thus student learning in PDHPE will also be enhanced through the use of computer-based technologies (Board of Studies, 2007:5).

Another aspect of PDHPE is that it encourages parent involvement, and since the syllabus is flexible, teachers can adjust their programs to accommodate different cultures. Parents will also be in a better position to play an active role in their child's learning (Board of Studies, 2007:5). The aim of the PDHPE syllabus is to develop in each student the knowledge, skills, values and attitudes needed to lead active, healthy and fulfilling lives.

- **United Kingdom: life skills and the development of the whole person**

In the UK, life skills education is referred to as Personal, Social, Health and Economic education (PSHE). PSHE is a planned program of learning opportunities and experiences

that help children and young people grow and develop as individuals and as members of families and of social and economic communities. PSHE education forms a major part of schools' statutory responsibilities to promote children and young people's well-being. According to the Children's Act (Ministry of Justice, 2004) which was promulgated in 2004, well-being is defined as the promotion of physical and mental health; emotional well-being; social and economic well-being; education, recognition of the contribution made by children to society and protection from harm and neglect.

- **African countries: cultural and social factors**

According to research that has been conducted by UNESCO (2003), many sub-Saharan African countries are currently exploring the concept of life skills and how to set about accepting it and adopting it into their education systems. Inevitably, cultural and social factors determine the exact nature of life skills. The content of life skills education is determined at the country level, or in a more local context.

Several different types of HIV/AIDS prevention interventions target young people in sub-Saharan African countries. Some offer HIV/AIDS education as part of the school curriculum; others offer it through extracurricular activities targeting in-or out-of-school youth. The majority of extracurricular programs are provided by non-governmental organizations (NGOs). Most programs started as pilots or projects, with the aim of scaling up to cover a larger geographic area and reach younger adolescents (UNESCO, 2003).

Furthermore, in the high HIV-prevalence countries of Southern and Eastern Africa, the education sector is being hit by massive teacher shortages due to death, absenteeism, and attrition as teachers fall ill, care for sick family members, or fills vacancies in other fields (UNESCO, 2003). At the same time, the needs of learners are changing as young people must learn at an earlier age how to protect themselves from HIV/AIDS, and care

for affected family members and friends. Thus, life skills programs in African countries, initiated by the WHO and UNESCO, are designed to reinforce adolescents' personal risk perception and self-esteem, to provide them with skills in such areas as assertiveness, decision-making, as well as coping with peer pressure and emotions (UNESCO, 2003).

It is clear from the abovementioned paragraphs, that initiatives to develop and implement Life Skills/Life Orientation in schools have been undertaken in several countries around the world.

- **Global role players and life skills: United Nations, WHO and collaborators**

It is evident from the literature that the United Nations has been influential in promoting life skills education globally (WHO, 1993; 1999). The major force behind United Nations agencies' support for the advancement of life skills education in schools is the United Nations Convention on the Rights of the Child held in 1989 (UNICEF, 2005), which makes clear statements about the role of education systems in support of the healthy psychosocial development of children (WHO, 1999:11). International recommendations in this Convention on the Rights of the Child include educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse; recognizing the right of the child to education, taking measures to encourage regular attendance at schools and the reduction of drop-out rates and to promote and encourage international cooperation in matters relating to education, in particular with a view to facilitate access to modern teaching methods (WHO, 1999:11).

The common denominator in most definitions of Life Skills/Life Orientation is the focus on *skills needed to cope* and the holistic development of the self-in-society. The WHO (1993) sees life skills as abilities for adaptive and positive behaviour that equip people to deal effectively with the demands and challenges of daily life.

At the World Education Forum in Dakar, Senegal, in April 2000, the WHO, UNICEF, UNESCO and the World Bank met and agreed to work collaboratively in promoting the implementation of an effective school health program. Their framework, called Focusing Resources on Effective School Health (FRESH), calls for the following four core components to be implemented together, in all schools, namely health-related school policies, provision of safe water and sanitation as essential first steps toward a healthy learning environment, skilled-based health education and school-based health and nutrition services.

FRESH supports Education for All (EFA) which originated in Jomtien, Thailand, where world leaders gathered in March 1990 for the first EFA World Conference to launch a renewed worldwide initiative to meet the basic learning needs of all children. This commitment was renewed during the World Education Forum in Senegal, Dakar in April 2000 (WHO, 2003:7).

The resulting Dakar Framework for Action (UNESCO, 2000) refers to life skills in:

- Goal 3 “ensuring that the learning needs of all young people and adults are met through equitable access to appropriate learning and life skills programs”;
- Goal 6 “improving all aspects of the quality of education, and ensuring excellence of all so that recognized and measurable learning outcomes are achieved by all, especially in literacy, numeracy and essential life skills”.

The shared concerns identified by participants in relation to life skills education included the need to strengthen and improve school health; to promote the development of long-term and holistic life skills curricula in schools; to promote democracy, gender equality and peace; to prevent health and social problems including psychoactive substance use, HIV/AIDS, adolescent pregnancy and violence (WHO, 1999:2).

The WHO (2003:6) indicated that these components should be supported and implemented through effective partnerships between teachers and health workers and between the education and health sectors, effective community partnerships and through student awareness and participation.

The aim therefore was to encourage more schools and communities to use skills-based health education, including life skills, as the method for improving health and education.

To conclude, Life Skills/Life Orientation refers to the skills necessary for successful living and learning, enabling people to participate fully in community development and holistic environmental living.

In the subsequent paragraphs both Life Orientation and Life Skills will be defined more closely.

2.3 DEFINING CONCEPTS

2.3.1 Introduction

In Life Orientation, there has been minimal research and academic discourse regarding the over-all efficacy, implementation and assessment of the goals that should be reached (Rooth, 2005:57; Karstens, 2010:66). Life Orientation was implemented as part of a new education system called "*Outcomes Based Education*" (OBE), which was instituted in 1996 with the *National Education Policy* and the *Schools Act* (Horsthemke and Kissack, 2008:277).

During 2010 the Minister of Basic Education declared that there would be a plan for schools in South Africa called Action Plan to 2014, and that this would form part of a larger vision called Schooling 2025. New Life Orientation curriculum documents (CAPS), were also introduced in schools in 2012. Important aspects, including the National

School Nutrition Program (NSNP) as well as the Prevention and Management of Teenage pregnancy were included in this revised curriculum (Department of Education, 2012a:80).

Schooling 2025 is a long-term plan for the basic education sector which is to allow for the monitoring of progress against a set of measurable indicators covering all aspects of basic education including amongst others, enrolments and retention of learners, teachers, infrastructure, school funding, learner well-being and school safety, mass literacy and educational quality.

The aim of the paragraphs that follow will be to outline Life Orientation in its current state. The purpose, definition of Life Orientation and Life Skills concepts as well as the theoretical perspectives, the scope and the outcomes of Life Orientation will be discussed.

2.3.2 Life Orientation

Life Orientation replaced and incorporated subjects such as Guidance, Family Guidance, Vocational Guidance, Health Education, Bible Study and Physical Education (Department of Education, 2008b:7, 2008c). The aim was to introduce a subject that encompasses all aspects of a young person's life which ensure that they reach their full potential. Life Orientation thus develop and engage learners in personal, psychosocial, neuro-cognitive, motor, physical, moral, spiritual, cultural and socio-economic areas (Department of Education, 2003b:9).

In 1992 the National Education Policy Investigation (NEPI) made significant recommendations about how the subject Guidance could be reformulated and implemented in a new educational dispensation in South Africa. Taking into consideration the problems of guidance as being "*...marginalization, fragmentation,*

inequality and lack of focus" (National Education Policy Investigation, 1992:3), it was recommended that a future policy attempted to ensure quality preventative support for all school children (NEPI, 1992).

Recommendations made by NEPI (1992) included the cardinal shift from guidance being problem-orientated towards being preventative, with the focus on strengths, competencies and development. Results of research conducted in guidance in South African schools from 1994 onwards show the low status of guidance, the neglect and lack of guidance implementation, the diffuseness of terms and uncertainty of guidance educators' job descriptions (cf. the work of Mashimbye, 2000; Rooth, 2005). Problems experienced with guidance in schools were manifold. The legacy of the past meant that the majority of the schools were under-resourced when it came to facilities, resources and guidance educators. The separate education departments, with their differing guidance implementations, found it difficult to implement a coherent form of guidance once they were amalgamated into one department. These are some of the factors why guidance was not taught in the majority of schools (Ganie, 1997; Mashimbye, 2000; Rooth, 2005).

Wilson (1995) indicates that Guidance as a subject remained a marginalised service in the majority of the schools in South Africa, due to economic, political and rationalisation issues. Concurring with this, Mbokazi (1999) found that generally guidance was not taught properly because it was a non-examination subject and economic factors did not enable schools to appoint full-time guidance teachers. In contrast to this negative aspect of the situation, Mbokazi (1999:15) noted that in contrast to the past when school guidance was used as a tool for social control, Life Orientation will attempt to focus on accountability, transparency, affordability, sustainability, relevance and integration.

Life Skills, health and career education are the core aspects of guidance that have been absorbed into Life Orientation, with personal and career development dealt with in depth. With regards to Career Guidance, Life Orientation includes it in Learning Outcome 5, which focuses on an orientation towards the world of work in the Senior and FET Phase (Department of Education, 2003b). There is no specific career education offered in the Intermediate Phase. However, the focus on psychosocial life skills in the intermediate phase will enhance future career education (Rooth, 2005:85).

The importance of linking learning outcome 5 (which deals with orientation to the world of work) specifically with Learning Outcome 3 (which deals with personal development) in Life Orientation is evident. Self-knowledge, self-concept and self-esteem are integral to career choice (Rooth, 2005:85).

Life Orientation Learning Outcome 5 is also linked to Learning Outcome 2, which deals with social development. Human rights, the needs of the community and life skills are vital aspects that need to be part of any career education initiative (Rooth, 2005:86). Apart from career education, the most significant parts of guidance to manifest in Life Orientation are life skills and health education, which are discussed in the next section.

The key to understanding the term lies in the title, Life Orientation. "*Life*" includes capacity for growth and continued change, while "*orientation*" refers to an ability to adjust to circumstances – political, social, psychological or economic (Maree and Ebersöhn, 2002:229). There are a plethora of descriptions and definitions of the term, but the Department of Education noted two key aspects:

"Life Orientation is the study of the self in relation to others and the society and applies to the holistic approach" (Department of Education, 2001a:11).

“Life Orientation prepares learners for life and its opportunities and equips learners for significant and successful living in a rapidly transforming society” (Department of Education, 2002:4).

According to Kriege (2002:7), Life Orientation equips learners to solve problems, to make informed choices and decisions, and to take appropriate actions to live meaningfully and integrate into a changing society. Life Orientation further promotes physical development (Department of Education, 2002) along with personal, social and emotional growth (Department of Education, 2003b:19).

Essentially, Life Orientation is the Learning Area that develops learners as productive members of society, though there is still an emphasis on self and own health and well-being (Department of Education, 2002:5).

2.3.3 Life Skills

Initially “*life skills*” was a term associated with ancillary health professions such as occupational therapy (Larson, 1984:67). The concept of “*life skills*” has also often been used in relation to health skills associated with adolescent risk behaviour (Botvin, 2000; Sinclair, 2003). Therefore life skills are problem-solving skills for coping with the predictable problems of development - self-help skills - abilities for adaptive and positive behaviour that enable people to deal effectively with the demands and challenges of everyday life (WHO, 1993), and the skills necessary for success in living and learning (Rooth, 2005:88).

Generic to most definitions is that life skills promote personal and social well-being, and equip humans to cope with the challenges that life brings. Life skills assist learners to become socially and psychological competent, as well as to function confidently and competently by themselves, with other people and with the community. According to the Department of Education, (2002:4), the conceptualisation of Life Orientation as

focussing on '*self-in-society*' gives credence to life skills as proficiencies that reach beyond the realm of personal development. In accordance with this, the United Nations (2003:14) defines life skills as follows:

"Life skills are a set of psychosocial competencies and interpersonal skills that help people make informed decisions, solve problems, think critically and creatively, participate in their community effectively, build health relationships, empathize with others, and manage their lives in a healthy and productive way".

The Inter-Agency Meeting on Life Skills Education that was held at the WHO headquarters in Geneva, Switzerland in 1998 stated that there were many different reasons why life skills are taught. The countries of Zimbabwe and Thailand were mentioned where the prevention of HIV/AIDS was the impetus for initiating life skills education. In the United Kingdom, an important life skills initiative was set up to contribute to child abuse prevention, and in the USA there are numerous life skills programs for the prevention of substance abuse and violence (WHO, 1999:1-2). It seems that there are many initiatives of this nature in which, in addition to primary prevention objectives, life skills education has been developed to promote the positive socialization of children.

Evolving definitions and understandings of life skills characterise this growing dynamic field. However, the common denominator in most definitions of life skills is a focus on *skills* and *abilities* needed to *cope*. Consequently, life skills are problem-solving skills for coping with the predicable problems of development (Ebersöhn and Eloff, 2003:43) and self-help skills (Van Heerden, 2005).

The following reasons why life skills are essential for primary prevention were listed during a brainstorming session lead by the World Health Organisation: the demands of modern life, poor parenting, changing family structure, dysfunctional relationships, new

understanding of young people's needs, decline of religion and rapid socio-cultural change (WHO, 1999:4).

South Africa, like many other countries, considered the development of life skills education in response to the need to reform traditional education systems which appear to be out of step with the realities of modern social and economic life (Pretorius, 1998:14).

Problems such as violence in schools and student drop-out are crippling the ability of school systems to achieve their academic goals. Furthermore, in addition to its wide-ranging applications in primary prevention and the advantages that it can bring for education systems, life skills education lays the foundation for learning skills that are in great demand in today's job markets (WHO, 1999:2-3; Gouws, 2002:6).

As already indicated, Life Orientation aims to *"equip students with skills, values and knowledge necessary to adapt, survive and succeed in a constantly changing world"* (Department of Education, 2002). In concurrence with this, life skills may be defined as *"abilities for adaptive and positive behaviour, which enable individuals to deal effectively with the demands and challenges of everyday life"* (WHO, 1997b:1).

The relationship of the learning area "Life Orientation" and the term "life skills" is one of positive reciprocity: Life Orientation will equip learners with life skills, while the attained life skills will enable learners to satisfy the various learning outcomes of Life Orientation.

Given the above, it is clear that there are vast areas of overlap between the core content, aims and purposes of Life Orientation and life skills.

In the following paragraph the need for life skills and Life Orientation will be discussed.

2.4 THE NEED FOR LIFE SKILLS EDUCATION

In this section the importance of life skills/Life Orientation will be provided on the basis of perceived problems and needs. According to the WHO (2003:4), the teaching of life skills appears in a wide variety of educational programs. These programs include the prevention of substance abuse, and of adolescent pregnancy, the prevention of bullying, the prevention of AIDS, peace education and the promotion of self-confidence and self-esteem (WHO, 1993:4). Teaching life skills as generic skills in relation to everyday life could form the foundation of life skills education for the promotion of mental well-being, and healthy interaction and behavior (WHO, 2003:5). More problem-specific skills, such as assertively refusing peer pressures to use drugs, to have unprotected sex, or to become involved in vandalism, could be built on this foundation.

Mangrulkar *et al.* (2001:1) cite results of programme evaluations which indicate that life skills education can delay the onset of drug usage, prevent high-risk sexual behaviour, teach anger management, improve academic performance and promote beneficial social adjustment. Adolescents and increasingly pre-adolescents engage in behaviours that are harmful to their health and well-being (Coetzee and Underhay, 2003; Karstens, 2006; Prinsloo, 2007:155). The World Bank (2011a) added that the challenges and risks the youth are facing while growing up in the 21st century looked greater than ever before. This is especially true for the poorest and most disadvantaged youth residing in low income countries (World Bank, 2011a). Furthermore, increasing numbers of school learners are attending school while they are facing a wide variety of health-related problems and/or engaging in behaviours that are endangering their health (California Department of Education, 2003:7).

Millions of youths are facing problems related to substance abuse, poor nutrition, insufficient access to clean and fresh water as well as sanitation, the threat or burden of

living with HIV/AIDS, infectious diseases and violence (World Bank, 2011a). A study by the California Department of Education (2003:7) reported that students are also affected by problems such as inadequate access to health services, weapon carrying by school learners, suicide and engagement in early sexual activities.

Francis (2007:1) add that a large number of youth nowadays engage in antisocial activities; which create many social problems like alcoholism, drug abuse, sexual abuse, smoking, etc. Such habits impede their physical and intellectual capabilities and could be a burden on society. Learners are engaging in much antisocial behaviour, which adversely affect other members of society. Bharath, Kumar and Vranda (2002:1) add on this by stating that there was an urgent need to provide today's youth with a set of ways and skills to deal with the demands and challenges of life.

Botvin's (2000) influential work on substance abuse indicates that substance abuse cannot be dealt with alone, but needs to be addressed as part of a programme that includes life skills such as goal setting, self-esteem enhancement, decision making, problem solving, resisting peer pressure and stress management.

Learners' needs are similarly identified in South African research in life skills education. Mashimbye (2000) indicates the following as crucial within the South African context: problems with parents regarding sexuality education, absence of parents from home, parental alcoholism, passive entertainment, unemployment, peer group pressure, substance abuse, teenage suicide and teenage pregnancy. There is a large cohort of young people who engage in criminal behavior, some of which takes place at school (Rens, Van der Walt and Vreken, 2005:215; De Klerk, 2005:169) and is sometimes even directed at teachers (George, 2007:4).

In the following section some perturbing trends in detrimental behaviours in contemporary society will be discussed which either have an impact on young people, or which young people themselves choose to engage in.

2.4.1 Risk behaviours

The National Center for Chronic Disease Prevention and Health Promotion in the USA (2001) published a list of behavior patterns which are initiated during adolescence and which rank among major causes of death such as tobacco use; behavior that results in injury and violence; alcohol and substance abuse; dietary and hygienic practices that cause disease; sedentary lifestyle and sexual behavior that causes unintended pregnancy and disease. Among American teenagers, risk behavior has significantly increased in the past decades, and done so more than in other First World countries. However, other countries such as Latin American report the same type of problems (PAHO, 2001:8).

In South Africa, the Department of Health acknowledged high risk youth behaviour and therefore identified the need for a broad-based and comprehensive national survey covering the whole adolescent population. It subsequently conducted the National Youth Health Risk Behaviour Survey in partnership with the Department of Education (Department of Health, 2002:8).

The following list represents the core risk behaviours:

- Intentional and unintentional injuries;
- Violence and traffic safety;
- Suicide-related behaviours;
- Behaviours related to substance abuse (tobacco, alcohol and other drugs),
- Sexual behaviour; nutrition and dietary behaviours;
- Physical activity and hygiene related behaviour patterns.

The consequences of risky behaviour in South Africa are serious. These include: assaults; traffic accidents; suicides; teenage pregnancies and infectious diseases such as sexually transmitted infections, including HIV and AIDS. In addition, the long-term effects of unhealthy lifestyle choices like smoking, addiction to alcohol and other substances, the consumption of foods, and particularly fast foods, that contain high quantities of fat and sugar, and inactive lifestyles, often initiated during the youthful years, eventually translate into a range of chronic diseases in later life. Many types of risk behaviours also lead to psycho-social problems including depression and anxiety. All of these cause human pain and suffering and places a significant financial burden on the public health system (Department of Health, 2002:8).

The 2nd South African National Youth Risk Behaviour Survey was conducted in 2008 by the Medical Research Council of South Africa. This survey investigated behaviours related to infectious diseases (sexual risk behaviour and hygiene), injury and trauma (violence and traffic safety), mental health (depression, suicide related behaviour, substance use) and chronic diseases (nutrition and physical activity) (Medical Research Council, 2010:10).

The survey showed clear reductions in physical activity, an increased threat to mental health and unsafe traffic behaviour. A significant increase in physical inactivity (38% to 42%) and TV watching for more than 3 hours per day (25% to 29%) was observed. Regarding mental health, more learners made one or more suicide attempts during the past six months (17% to 21%). Another alarming fact regarding unsafe traffic behaviour revealed that more learners drove a vehicle after drinking alcohol in the past 30 days (8% to 18%) and were driven by someone who had been drinking alcohol in the past 30 days (35% to 38%).

The paragraphs below discuss risk behaviours related to HIV/AIDS, substance abuse, teenage pregnancy, depression and suicide.

2.4.1.1 HIV/AIDS

The repercussions of HIV (Human Immunodeficiency Virus)/AIDS (Acquired Immune Deficiency Syndrome) can clearly be noted in a country's education system (UNICEF, 2004). On the one hand, it negatively affects the ability to provide schooling services, and on the other hand it increases the demands on the formal school system (UNICEF, 2004). The effects of this pandemic can be observed in the impaired quality of education at schools where both learners and teachers may be affected by HIV/AIDS within the family environment as well as individually (UNICEF, 2004).

According to UNAIDS (2010) there are currently around 1,2 million people living with HIV in the United States of America and around a fifth of these are unaware of their infection, posing a high risk of onward transmission. The importance of life skills education is confirmed by these alarming facts. Therefore, the education of youths with regards to HIV/AIDS plays a pivotal part in worldwide efforts to curb the HIV/AIDS pandemic.

According to UNICEF (2004) Life Skills programmes focusing on the prevention of HIV/AIDS proved to be more effective in changing behaviour if they included balanced knowledge, skills and attitudes with relation to HIV/AIDS opposed to prevention programmes that emphasised information alone. This is true even for young children who are not yet engaging in risky sexual behaviour. It also has been found that skills-based programmes have shown to be more effective in delaying the age of first sexual intercourse as well as in increasing safe sexual behaviours amongst youths who are sexually active (UNICEF, 2004).

South Africa is one of the countries that is most affected by the HIV/AIDS pandemic (Population Council, 2008:1). An estimated 5.6 million people were living with HIV and AIDS in South Africa in 2009, the highest number of people in any country (UNAIDS, 2010). In the same year, it is estimated that 310,000 South Africans died of AIDS-related causes (UNAIDS, 2010).

South Africa's HIV and AIDS epidemic has had a devastating effect on children. There were an estimated 330,000 under-15s living with HIV in 2009, a figure that has almost doubled since 2001 (UNAIDS, 2010). HIV in South Africa is transmitted predominantly through heterosexual sex, with mother-to-child transmission being the other main infection route. Because the virus is transmitted from the child's mother in cases of mother-to-child transmission, the HIV-infected child is born into a family where the virus may have already had a severe impact on health, income, productivity and the ability to care for each other.

The age bracket that AIDS most heavily targets – younger adults – means it is not uncommon for one or more parents to die from AIDS while their offspring are young. The number of premature deaths in South Africa due to HIV/AIDS has risen significantly over the last decade from 39% to 75% in 2010 (Harrison, 2009).

HIV/AIDS can have a worldwide debilitating impact on health as well as social-, economic- and cultural systems (UNICEF, 2004). Life skills education that focuses on HIV/AIDS education will not only equip learners with the knowledge and skills to make informed life decisions, but it will also assist to reduce discrimination and stigma toward those individuals living with HIV/AIDS as it will dispel false information that can lead to fear, blame and stigmatisation (Avert, 2011).

2.4.1.2 Substance abuse

The use as well as misuse of alcohol, cigarettes and other substances is observed on a global level (Bühler, Schröder and Sibereisen, 2008:621). Over the past twenty years, life skills education has become part of the vocabulary in substance education and the prevention of substance misuse. The term refers to programmes targeted primarily at young people and based on the need to promote healthy lifestyles through health education (International Centre for Alcohol Policies, 2011). In relation to alcohol, Life Skills programs attempt to teach young people to make healthy, responsible and appropriate choices about drinking in an effort to reduce alcohol misuse and problems related to excessive and abusive drinking patterns (International Centre for Alcohol Policies, 2011).

According to the WHO (2003), Life Skills programmes contributed to a decrease in alcohol misuse, drug abuse, smoking, delinquency, violence and suicide and to an improvement in pro-social behaviour. In connection with this, the family has been shown to be the strongest single influence of all external factors on young people's attitudes about drinking (Caria, Faggioano, Bellocco and Galanti, 2011:183). Given the wide range of cultural views on alcohol, Life Skills programmes need to be implemented in a culturally sensitive way and should address specific cultural issues.

Media and culture awareness have also been suggested as essential adjuncts to the life skills approach, beyond the critical thinking component already included. In addition, issues related to social environment, economics and opportunity also need to be addressed, given their impact on the choices and decisions that people make about drinking and health in general (International Centre for Alcohol Policies, 2011).

The Canadian Centre on Substance Abuse (CCSA) has recently released a newer version of "Building on Our Strengths: Canadian Standards for School-Based Youth Substance

Abuse prevention” (United Nations Office on Drugs and Crime, 2011). This document is aimed to reinforce the existing and new youth substance abuse prevention as well as health promotion efforts in Canadian schools (United Nations Office on Drugs and Crime, 2011). This document has become a very valuable resource for professionals within the education system as it provides a practical, evidence-informed framework that can be used to assess, develop and implement a comprehensive approach to drug prevention (United Nations Office on Drugs and Crime, 2011).

According to the National Youth Risk Behaviour Survey in South Africa, Medical Research Council (MRC) (2010), 30% of the learners who participated in the survey, reported that they were smoking. Of those who currently smoke, 43% had a parent or guardian who was smoking. Of those learners who did not smoke, 44% reported that they had a parent or guardian who smoked. Drug consumption varied from 13% for sometimes having smoked dagga, 12% for inhalants, 7% for cocaine, 7% for ‘tik’ and 7% for Mandrax (MRC, 2010).

2.4.1.3 Teenage pregnancy

According to Bishop (2007:2), America appears to be the country with the highest adolescent pregnancy rate globally with approximately 750000 adolescent births recorded per year. The National Campaign to Prevent Teen Pregnancy (2010) in America emphasizes the relationship between academic failure and teen pregnancy. Moreover, given the increasing demands in schooling necessary to qualify for a well-paying job, it is more important than ever for teens to finish high school and attain post-secondary education when possible. When looking at the impact of adolescent pregnancy it is evident that those concerned with the education of the youth should place emphasis on preventing adolescent pregnancy (The National Campaign to Prevent Teen Pregnancy, 2010:3). Several researchers have stated that children and adolescents who are involved

in their school environment are less at risk to fall pregnant compared to their peers (The National Campaign to Prevent Teen Pregnancy, 2010:3).

In 2005 the Australian Bureau of Statistics (ABS) reported that the number of registered births to adolescent mothers below the age of 15 added up to 10744, which represented 4% of all births within the country during that year (ABS, 2005:1).

According to the Department of Education in the United Kingdom (UK) (2011), the lack of quality sex and relationship education may contribute to high adolescent pregnancy rates. Research stated that school learners rarely obtain information about sex and relationships from their parents. Most sex and relationship education for school learners will happen within the school context (DoE (UK), 2011). Because this major source of information is not established to its full potential, it leaves many school learners without a credible source of information on which to base their decisions (DoE, 2011b). The Department of Education (UK) (2011:10b) further estimates that roughly 81% of adolescents obtain their sexual health knowledge mainly from less dependable sources such as peers and in lesser cases from TV programmes and online pornography.

According to the Human Sciences Research Council of South Africa (Panday, Makiwane, Ranchod and Letsoalo, 2009:2), it was estimated that during the period of 2004 and 2008 the adolescent pregnancy rate increased from 51,42 per 1000 learners becoming pregnant in 2004 to 62.81 per 1000 learners in 2008. This indicates a steady increase of 10, 39 adolescent births per 1000 adolescents during a period of 5 years (Panday *et al.*, 2009:22).

Furthermore, serious consequences regarding these estimates emerge when one explores the rates of adolescent abortions in South Africa. According to Panday *et al.*, (2009:58) there has been a 200% increase in adolescent abortions during the period from 1997 to 2003. For instance, it is estimated from the Department of Health records

that more than 70000 adolescent abortions occurred in 2003 (Human Sciences Research Council in Panday *et al.*, 2009:58). Therefore, it can be argued that the above-mentioned estimates of adolescent pregnancy only include those adolescents who gave birth. Thus the prevalence of adolescent pregnancy in South Africa is probably higher than originally estimated.

According to the National Youth Risk Survey in South Africa (MRC, 2010), a substantial number of young people are at risk in terms of their sexual health, and subsequently their physical and mental health as a result of the sexual choices they make or situations they find themselves in. Attempts to include sexuality education in schools have had limited success due to discrepancies in implementation in different schools (Varga, Shongwe, Edward-Miller and Makhanya, 1999). The implementation, quality and content of sexuality education are imperative for effecting changes in knowledge, in the cognitive determinants of sexual behaviour and in actual behaviour change like condom use (James, Reddy, Ruiters, McCauley and Van den Borne, 2006).

It is evident from the above discussion that a quality and reliable sexual health education is crucial for the development of children and adolescents. The impact of adolescent pregnancy stretches wide and can affect various areas of an individual's life. The first of these would be related to education.

The Human Sciences Research Council (Panday *et al.*, 2009) released a report based on a study it had conducted on behalf of the Department of Education. During a review of 56 programmes that were curriculum based (of which half were implemented within the school environment), it became evident that adequate sexual health education can both delay sexual activity and promote safer sexual practices amongst adolescents. In the same study Visser (2005) found that comprehensive programs with emphasis on both

abstinence and contraceptive use were more successful than programs that only focussed on abstinence.

Visser (2005) confirmed that the lack of proper implementation of Life Orientation in South Africa is mainly due to the fact that teacher training is not effective enough. Teachers lack the skills and knowledge to share information and teach skills on various issues such as HIV/AIDS and adolescent pregnancy. Visser (2005) furthermore suggests that life skills training with a specific focus on sexual health education should be incorporated into undergraduate educator training in order to improve teachers' skills and knowledge.

2.4.1.4 Psychological features, depression and suicide

Suicidal behavior has been described as ranging from merely thinking about ending one's life, through developing a plan to commit suicide and obtaining the means to do so, and attempting to kill oneself, to finally carrying out the act successfully (WHO, 2002). Although suicide rates tend to increase with age, global trends suggest that suicide is increasingly being reported among younger people (WHO, 2002). Suicidal behaviour is a major health concern in many countries, developed and developing alike. At least a million people are estimated to die annually from suicide worldwide (Bertolote, 2001).

Savignac (2002) describes various and increasing trends among young people in Germany, who engage in types of behaviors that indicate psychological disturbances, such as an addiction to lacerating their skin in order to release pressure and depression. Young people, it is claimed, have a lack of self-esteem, and are increasingly without orientation in a society which often approves of or condone deviant behavior (Savignac, 2002).

Suicide is also an immense problem in the USA, where it is estimated that suicide is the third-largest cause for death amongst adolescents aged 15-24 and the sixth-largest cause for children aged 5-14 (Facts for families, 2008:1). Adolescents experience strong feelings of stress, confusion, self-doubt, pressure to succeed and financial fears while growing up. For some adolescents suicide seems to be the quickest and most effective solution to their problems (Facts for families, 2008:1).

Childhood and adolescent depression have increased significantly within the past forty to fifty years. It seems that the average age of onset for mood disorders has fallen dramatically (Watkins, 2006). What is alarming about the prevalence of child and adolescent depression is that more children and adolescents with depression undergo one or more other major psychiatric diagnoses (Watkins, 2006). Anxiety disorder, substance abuse and Attention Deficit Hyperactivity Disorder (ADHD) are frequently associated with childhood and adolescent depression. Moreover, substance abuse often starts after the first episode of depression, although this can vary in different individuals. Other related conditions may persist even after the major depressive episode passes, and can render the child or adolescent more vulnerable to a recurrent depression (Watkins, 2006).

It has also been found that children and adolescents with depression accompanied by ADHD or conduct disorder are more likely to have adult criminal records and suicide attempts than their peers' who only experience depression. Besides the personal problems which depression and related disorders may cause, depression is also associated with school and interpersonal problems (Watkins, 2006). Furthermore it also correlated with increased incidence of suicidal behaviour, early pregnancy, alcohol consumption, tobacco consumption, violent thoughts and drug abuse (Watkins, 2006).

Karstens (2010:89) stated in a South African study that 42,5% of Grade 10 learners in former Model C schools had already experienced depression and/or had considered suicide, whereas 9,2% have actually attempted suicide. These findings are confirmed by the 2nd Youth Risk behaviour report (MRC, 2008), which indicated that for the six months prior to the research project, a quarter of learners (24%) reported having experienced feelings of sadness or hopelessness, 21% had considered suicide and 21% had attempted suicide; 29% of those who attempted suicide required medical treatment.

2.5 LIFE SKILLS EDUCATION/LIFE ORIENTATION IN SOUTH AFRICA

2.5.1 Introduction

Adapting to the new socio-political circumstances after 1994 in South Africa is a prime example of how people were enabled by life skills to cope with different situations. All of a sudden people from various backgrounds had access to neighbourhoods, schools and occupations from which they had been excluded in the past. The peaceful integration between people of cultural diversity demanded adaptive and inter-personal skills (Department of Education, 2010).

At the United Nations Millennium Summit in 2000, international consensus was reached to work toward achieving eight critical economic and social development priorities by 2015. The South African government used these priorities and accordingly formulated its *"Millennium Development Goals"* (MDG) (Republic of South Africa, 2010a:12). As a member state of the United Nations, South Africa is a signatory to this agreement (Republic of South Africa, 2010a:13). The eight MDGs are: (Republic of South Africa, 2010:12):

- to eradicate extreme poverty and hunger;
- to achieve universal primary education;

- to promote gender equality and empower women;
- to reduce child mortality;
- to improve maternal health;
- to combat HIV/AIDS, malaria and other diseases;
- to ensure environmental sustainability; and
- to develop a global partnership for development.

In accordance with the above MDGs, the South African government established the Medium Term Strategic Framework (MTSF, 2009-2014) which is a statement of government intent that identifies the development challenges facing South Africa and outlines the medium-term strategy for improving living conditions of South Africans (Republic of South Africa, 2010a:16). A comprehensive and integrated approach will reflect a range of MDG-related targets and indicators, including those on poverty, food security, education, gender, access to health services and environmental sustainability.

From the above it is thus evident that South African learners face the complex challenge of living in an increasingly demanding and rapidly changing world, where they have to make informed decisions, particularly about their health and well-being, lifestyles, relationships and careers. Protection from abuse, knowledge and application of their human rights and the practical application of democratic principles in our emergent democracy are additional issues learners have to deal with. Learners have a range of needs. Life Orientation has the potential to respond to many of these needs from a preventative and promotive perspective.

2.5.2 Curriculum review towards a new vision in education

Under the previous government in South Africa, the quality of education, teaching methods and assessments one would receive was determined by race (Dockrat, 1999:4). The system of segregation resulted in huge discrepancies between the quality of education in different geographical, race and socio-economic settings (Dockrat, 1999:4). Of all the race groups, the African schools were most neglected and especially Guidance Services were virtually non-existent (NEPI Report, 1992:21).

Curriculum change in post-apartheid South Africa started immediately after the election in 1994 when the National Education and Training Forum began a process of syllabus revision and subject rationalisation. The purpose of this process was mainly to lay the foundations for a single national core syllabus (Department of Education, 2002:4; Cronje, Dimant, Lebone, Macfarlane, Cardo and Ericsson, 2004:272-273).

The *Lifelong Learning through a National Curriculum Framework* document (Department of Education, 1996a) was the first major curriculum statement of an inclusively democratic South Africa. It was informed by principles derived from the White Paper on Education and Training (Department of Education; 1995b), the South African Qualifications Act No 58 of 1995 (1995a) and the National Education Policy Act No 27 of 1996 (Department of Education, 1998). In terms of the White Paper, it emphasised the need for major changes in education and training in South Africa in order to normalise and transform teaching and learning in South Africa. It also stressed the need for a shift from the traditional aims-and-objectives approach to outcomes-based education. It promoted a vision of (Department of Education, 2002:5):

“A prosperous, truly united, democratic and internationally competitive country with literate, creative and critical citizens leading productive, self-fulfilled lives in a country free of violence, discrimination and prejudice”.

The impetus for amendments to the old curriculum was thus to firstly redress the imbalances of the past; and secondly to provide a competent, holistic and practical replacement for guidance services. In the words of Shertzer and Stone (1971:40) formulated some years before these major changes, "*guidance is a process of helping an individual to understand himself and his world*". Thus Guidance focused on the total development of the child and it included both service and subject components (Department of Education, 2002:5).

According to the *National Education Policy Investigation Report* (NEPI, 1992:23), Guidance services encompassed a number of activities aimed at the vocational and general development of students. These activities included group guidance sessions which focused on career, education, social and personal development; programs such as life skills; psychometric testing and counseling.

Over the years, Guidance has become an undervalued and under-utilized subject (Dockrat, 1999:4). One major drawback to Guidance was that it required specialists to deal with the individual needs of children. Another shortcoming was that Guidance teachers often lacked the support of the management staff and other educators, since Guidance teachers only taught Guidance. Other teachers complained about the workload and felt that Guidance teachers carried an inadequate workload (Dockrat, 1999:45; Roets, 2002:4).

The new curriculum indeed offered the prospect that the imbalances of the past, and the ineffective teaching and learning of Guidance, would finally be addressed and overcome. The review of the curriculum led to the development of an innovative new learning area called "Life Orientation". Life Orientation replaced all forms of Guidance and was introduced to (Department of Education, 2002:7):

“guide and prepare learners for life and its possibilities, and equip learners for meaning and successful living in a rapidly changing and transforming society”.

However, given the historical context of Guidance in South Africa, the way it is incorporated into Life Orientation holds important ramifications for this Learning Area. Life skills, health and career education are the core aspects of Guidance that have been absorbed into Life Orientation. Career Education is part of Learning Outcome 5 of Life Orientation, which focuses on an orientation to the world of work in the Senior Phase (Department of Education, 2002).

2.5.3 Life Orientation in a challenging environment

Many children in South Africa, including those in biological and reconstituted families, foster-homes, safe-houses and the street, are at risk because of inadequate opportunities for harmonious socialisation in their communities (Richter, Brookes, Shisana, Simbayi and Desmond, 2004). Children and young adults are not adequately guided towards positive self-concept formation or the realisation of their full potential. Consequently, they grow towards irresponsible and unfulfilled adulthood where they may never experience the joy of harmonious relationships with their fellowmen (Prinsloo, 2005:29-30). Their lack of emotional stability contributes to the trend of violent crime, rape and murder, according to the South African Department of Basic Education (2011).

As a young democracy, South Africa has particular challenges to overcome. The years of suppression and exploitation under the previous government culminated in problems such as unemployment, poverty, lack of infrastructure and lack of access to basic needs. HIV/AIDS has led to many single-parent and child-headed households, which aggravates poverty. As a result, child abuse and neglect increase and worsen (Beckmann, 1994:228).

Many of these needs and challenges can be addressed through the Life Orientation learning area. The Department of Education has realised the scope and intensity of the above problems, and introduced Life Orientation to make a difference in the lives of a new generation of learners. The Department of Education (2002:5) further stated that: "the features of contemporary South Africa, and the nature of the personal challenges learners encounter in this society, guide the choice of the content of Life Orientation".

The development of Life Orientation has brought teachers and educational planners to the realisation that the only hope of reaching children at risk, lies in a holistic support and orientation system. Extensive research globally highlights the need for orientation programs that prepare learners adequately for the complex and dynamic life in the 21st century (cf. Pretorius, 1998, Engelbrecht, 1998, Department of Education, 2002; National Education Policy Investigation, 1992; White Paper on Education and Training, 1995b). Life Orientation is thus important as a possible answer to the various problems and challenges facing young people (Groves and Groves, 1980; Rooth, 2005).

The Department of Education in South Africa has taken cognisance of these findings of the research on the need for such orientation programs, which further motivated the development of a series of Life Orientation programs, which will be implemented over a period of twelve school years.

2.5.4 Scope of Life Orientation

2.5.4.1 Introduction

Learners have to find a place for themselves in a world which is radically different from when their parents were growing up. Despite the political changes in South Africa, learners' circumstances remain challenging. Crime and violence affect virtually every school, community and individual learner. Environmental issues affect the health and

well-being of communities. Within this context, learners have to develop a sense of confidence and competence in order to live well and contribute productively to the shaping of a new society (Department of Education, 2003b:19).

Outcomes Based Education means focusing and organising learning according to what is essential for all learners to know and be able to do successfully. Learning is thus framed in terms of outcomes. Learning Outcomes are clearly stated to guide the learning process. Assessment Standards identify the knowledge, skills, values and attitudes required to achieve the learning outcomes. They set the criteria that will provide the evidence for what learners know and are able to do at the end of each grade. The Learning Outcomes and their concomitant Assessment Standards indicate the centrality of health promotion in Life Orientation.

2.5.4.2 Learning Outcomes of Life Orientation

Life Orientation prepares learners to live meaningfully in a rapidly changing society. It opens channels of communication between the learner and the educator so that learners can see and understand the world better (Department of Education, 2003b:13). Life Orientation makes a unique contribution to the General Education and Training (GET) band as it:

- enables learners to make informed decisions regarding personal, community and environmental health;
- enables learners to form positive social relationships, respect different world views and exercise their constitutional rights and responsibilities;
- empowers learners to achieve and extend their personal potential to contribute positively to society, and cope with and respond to the challenges in the world;

- promotes physical development as an integral part of social, cognitive and emotional development from early childhood to the General Education and Training band; and
- develops a positive orientation to study and the world of work and the ability to make informed decisions on one's further study and career.

The Foundation, Intermediate and Senior Phases all cover the first Learning Outcomes 1 to 4, while the senior phase also includes Learning Outcome 5 (Department of Education, 2003b:19). Although these learning outcomes are similar across all 12 grades of school-going learners, it is adapted to be age-appropriate. It needs to be noted that the learning area in the Foundation Phase is called Life Skills and Life Orientation in the Senior Phase. For example, under "Health promotion" Grades 1 and 2 learners will be taught the importance of hand washing, while Grades 10 to 12 learners will be equipped with more advanced knowledge such as diet, sexuality and habits. The subject is termed Life Orientation in the Intermediate, Senior and FET phases, while it is called Life Skills in the foundation phase.

The first learning outcome is Health Promotion.

2.5.4.2.1 Learning Outcome 1: Health Promotion

The Department of Education (2003b:20) indicated that when this outcome is achieved, "the learner will be able to make informed decisions regarding personal, community and environmental health".

Health promotion in Life Orientation is developmental, promotive and preventative. It is focused on wellness, rather than merely on disease (Hoelscher *et al.*, 2004). The focus on preventative teaching helps learners to avoid problems, instead of waiting until problems occur. Life Orientation further aims to inform learners about their health

options, and is uniquely positioned to prepare learners to follow lifelong healthy lifestyles, reduce risk behaviour and attain optimal well-being.

Learners should be able to make informed decisions regarding personal health, community health and the environment (Department of Education 2002:5). In this regard learners should make choices regarding their personal health. This outcome addresses issues relating to nutrition, diseases including HIV/AIDS and sexually transmitted infections, safety, violence, abuse and environmental health. Issues involving risk factors such as crime, drugs, teenage pregnancy, sexually transmitted diseases are imported topics to be dealt with.

For the Intermediate Phase (Grades 4 to 6) the core components of Learning Outcome 1 are: safety, nutrition and substance abuse, physical changes and HIV/AIDS. For the Senior Phase they are: healthy lifestyles, sexuality, HIV/AIDS and safety (Department of Education, 2003b).

The following themes are prominent aspects of Learning Outcome 1:

- **Water and sanitation**

Knowledge of the source and quality of water is found in the learning outcome from the Foundation phase (Grades R-3) up until Senior Phase (Grades 7-9). In Grade R, for example, learners should be able to identify the importance of drinking only clean water. In Grade 2 learners must be able to describe sources of both clean and unclean water and be familiar with purification methods. In Grade 5, learners should be able to identify ways to protect the quality of water. In all grades, the link between sanitation and health is also explored, and the importance of personal hygiene – such as hand washing – is paramount in this outcome. Learners of all ages should be able to identify steps that can be taken to improve personal hygiene.

- **Tobacco and substance abuse**

In relation to alcohol and substance abuse, Life Orientation attempts to teach individuals the appropriate choices and consequences about drinking and drug use, in an effort to eradicate excess and abusive alcohol and drug use patterns (International Center for Alcohol Policies, 2011:1, Schönfeldt, 2007:12). Teachers should provide balanced and appropriate information about alcohol consumptions, drinking patterns and the consequences of alcohol and drug abuse.

Education regarding the use and abuse of illicit substances begins in the intermediate phase. In Grade 5, learners are evaluated on their ability to explain the effects of substance abuse on individual health and society, and in Grade 6 they have to identify the different types of abuse, and propose strategies to deal with them. In the senior phase, learners are taught the personal and social factors that contribute to substance abuse and must be familiar with rehabilitation options.

This topic is taught in great detail to learners in the Further Education and Training (FET) phase (Grades 10-12). They should be familiar with the symptoms of abuse and its effect on mind and body and be able to identify available support services and ways to access them. Furthermore, these learners are also introduced to medicine addiction and must be able to identify the importance of following instructions on medicine packets. They should be able to name the drugs that are illegal in South Africa (Botvin, 2000).

- **Nutrition**

Given the extremely high unemployment rate, poverty in South Africa is widespread (Integrated Regional Information Networks, 2004; Woolard, 2002). According to the national census conducted in 2001, the poverty index shows that 33% of South African households live below the poverty line (Statistics South Africa, 2001). One devastating

consequence of poverty is that basic needs such as nutrition cannot be met. The importance of nutrition to intellectual power and education is well established (Jukes, McGuire, Method and Sternberg, 2002).

In response to this, the Department of Education introduced the *The National School Nutrition Programme* (NSNP) (Department of Education, 2010:3). This programme was conceptualised primarily as an educational intervention aimed at enhancing the educational experience of the most needy primary school learners by promoting punctual school attendance, alleviating hunger, improving concentration and contributing to general health development (Department of Education, 2010:66).

Since its inception, the NSNP catered only for learners in public primary schools. However, following the 2006 survey by the Fiscal and Finance Committee (Department of Basic Education, 2009:3), it was confirmed that there was a need to expand the programme to secondary schools. In October 2008, the National Treasury increased the NSNP budget to progressively extend the programme to these schools (Department of Basic Education, 2010:67).

The key objectives of the NSNP are to contribute to enhanced learning capacity through school meals, strengthen nutrition education in schools and promote sustainable food production initiatives in schools.

In the Foundation Phase, learners must be able to explain the importance of eating fresh foods and make nutritious choices from a range of commonly available foods. They must be able to differentiate between healthy and poor dietary habits, and describe the effects of such habits on personal health. In the Intermediate Phase, learners investigate menus from different cultures and are asked to suggest plans for healthy meals. In Grade 6, they are taught how to interpret food labels and discuss the health effects of such listed ingredients. In the Senior Phase the emphasis is on self, and the learners

should be able to identify the nutritional value of their own personal diets. In the FET Phase, the focus is on the five main food groups and the links between a healthy diet and a healthy body (Department of Education, 2003b).

- **Safety and protection**

This section relates to both the safety of the physical school and home environment as well as personal health. In the Foundation Phase, learners are vulnerable to abuse. Addressing safety measures is particularly important to these learners. Firstly, their health is addressed: they should be able to demonstrate ways to protect themselves against diseases identify safe and unsafe precautions against communicable diseases, and distinguish between myths and facts regarding protection against illnesses (Stewart-Brown, 2006).

Secondly, the school and home environment is addressed: learners should be able to identify the term '*safety*' at school and home. They are informed about dangers and appropriate precautions on the route to school, and how to identify road signs relevant to pedestrians and know their meanings. In Grade 4, learners are taught the relevant people to contact in case of abuse, crime, fire or injury. In the Intermediate Phase, the focus is also on travel, as learners should list and explain traffic rules relevant to road users.

In the Senior Phase, personal input and responsibility is combined with safety and security. Learners should demonstrate informed and responsible decision-making regarding their safety and examine safety issues related to violence. They are asked to propose alternatives to violence and should be able to apply the insights gained from participating in activities such as a safety promotion program. Each school is supposed to have a school safety policy (see Chapter 5).

- **Sexual health**

HIV/AIDS has reached epidemic proportions in South Africa (Visser, 2005). By the end of 2002, it was estimated that 12 - 15% of the population was already HIV-infected (Department of Health, 2003; Shisana and Simbayi, 2002). The largest percentage of HIV-infected people was in the age group 15 – 29 years. Although exact figures about HIV/AIDS as a whole are not available, research findings show that many youth engage in high-risk sexual behaviour, including early sexual contact, infrequent condom use and multiple sexual partners (Taylor, Dlamini, Kagoro, Jinabhai and de Vries, 2003).

In 1998 Kushlick and Rapholo conducted a study among 18,500 learners from 600 secondary schools throughout South Africa. It emerged that 49% of learners indicated that they were sexually experienced. The average age of becoming sexually experienced in this group was 13 years. Furthermore, the study showed that learners do have a basic knowledge of HIV/AIDS. However, knowledge alone is not enough to assure 'safe' sexual behaviour (Eaton and Flisher, 2000).

In response to the HIV/AIDS epidemic the South African Departments of Education, Health and Welfare in 1995 embarked on a national program to implement life skills training, including sexuality and HIV/AIDS education in secondary schools (Department of Health and Department of Education, 1997/1998). However, the implementation of this specific program experienced many obstacles and did not take place in every school countrywide. There was no time on the timetable to present the programme, since all the periods were allocated to examination subjects (Visser, 2005). Magome, Louw, Mothoioa and Jack (1998) state that *"time for the life skills and HIV and AIDS intervention had to be negotiated."* With the introduction of Life Orientation as a compulsory Learning Area, HIV/AIDS as a component of Learning Outcome 1 was finally given

allocated periods on timetables, and each and every learner in the South African school system is exposed to HIV/AIDS education.

In the Foundation Phase, learners should be aware of HIV/AIDS and know how to protect themselves against the disease. Importantly, they are made aware of the basic routes of HIV/AIDS transmission. In the Intermediate Phase, the emphasis shifts to cures, prevention strategies and the effect of community and personal values. In the Senior Phase, learners should critically evaluate the resources on information and health services and be acquainted with a range of treatment options. In the FET Phase (Grades 10-12), more advanced concepts such as “sexually transmitted infections”, “opportunistic diseases” and “effectiveness of various protection methods” are introduced.

Sexual health also largely consists of outcomes related to sexual abuse. Already in Grade R, learners should know their right to say “no” to sexual abuse and be able to describe ways to do so. In Grade 1 they are taught to recognise situations that may be, or may lead to, sexual abuse. Learners in the Foundations Phase are also made aware of whom to contact in the case of abuse. In the Senior Phase, learners must discuss their personal feelings regarding social pressures associated with sexuality. Health Promotion as a part of Life Orientation is will be further discussed in Chapter 5.

2.5.4.2.2 Learning Outcome 2: Social development

According to the Department of Education (2002:5), learners should commit and show sensitivity to diverse cultures and belief systems. Recognition of other cultural groups will enhance respect, tolerance, compassion and empathy with people from different backgrounds (Maree and Ebersöhn, 2002:231).

Social development will further help learners to develop into adults who value and appreciate the importance of human rights and peace. Sinclair (2003) emphasises the

integration of life skills with human rights education. In this outcome, learners are also taught to understand the importance of relationships. According to Bruene-Butler, Hampson, Elias, Clabby and Schuyler (1997:37), teaching for human rights and peace can reach beyond the classroom into the community.

Life Orientation directly includes aspects of the Ottawa Health Charter (WHO, 1986) and WHO (1996) guidelines for Health Promoting Schools, such as the development of personal health skills and the promotion of learners' self-esteem. Life skills and self-efficacy, all pertinent to health promotion, are inherent in Life Orientation's learning and teaching (Rooth, 2006:1). Rooth (2006:2) also emphasises that Life Orientation aims to inform learners about their health options. Indigenous healing systems, traditional Western medicine and Eastern and complementary health approaches are dealt with as part of the Life Orientation curriculum. This enables learners to make informed decisions about their own health treatments.

In the Foundation Phase, this outcome largely consists of recognising one's responsibility towards others. Learners in Grade R should be able to name basic rights and responsibilities in the classroom. In Grade 1 learners are introduced to the class rules, and more importantly, should explain why they need to be followed. In Grade 2 and 3, this concept progresses to the rules and responsibilities of voting. In the Intermediate and Senior Phase the focus is on human rights, children's rights, citizen's rights and democracy (Rooth, 2006:2).

Another important aspect of Learning Outcome 2 is the concept of culture and religious diversity. Already in the Foundation Phase, learners are introduced to the South African flag and should recognise symbols and clothing from various cultures. Learners are also introduced to the diverse religions in the South African context. In the Intermediate Phase, they are assessed on their ability to relate the role of women, men and children in

different cultures and religions. In the Senior Phase, learners are introduced to the scriptures of different religions and reflect on their own role in promoting tolerance and peace despite the differences in cultural and religious beliefs (Department of Education, 2003b).

2.5.4.2.3 Learning Outcome 3: Personal development

This outcome concentrates on the acquisition of life skills. Learners should acquire Life Skills that will make them independent, creative and critical when solving problems (Maree and Ebersöhn, 2002:231). According to the Revised National Curriculum statement (DoE, 2002:47) this outcome gives learners an opportunity to develop survival and coping skills and acquire the ability to reflect and understand their emotional development, spiritual awareness, self-knowledge, self-concept and self-worth.

In the Foundation Phase, the learner already has some attitudes and feelings regarding personal worth and these are largely dependent on the learner's experience. In this phase, the outcome ranges from very simple concepts such as the ability to state your name and address, to more advanced skills such as the ability to explain how one copes with challenging emotions and demonstrate assertiveness. In the Intermediate Phase, learners are taught to consider and interpret the emotions of others and should demonstrate peacekeeping and mediating skills in different conflict situations (Department of Education, 2002). In the Senior Phase, the focus is on the recognition of ways to achieve and extent personal potential and to respond effectively to challenges in their world. They have to reflect on appropriate behaviours in various relationships and apply the acquired goal-setting and decision making strategies (Department of Education, 2003b).

Life Orientation, through this Outcome, also gives learners the opportunity to learn how to manage their emotions, through addressing emotions in all grades. It further includes

critical life skills dealing with conflict resolution, violence and self-management (Department of Education, 2003b).

2.5.4.2.4 Learning Outcome 4: Physical development and movement

This Learning Outcome focuses on physical development, and the golden thread of health promotion and skills development is also evident in this theme. Specifically, aspects of body image, motivation, locus of control and communication, team and lifestyle decisions are at the core of this outcome. In accordance, the close relationship between health education and physical education is well established (Biddle and Wang, 2003; Wilson and Rogers, 2004).

However, physical education in South Africa was one of the non-examinable subjects before the curriculum transformation. It was not taught at many schools, and, with retrenchments, many physical education teachers were lost to schools (Sitzer, 2001; Van Deventer, 2004; Wentzel, 2001). Reddy, Panday, Swart, Jinabhai, Amosun, James, Monyeki, Stevens, Morejele, Kambaran, Omardien and Van den Borne (2003) established that only 54.3% of learners had physical education on their school timetables and found that insufficient physical activity is indicated by 37.5% of learners. The hardest hit provinces are Gauteng and Western Cape, and more learners in these two provinces watch TV or play computer or video games for more than three hours per day than learners in the remaining seven provinces. Van Deventer (2004) and Wentzel (2001) also highlight the problem of insufficient attention paid to physical education in South African schools.

After the transformation of the education curriculum, physical education forms part of Life Orientation, with physical development and movement as the Learning Area (Department of Education, 2002). Physical development deals primarily with the body, while the term '*movement*' refer to the development, mastery and refinement of physical

and motor skills. The Western Cape Department of Education (2004a) stated that the efficient use of the human body and the development of healthy attitudes towards caring for the body are developed.

This Learning Outcome will ultimately aim to equip learners with the ability to demonstrate an understanding of, and participate in, activities to promote movement and physical development (Department of Education, 2002). The emphasis is on perceptual-motor development, physical growth and development, games and sport, as well as on recreational activities (Department of Education, 2002). The Department of Education (2002:6) concludes that these activities *"contribute to developing positive attitudes and values"*. Physical development is viewed as core to the holistic development of learners and, as such, augments their social and personal development. Hence, physical education is integral to Life Orientation as a Learning Area, as its contribution is vital in the achievement of all Life Orientation's Outcomes. The relationship is one of positive reciprocity: Life Orientation strengthens physical education by its inclusion and is strengthened by the incorporation of physical education.

The enjoyment is related to the maintenance of physical activity (Motl, Dishman, Saunders, Dowda, Felton and Pate, 2001). Ntoumanis (2002) concludes that it is logical to assume that physical activity programs in schools will have a more positive effect on learners when they are motivated to participate. With Life Orientation clearly aiming for learners to participate in physical activities on a lifelong basis, the concept of enjoyment needs to be considered.

Physical education can readily be integrated in all Life Orientation outcomes. Learning Outcome 1, dealing with Health promotion, is clearly interwoven in physical

development and movement. This is illustrated by various FET Assessment Standards, such as (Rooth, van der Straaten, Maluleke, Ferreira and Mbhele, 2006):

- participating in programmes to promote well-being;
- understanding the link between physical fitness and physical health;
- monitoring and evaluating one's own progress in the achievement of personal fitness and health goals through regular participation in a programme; and
- demonstrating an understanding of sports and recreational activities for a healthy lifestyle.

In Learning Outcome 2, Social development is promoted through physical education in the form of nation building, beneficial community and social interactions, and human rights in sports (Singh, 2002).

Hassandra, Goudas and Chroni (2003) suggest that physical education could have an important educational contribution to make to learners' personal development, as it provides opportunities for enjoyment, learning of new motor skills and for cooperating with others, as well as giving the potential for learning about a healthy lifestyle. Thus, Learning Outcome 3 integrates well with physical development, specifically with emotional literacy and life skills that deal with body image and general self-concept enhancement, relationships, leadership and organisational skills.

2.5.4.2.5 Learning Outcome 5: Orientation to the world of work

Learners in the Senior and FET Phases are exposed to Life Skills that emphasises the world of work. Learners must feel that courses and contents are directly relevant to the true business of life and to survival outside the artificiality of the traditional school setting (Rubenstein, 1994:58).

As the Senior Phase is the exit point to the Further Education and Training Band, learners should be trained in such a way that they will be able to make right decisions in terms of career choices. Life Orientation aims not only to empower but also to unlock the learners' abilities, talents and potentials (Maree and Ebersöhn, 2002:231).

Life Orientation broadens the range of career options for learners by being relevant and responsible to employment prospects and higher education opportunities. Work is an essential aspect of living a meaningful life. According to the Revised National Curriculum Statement for Grades R-9 (Department of Education, 2002:6), all learners in the GET Band require a general orientation to work and further study, whether they intend to enter employment or study further. Orientation to the world of work as stated in the Revised National Curriculum Statement Policy document (DoE, 2003b:47) includes career information, gathering and planning skills; personal evaluation skills and a positive attitude to work and work ethics.

Learning Outcome 5 is only applicable to learners in the Senior Phase (Grades 7-9). In Grade 7, learners have to discuss interests and abilities related to career and study opportunities. In Grade 8 they should be familiar with the requirements of study fields and in Grade 10 the focus is on the ability to research study and career funding providers and critically reflect and report on opportunities in the workplace. Finally, one must be able to outline a plan for one's own lifelong learning.

2.6 THE LIFE ORIENTATION LEARNING PROGRAMME (CURRICULUM)

2.6.1 Weighting of the Learning Programmes

In the Foundation Phase, the formal teaching time allocation for each Learning Programme is described in Figure 2.1:

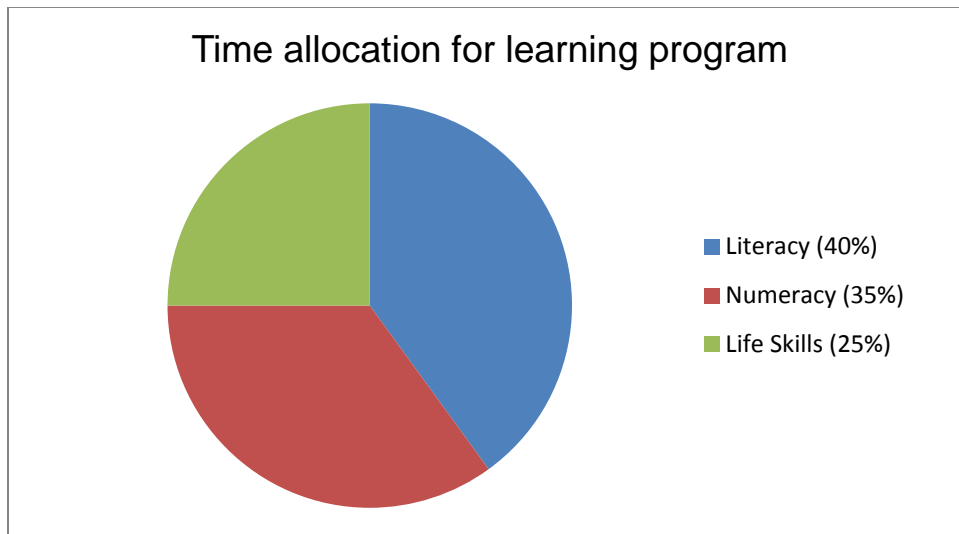


Fig 2.1: Percentage of time spent per Learning Programme in the Foundation Phase.

The Learning Outcomes are formally assessed in the Intermediate and Senior Phases, thus the time allocation for each outcome is discussed for these two phases. In the Intermediate Phase, the weight carried by each Learning Outcome as a percentage of total time dedicated to Life Orientation is (see Figure 2.2):

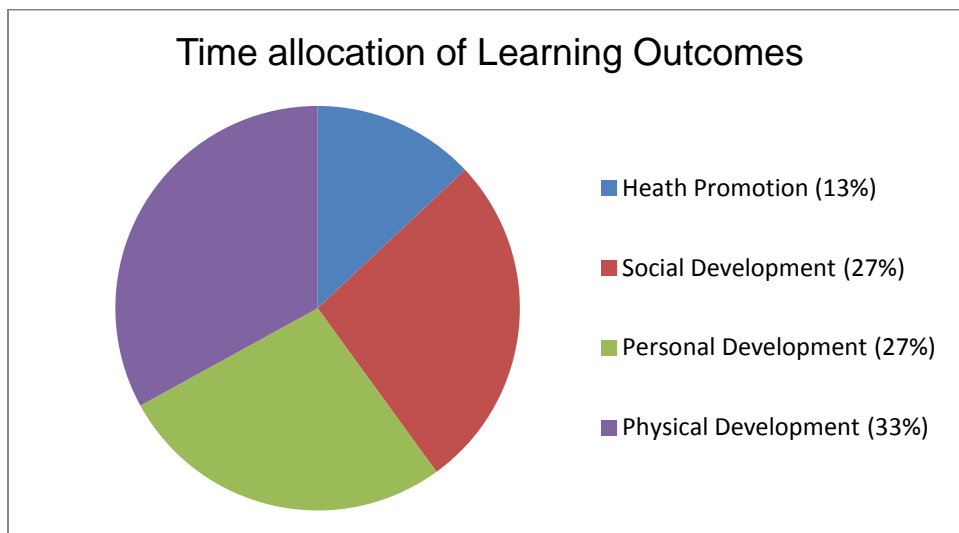


Figure 2.2: Percentage of time spent per Learning Outcome in the Intermediate Phase.

It is evident that most time is spent on physical development (see paragraph 2.5.4.2.4), less on social and personal development, and the least amount of time on health promotion.

In the Senior Phase, the time allocation is as follows:

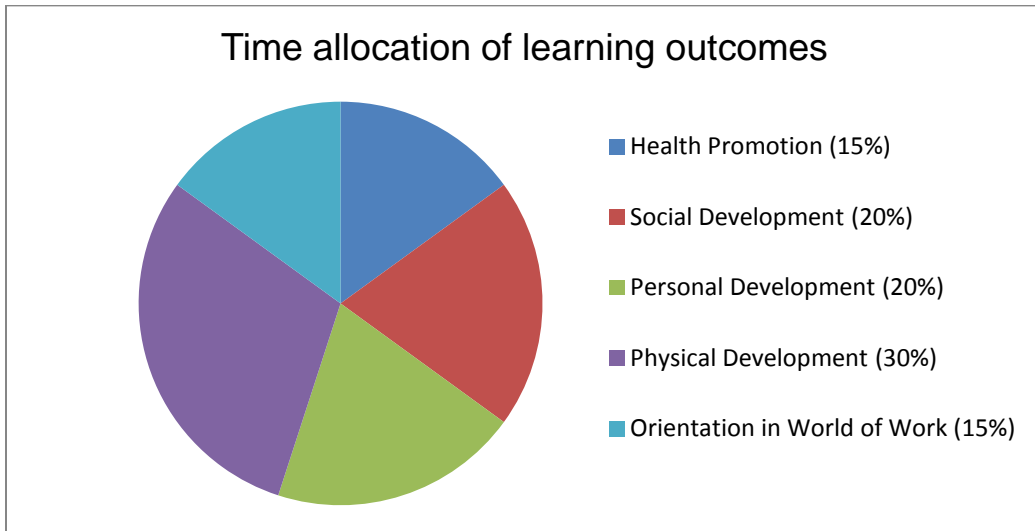


Figure 2.3: Percentage of time spent per Learning Outcome in the Senior Phase.

Once again, in accordance with the importance of physical activity as mentioned in paragraph 2.5.4.2.4, the most time is spent on physical development. Second is Personal and Social development and lastly there is Health promotion and Orientation to the world of work.

2.6.2 Assessment in Life Orientation

Teachers are encouraged to use experiential learning as a teaching-learning methodology in Life Orientation. The learning and teaching activities have to focus on the acquisition of knowledge, skills, attitudes and values relevant to one's functioning effectively in society. The main thrust of Life Orientation is according to the Department of Education (2003b:23), to enhance the *self-in-society*.

Lessons should be interactive and stimulate learner interest. Teachers should be flexible and always take the needs and realities of the learners into account, as the learners' needs and experiences form the basis for learning and teaching. Teachers need to encourage reflection and allow for the application of the knowledge and skills learnt (Department of Education, 2003b:7).

Although attitudes and values are not easily observable, they do exist and form an integral part of the assessment. Values and attitudes are difficult to assess because they refer to internal states that are closely linked with emotions. They influence what people like and dislike doing. Thus the assessment is not only carried out on the product at the end of the learning experience, but also on what is happening during the learning process, particularly in the changes occurring in knowledge, skills, attitudes and values (Department of Education, 2003b:24). For example, when making a poster the emphasis is on what the learner is feeling, thinking, learning and doing during the learning process, rather than what the poster looks like in the end. Therefore the assessments methods used need to be carefully considered and structured to measure the processes and not the end products alone.

From the learner's external actions and behaviours one can infer his/her internal state. Methods to assess in Life Orientation include action research, projects, written tasks/tests, practical demonstrations/performances, assignments, debates and role play (Department of Education, 2003b:24).

A four-point rating scale is used for assessments in Grades R to 6, and a seven-point rating scale in Grades 7 to 12 and at NQF Levels 2-4. In FET, external Certificate Assessment Tasks form part of the assessment process, but there is no formal examination at the end of Grade 12. The various achievement levels and their corresponding percentage bands are as shown in Table 2.1 below.

TABLE 2.1: Scale of achievement

RATING CODE	RATING	MARKS %
7	Outstanding achievement	80-100
6	Meritorious achievement	70-79
5	Substantial achievement	60-69
4	Adequate achievement	50-59
3	Moderate achievement	40-49
2	Elementary achievement	30-39
1	Not achieved	0-29

2.6.3 Inclusive education

Education White Paper 6: Special Needs Education – Building and Inclusive Education and Training System (Department of Education, 2001b) makes it very clear that all learners need to be taught and assessed within the same curriculum and assessment framework. The White Paper moves from the categorisation of learners according to disability (medical model) to assessing the needs and levels of support required by individual learners to facilitate their maximum participation in the education system as a whole. The focus is on providing sufficient differentiation in curriculum delivery to accommodate learner needs and making the support systems available for learners and schools (Department of Education, 2001b:8).

The following statements emphasise the fact that inclusion is centrally a curriculum issue (Department of Education, 2001b:9): inclusive education and training are about acknowledging that all children and youth can learn provided they receive support and that participation in special and full-service schools will be expanded by promoting the opportunity for specific life skills training and programme-to-work linkages.

Teachers should understand the wide range of barriers encountered by many learners in their classrooms. Barriers to learning according to White Paper 6 (Department of Education, 2001b:24) within the South African context include the following:

- systematic barriers – including lack of access to basic services, poor teaching, lack of basic and appropriate teaching-and-learning support materials and assistive devices, inadequate facilities at schools, and overcrowded classrooms;
- societal barriers – including abject poverty, late enrolment at school, urban/rural disparities, and discrimination on the grounds of race, gender, language and disability;
- barriers rooted in inappropriate pedagogy, insufficient support of teachers, inappropriate and unfair assessment procedures, the language of instruction, inflexible classroom management, and inappropriate attitudes; and
- factors that emerge from within the learner because of disabilities (e.g. neurological, physical, sensory, cognitive) and other conditions (e.g. disease, chronic illness, trauma).

It is essential to acknowledge that many of the barriers to learning that draw attention in the White Paper are being tackled within many other national and provincial programmes of Departments of Education, Health, Welfare and Public Works. To illustrate, in the case of the Department of Education, the Tirisano programme, the District Development Programme, the Language-in-Education Policy, the HIV/AIDS Life Skills Programme and the joint programmes with the programmes that are already seeking to uncover and remove barriers to learning experienced in mainstream education (Department of Education, 2001c:25).

The Department of Public Works is implementing a job creation project to provide ramp access for learners on wheelchairs to schools. The Department of Health is implementing an Integrated Nutrition Strategy including the Primary Schools Nutrition Project to provide learners from poor families with a nutritious meal. The Department also provides free health care for children younger than six years, while the Technical Guidelines on Immunisation in South Africa (1995) provide for children younger than five years to be prioritised for nutritional intervention (Department of Education, 2001b:25).

2.7 LIFE ORIENTATION AND HEALTH PROMOTION

2.7.1 Learning Outcomes related to Health promotion

Each of the five Learning Outcomes is directly linked to Health promotion.

2.7.1.1 Learning Outcomes related to Health promotion in Grades R to 9

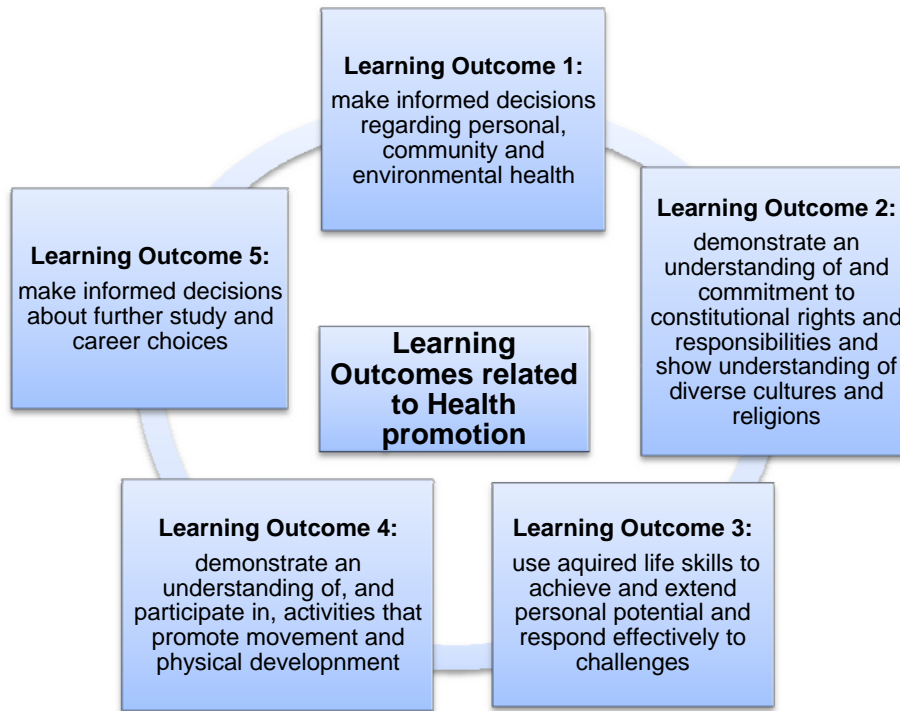


Figure 2.4: Learning Areas related to Health promotion Grade R – 9.

2.7.1.2 Learning Outcomes related to Health promotion in Grades 10 to 12

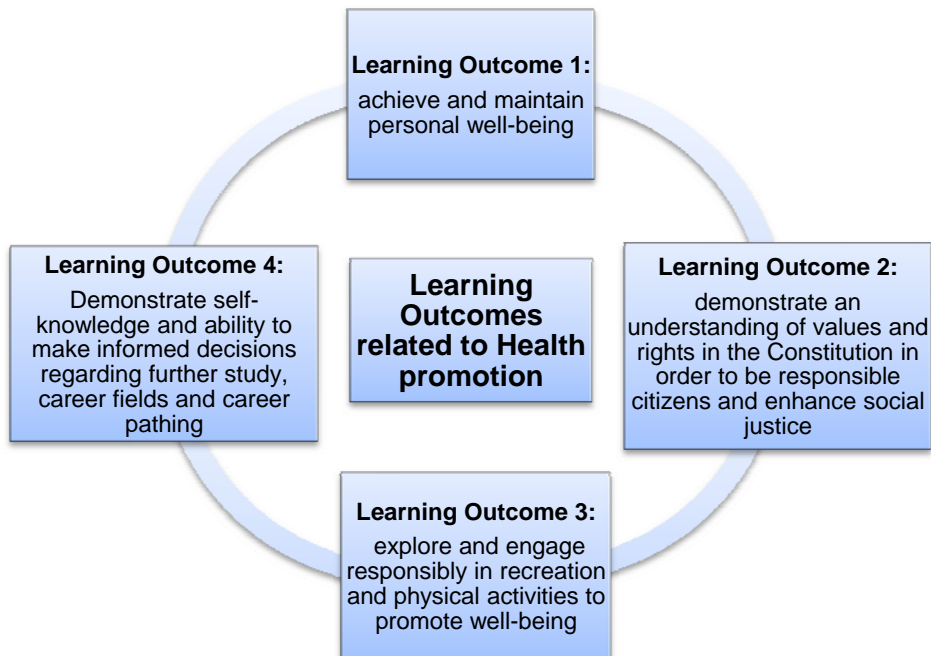


Figure 2.5: Learning Areas related to Health promotion Grades 10 to 12.

2.7.2 Assessment Standards related to Health promotion

Some of the Assessment Standards used in the evaluation of learners are directly linked with Health promotion. Table 2.2 shows grade-per-grade data regarding assessments and their relation to health promotion. In this table LO refers to the Learning Outcome. Indicated in the table below, the most significant assessment outcomes are in bold.

2.7.2.1 Foundation Phase (Grades R to 3)

In the Foundation Phase the focus is on clean water, nutrition and personal hygiene. Furthermore, learners are introduced to communicable diseases, sexual abuse and getting to know one's own body. Learners are taught how to protect themselves from environmental hazards, abuse and diseases. Learners are also assessed based on their perceptual motor skills, coordination and movement.

Table 2.2: Grade and Assessment Standards - Grades R to 3

Grade	Assessment Standard
R	LO1: Explain the importance of drinking only clean water and eating fresh food . Describe steps that can be taken to ensure personal hygiene . Demonstrate precautions against the spread of communicable diseases and explain safety at home and school. Know the right to of children to say "no" to sexual abuse and ways to say no. LO3: Describe what your own body can do. Express emotions without harming self, others or property. LO4: Play running and chasing games while using space safely . Explore different ways to rotate, elevate and balance . Perform expressive movements using different parts of the body and participate in free play activities.

1	<p>LO1: Identify nutritious choices from a range of commonly available food and drinks. Explain steps to ensure personal hygiene and link these steps to environmental health. Learners should distinguish between safe and unsafe precautions against communicable diseases. Identify dangers and appropriate precautions on route to school and recognise situations that may lead to, or are sexual abuse.</p> <p>LO2: Describe own body in a positive way and be able to express emotions in a non-destructive way.</p> <p>LO4: Demonstrate ways of throwing, rolling, bouncing and receiving with a ball or similar equipment. Use a combination of body parts to move, rotate, elevate and balance with or without equipment. Respond to a variety of stimuli and express different moods and feelings through movements. Learners should participate in free play activities using a variety of equipment.</p>
2	<p>LO1: Describe sources of clean water and know simple purifying methods. Suggest ways to make the home and school environment safer. Identify communicable diseases and ways to prevent spread.</p> <p>LO3: Describe how to treat your own body well.</p> <p>LO4: Participate in a variety of indigenous games with simple rules, both individually and in a group. Participate in activities to promote control, coordination and balance. Perform expressive movements or patterns rhythmically using various stimuli. Take part in structured activities using equipment.</p>
3	<p>LO1: Compare healthy and poor diets and know the effects of such habits on personal health. Discuss myths surrounding communicable diseases as well as causes and prevention. Learners should be aware of authorities to report accidents, abuse, crime, fire and illness.</p> <p>LO3: Explain why your own body should be respected. Explain how one should cope with challenging emotions, including dealing with people living with disease and illness.</p> <p>LO4: Demonstrate a variety of perceptual motor skills and be able to perform basic movements in sequence and with repetition. Learners should explore movements using contrasts such as speed, direction and body shape.</p>

Adapted from Department of Education (2003)

2.7.2.2 Intermediate Phase (Grades 4 to 6)

In the Intermediate Phase (Table 2.3), nutrition is assessed in more detail, learners should be able to set healthy menus and interpret food labels. They should be able to establish a link between a healthy environment and personal health, and be aware of the changes associated with entering puberty. Participation in sports and indigenous games are encouraged.

Table 2.3: Grade and Assessment Standards: Grades 4 to 6

Grade	Assessment Standard
4	<p>LO1: Investigate menus from various cultures and suggest plans to make them healthier. Explore the link between a healthy environment and personal health. Explain children’s health rights and how to apply them.</p> <p>LO3: Explain why other persons’ bodies should be respected.</p> <p>LO4: Participate in a variety of games and demonstrate ways to rotate elevate and balance using different part of the body, with control. Demonstrate basic athletic techniques. Perform rhythmic movements with awareness of posture. Identify dangers and responsible safety measures in and around water.</p>
5	<p>LO1: Explore the ways to protect the quality of water and food in various contexts. Investigate a local environmental health problem and propose strategies to address the problem. Recognise the symptoms and preventions of local diseases. Explain the causes of communicable disease (including HIV/AIDS) and identify different types of abuse.</p> <p>LO2: Show an understanding of and respect for body changes.</p> <p>LO4: Explore a range of games and perform movement sequences that require consistency and control in smooth and continuous situations. Demonstrate a range of athletic techniques. Perform rhythmic movements and steps with attention to posture and style. Demonstrate knowledge of safety measures in and around water.</p>
6	<p>LO1: Interpret food labels and discuss the health effects of the ingredients. Participate in problem-solving activities to address environmental health issues. Explain the causes of communicable diseases (including HIV/AIDS) and available cures and prevention strategies. Identify the different forms of abuse.</p> <p>LO2: Discuss the effect of abuse on personal and social relationships.</p> <p>LO3: Reflect on body image and how to respond to peer pressure. Demonstrate peacekeeping and mediation skills.</p> <p>LO4: Apply relevant concepts in a variety of striking and fielding games. Demonstrate refined sequences emphasising changes in shape, speed and direction through gymnastic actions. Participate in physical fitness programs to develop aspects of fitness. Perform rhythmic patterns of movement with coordination and control. Apply basic First Aid in different situations.</p>

Adapted from Department of Education (2003)

2.7.2.3 Senior Phase (Grades 7 to 9)

Learners are introduced to the effect of diseases and the influence of the environment on their health, as well as disease prevention. Learners should be able to recognise social factors contributing to substance abuse and to cope with depression, crisis and

trauma and to respond appropriately on an emotional level to challenging situation (Table 2.4).

Table 2.4: Grade and Assessment Standards: Grades 7 to 9

Grade	Assessment Standard
7	<p>LO1: Propose ways to improve the nutritional value of own diet. Evaluate actions to address an environmental health problem. Describe strategies for living with disease, including HIV and AIDS. Discuss personal feelings, community norms, values and social pressures associated with sexuality.</p> <p>LO3: Report on the implementation of strategies to enhance own and others' self-image through positive actions. Evaluate media and other influences on personal lifestyle choices and propose appropriate responses. Demonstrate and reflect on decision-making skills.</p> <p>LO4: Perform a sequence of physical activities including rotation, elevation and balance movements. Participate in and report on a fitness program.</p>
8	<p>LO1: Plan an action in which laws/policies for protecting environmental health are applied to address an environmental health issue. Critically analyse the causes of common diseases in relation to socio-economic and environmental factors. Describe what a healthy lifestyle is in your own personal situation, as a way to prevent disease. Demonstrate informed, responsible decision making about health and safety. Examine a health and safety issue related to violence, and propose alternatives to violence as well as counter strategies.</p> <p>LO3: Explain how to cope with depression, crisis and trauma. Design and implement a personal plan for preventing and managing stress.</p> <p>LO4: Participate in a fitness program and record progress.</p>
9	<p>LO1: Illustrate and evaluate the influence of ecological, social, economic, cultural and political factors on own personal choice of diet. Develop and implement an environmental health program. Investigate personal and social factors that contribute to substance abuse and suggest appropriate responses and rehabilitation options. Critically evaluate sources on health information, health services and a range of treatment options, including HIV and AIDS. Discuss ways to apply insights gained from participating in an activity related to a national health or safety program.</p> <p>LO3: Respond appropriately to emotions in challenging situations.</p> <p>LO4: Assess own physical wellness level and set personal goals for improvement.</p>

Adapted from Department of Education (2003)

2.7.2.4 FET Phase (Grades 10 to 12)

In the Further Education and Training (FET) Phase the focus is on successfully entering adulthood and making the correct lifestyle choices to ensure optimal potential of each individual. Learners are assessed on their knowledge of fitness, managing of stress and their understanding of a healthy lifestyle (Table 2.5).

Table 2.5: Grade and Assessment Standards: Grades 10 to 12

Grade	Assessment Standard
10	<p>LO1: Explain changes associated with growing towards adulthood and describe values and strategies to make responsible decisions regarding sexuality and lifestyle choices in order to optimise personal potential.</p> <p>LO2: Identify social and environmental issues and participate in a group project to address a contemporary issue e.g. HIV and AIDS.</p> <p>LO3: Participate in programs to promote well-being and describe the relationship between physical fitness and physical, mental and socio-emotional health.</p>
11	<p>LO1: Describe the characteristics of a healthy and balanced lifestyle, and factors influencing responsible choices and behaviour in the promotion of health, and the impact of unsafe practices on self and others.</p> <p>LO2: Participate in a community service that addresses a contemporary social or environmental issue, indicating how this harms certain sectors of society more than others (e.g. HIV and AIDS).</p> <p>LO3: Set own goals and participate in programs to improve current level of fitness and health, and investigate how nutrition relates to these.</p>
12	<p>LO1: Apply a range of life skills, evaluate own ability to prevent and manage stress, and adapt to change as part of own ongoing healthy lifestyle.</p> <p>Investigate the human and environmental factors that cause ill-health, accidents, crises and disasters, and explore appropriate ways to deal with these.</p> <p>Explain how unequal power relations between the sexes are constructed and influence health and well-being and apply this understanding to work, cultural and social contexts.</p> <p>LO3: Monitor and evaluate own progress in achievement of personal fitness and health goals through regular participation in a program.</p> <p>Evaluate and participate in various relaxation and recreational activities, sports and games with a view to making a choice about participating and long-term engagement in at least one activity.</p>

Adapted from Department of Education (2003)

2.8 CONCLUSION

The purpose of this chapter was to explore the current scenario concerning Life Orientation in South African schools. This chapter also defined Life skills and Life Orientation, as well as the scope and assessment of the various Learning Outcomes. Finally, Health promotion as a component of Life Orientation was discussed. The next chapter will focus on Health promotion in schools and the aspects of a healthy school environment.

CHAPTER 3

THE HEALTH PROMOTING SCHOOL (HPS)

3.1 INTRODUCTION

The concepts of Health Promotion and the Health Promoting School (HPS) appear to have gathered a great deal of impetus over the years given the ever-increasing health and safety issues facing individuals and communities all over the world. This chapter presents an overview of various aspects and perspectives pertaining to the global health initiative, Health Promotion and the HPS. The current situation concerning Health promoting schools in the Gauteng Province in the South African context is also outlined.

3.2 HEALTH PROMOTION

Health promotion is a term that is used to describe activities which are intended to prevent diseases and ill-health as well as to increase well-being in the community. Health promotion therefore centres hugely around the concept of health.

3.2.1 What is health?

Health is a term that is open to multiple interpretations. Throughout history, society has entertained a variety of concepts of health (Edelman and Mandle, 2002). Therefore health can mean different things to different people, cultures and disciplines. The principles of the World Health Organization, Health for All (WHO, 1985) acknowledge that health is a relative concept to which people attach different meanings (Naidoo and Wills, 2005:35). Over the years the term health has been defined along and confined to the medical terms where it has been described as being free from diseases and ill-health as well as being in good shape. For instance some people consider themselves healthy if

they are not feeling ill. Others may think they are healthy if they engage in some practices that fulfil their interpretation of being healthy (Anspaugh, Dignan and Anspaugh, 2002).

To some extent the social functioning of the body was also regarded as being in state of good health. For instance Tarlov (1996), as cited by Tones and Tilford (2001), defined health as the capacity to perform the demands of the social environment, as well as a process of achieving individual fulfilment such as pursuit of values, tasks, needs, aspirations and potential. However, such definitions may seem inappropriate as they may imply that people should be healthy in order to perform certain tasks expected of them in the society.

However, the term health is now viewed differently to address the whole wellness of the human being. It is viewed in broader and more holistic approaches and includes all the components and aspects of health. Edelman and Mandle (2002) define health as a state of physical, mental and social functioning that realises the person's potential. This is in line with the WHO definition that health is "a state of complete physical, mental and social well-being and not the absence of disease and infirmity" (WHO, 2006:1). This definition may still be perceived limited in scope as it may suggest that anyone with the slightest imperfection in their bodily psychological or social functioning cannot be healthy (Lucas and Lloyd, 2005:6).

Health should be seen as being composed of a number of factors which enable a person to achieve all that he/she has potential to become. Health is to a certain extent a matter of cleanliness, proper diet, and exercise though it can mean more than that. Lucas and Lloyd (2005) assert that health should encompass all the areas of human existence. These are physical, mental, emotional, spiritual and social health. This was confirmed by Anspaugh *et al.* (2002) that the definition of health is of holistic nature.

The physical, mental, emotional, intellectual, spiritual and the social aspects of one's life should interact harmoniously if one seeks to maximise personal potential. Therefore an ideal state of health and wellness should be where no single component of health is emphasised at the expense of another (Viljoen and Kirsten, 2006:8).

To achieve optimal health and wellness, one must strive to maintain a balance in all the areas of human existence as stated by Anspaugh *et al.* (2002); Lucas and Lloyd (2005):

- **Physical wellness:** This indicates appropriate sleep/rest for maximum physical care. Physical wellness includes the development of the health-related components of fitness like avoiding use of drugs and alcohol.
- **Mental wellness:** This is concerned with the ability to think clearly and coherently.
- **Emotional wellness:** It is the ability to manage stress in a more positive manner and to express emotions appropriately. Emotional health includes the knowledge to recognise and accept human feelings as well as skills (coping mechanisms) to defeat setbacks and failures. Emotional wellness also includes a sense of belonging and being in harmony with the environment.
- **Spiritual health:** This is the ability to discover, articulate and act on basic purpose and beliefs about life. Spirituality includes morals, values and ethics. Spiritual health fosters an awareness that serves to identify and promote values such as patience, perseverance, kindness, compassion, hope and joy, all of which support good health practices (Culliford and Powell, 2005).

Health promotion places optimal health at the forefront. The Ottawa Health Charter (WHO, 1986) frames health as a resource that is created in the context of everyday life (Kickbusch, 2003:383).

3.2.2 What is Health promotion?

Health promotion at its simplest involves improving people's lives and keeping them healthy (Pike and Forster, 1997:3). Tones and Tilford (2001) state that in simple form Health promotion refers to a planned intervention that seeks to improve health and prevent diseases. Health promotion as expanded definition includes all activities that educate, guide and motivate the individual to take personal activities that improve the likelihood of sustained good health and increase the appropriateness of requested services (Fries, Koop, Sokolov, Beadle and Wright, 1998:76).

However, to be more appropriate and logical in elaborating the meaning of Health promotion, it is necessary to refer to the roots and origins of Health promotion. As confirmed by Edelman and Mandle (2002) over the years, the promotion of health has moved to the forefront together with public health and has become the driving force in health care and other health-related issues.

3.3 THE GLOBAL HEALTH INITIATIVE

Within the international context the Global Health Initiative, which was and still is driven by the WHO, had its initial point of departure in the *Lalonde Report* (1974). This report argued for perspectives on the health of the Canadian population which was based on preventing diseases and on promoting health. This was the initial development of Health promotion (Edmondson and Kelleher, 2000). The *Lalonde Report* was later used as a turning point in international policy development and new public approaches to health. The *Lalonde Report* suggests that health is determined by more than merely biological factors. The following are the four health fields that the *Lalonde Report* suggests that health depends on: environment, human biology, lifestyles and health care services.

Secondly, the *Alma Ata Declaration* (WHO, 1986) was also a major development towards Health promotion in recognising primary health care as a key to achieving a healthy population. The conference aimed at protecting and promoting the health of the people and groups living in community settings. The conference also advocated strongly for the attainment equity (Tones and Tilford, 2001). From this declaration WHO (1986) began to place a great emphasis on pre-requisites for health on housing and work, environment, social and economic factors and conditions for good health rather than concentrating on curing diseases (Pike and Forster, 1997). The following assertions were made at the Alma Ata Declaration (Tones and Tilford, 2001:21):

- the existence of inequalities between the advantaged and the disadvantaged people was politically, socially and economically unacceptable;
- pursuit of equity, economic and social development was essential to achievement of health; and
- people have a right to participate individually and collectively in the plan and implementation of their health.

Probably the most influential document on health and Health promotion, the *Ottawa Health Charter for Health Promotion*, was developed at a meeting in Ottawa Canada in 1986. The Ottawa Health Charter (WHO, 1986) made Health promotion operational and gave it a much more realistic base. It built on the progress made with the support of the Alma Ata Declaration on Primary health care and therefore was firmly based on principles of equity and social justice and on achieving '*Health for All*' by the year 2000 and beyond (Pike and Forster, 1997:30).

The Ottawa Health Charter (WHO, 1986) redefined and repositioned the meaning of health as well as the orientation of Health promotion. Health promotion began to shift from focusing on the modification of individual risk factors and risk behaviours to

addressing the context and meaning of health actions and the determinants that keep people healthy (Kickbusch, 2003:383). The Ottawa Health Charter (WHO, 1986) for Health promotion has since been a worldwide guidance and inspiration for health promotion development through its five principles or strategies (Edmondson and Kelleher, 2000:46). The basic principles of the Ottawa Health Charter are to build healthy public policies, to create supportive environments, to strengthen community action, to develop personal health skills and to re-orientate health services to new health-promoting functions (Pike and Forster, 1997; Edmondson and Kelleher, 2000; Tones and Tilford, 2001).

Internationally, the Ottawa Health Charter (WHO, 1986:3; Ntuli, 2000:5) recognises that health is created and lived by people working within the settings of their everyday life. Essentially, this is a setting where an individual is able to live, work, learn, play and love. Similarly, a school may also be regarded as such an environment.

According to the Ottawa Health Charter (WHO, 1986:3) health promotion is "*the process of enabling people to increase control over, and improve their health*". In order to reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and realise aspirations, to satisfy needs and to change or cope with the environment. The Ottawa Health Charter (WHO, 1986:3) advocates that good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, social, cultural, environmental, behavioural and biological factors can all favour or harm health. Thus, Health promotion action aims at making these conditions favourable through advocacy for health.

The international conference that gave further energy to the Health promotion agenda in the world was held in Adelaide 1988. The conference was based on the premise that health is both a fundamental human right and a sound social investment (Edmondson

and Kelleher, 2000; Tones and Tilford 2001). The conference urged governments to promote health through linked economic, social and health policies. It further stressed the importance of equity in health (Tones and Tilford, 2001). The Adelaide conference further identified four priority areas for public health policy are to improve the health of women, food and nutrition, tobacco and alcohol and creating supportive environments (Edmondson and Kelleher, 2000).

The next leading conference on Health promotion took place in Sundsvall, Sweden in 1991. The Sundsvall Conference (1991) highlighted the link between health and the physical environment. It mainly focused on environments and their spiritual, political and ideological dimensions (Tones and Tilford, 2001). The Conference focused on six specific areas, namely education, food and nutrition, home and neighbourhood, work, transport and social support and care (Tones and Tilford, 2001).

Six years later another declaration was signed at the 1997 Jakarta conference (WHO, 1997b). The conference reiterated the importance of the agreements made in the Ottawa Health Charter for Health promotion and added emphasis to aspects of public Health promotion. The Jakarta Conference set out priorities for the 21st century. It acted as a catalyst for Health promotion actions nationally, internationally and globally (Edmondson and Kelleher, 2000). The Conference was held against disparities of major global changes which included the widening gap between the rich and the poor, demographic changes as well as the double burden of diseases. The Jakarta Conference (WHO, 1997b) placed Health promotion firmly at the centre of health developments (Edmondson and Kelleher, 2000), and therefore was aimed at the following objectives: promoting social responsibility for health, increasing investment for health development, consolidating and expanding partnership for health, increasing capacity

and empowering the individual in health matters and securing an infrastructure for Health promotion (Tones and Tilford, 2001).

Three more international conferences on Health promotion were held. These include the *Fifth Global Conference on Health Promotion, Health Promotion: Bridging the Equity Gap* (2000) in Mexico; the *Sixth Global Conference for Health Promotion in a Globalized World, Policy and Partnership for Action: Addressing the Determinants of Health* (2005) in Bangkok, and the *Seventh Global Conference for Health Promotion, Promoting Health and Development: Closing the Implementation Gap* (2009) in Nairobi Africa (WHO, 2009a). With these last three global conferences the Health promoting community is, for more than twenty five years, putting the Health promotion squarely on the world agendas challenging world leaders and all other stakeholders to strive to achieve health for all.

The last document which was identified as a leading document, is the WHO's *Expert Committee on Comprehensive School Health Education and Promotion* (WHO, 1997a). This committee developed a set of recommendations to improve health as well as education. The goal of the WHO's Global School Health Initiative is to increase the number of schools that can be called 'Health promoting schools' (HPS) and relates to schools that constantly strengthen their capacity as healthy settings for living, learning and working (Meyer, 2005:45).

A range of factors has been identified as impacting the health and development of children world-wide. Among these factors are poverty and the environment in which children function. Nutritional status, sexual activity, HIV/AIDS and reproductive health also play a role. Furthermore, trauma, violence, mental health, hearing, visual and speech impairment (Lynagh, Knight, Schofield and Paras, 1999:227; Coulson, 2000:1; Department of Health, 2003:5) may have dire consequences for the health of a child.

These health problems have become key considerations in the development of proposed packages for school health activities such as HPS. The concept of the HPS is part and parcel a global school health initiative that offers a holistic approach, addressing the various factors that influence the health of young people (Nutbeam, 1998: 27; Lynagh, Perkins and Schofield, 2002:300; Kwan, Petersen, Pine and Borutta, 2005:677).

The link between the health and well-being of learners and their capacity to benefit from educational opportunities and attain high standards of achievement has been well-established for many years. Healthy children learn well and their ability to attend school is affected by their health. Good health narrows the opportunity gap and has significant positive effects on personal, social and educational achievement (St. Leger and Nutbeam, 2000:257). The promotion of healthy lifestyles can also benefit learners now and in the future, enabling them to contribute to their communities as adults (Coulson, 2000:1; Japanese International Co-Operation Agency (JICA), 2007:2).

Schools have been identified as important Health promotion settings since young people spend over one third of their day at such institutions (Rowling and Rissel, 2000:248). Furthermore, schools make it possible for learners to gain the knowledge, attitudes, values, skills and services they need to be healthy and to avoid important health problems (St. Leger and Nutbeam, 2000:258). Thus, promoting HPS could be one of the most efficient ways to improve learners' lives (JICA, 2007:3). Schools are also complex social systems which have the potential to influence the health of all of those which work within them through the way in which they function and the activities which they promote (Rowling and Rissel, 2000:249).

Formal evaluation of the HPS is currently limited. The WHO and the European community have funded a number of collaborative, nationally-run HPS schemes in

countries in Eastern Europe forming the European network of Health Promoting Schools – ENHPS (Burgher, Rasmussen and Rivett, 1999). However, in South Africa, government appears to be facing major challenges in terms of the improvement of the health status of its citizens, and in particular, of its youth and children (Vergani, Flisher, Lazarus and Reddy, 1998:44). Flisher and Reddy (1995:1) state that the concept of HPS poses an urgent challenge for South Africans and should receive immediate attention from planners and policy makers. Health promotion could also play an important role in establishing a society that is assertive, caring, educated and educative in response to increasingly demanding global pressures (WHO, 2002).

3.4 THE CONCEPT OF THE HEALTH PROMOTING SCHOOL (HPS)

The concept of the Health promoting school was first identified at a World Health Organisation European Conference in Scotland in the early eighties and has since been widely advocated as an effective approach to Health promotion in the school setting (WHO, 1986; WHO, 1996). HPS are therefore international in their development. Many countries around the world are working on programmes that support schools and their communities to engage in improved health actions (Swart and Reddy, 1999:48). The concept HPS also complements the WHO's *School Health Initiative* which provides an impetus for mobilising and strengthening school health promotion and education at local, national, regional and global levels.

The HPS model, based on the Ottawa Health Charter for Health Promotion (WHO, 1986:3) refers to those strategies which are designed to reduce disease and promote health in schools (Sizanang Centre for Research and Development, 2006:6). A global HPS goal is to improve the health status of children as well as to improve the development of quality education (Swart and Reddy, 1999:47). It is also aligned with similar

movements such as the Healthy Hospitals, Healthy Workplace and Health promoting universities (WHO, 1986:3).

According to the WHO (1996:2) a HPS views health as encompassing physical, social and emotional well-being. It strives to build health into all aspects of life at school and in the community. From province to province, even within different regions and communities of one province, schools have distinct strengths and needs. By building on those strengths and drawing on the imagination of learners, parents, teachers and administrators, every school can find new ways to improve health and address problems (Meyer, 2005:84). The WHO (1996:3) states that HPS are also a setting where all members of the school community work together to provide learners with integrated and positive experiences and structures that promote their health. This includes both formal and informal curricula in health, the creation of a safe and healthy school environment, appropriate health services and the involvement of the wider community in efforts to promote health (Meyer, 2005: 85; WHO, 1996:3).

3.4.1 Defining Health Promoting Schools (HPS)

A HPS provides school health education, which enhances learners' understanding of the factors that influence their health, enabling them to make healthy choices and adopt healthy behaviours as a lifelong process. In addition, health education includes critical health and life skills, a focus on promoting health and well-being and the prevention of health problems (WHO, 1999).

Schools are ideally suited for the implementation of comprehensive strategies to promote health (Department of Health, 2000). Health and quality of life rely on many community systems and factors, not simply on a well-functioning health and medical care system. Making changes within existing systems, such as the school system, can

effectively and efficiently improve the health of a large segment of the community (United States Department of Health and Human Services, 2000).

An HPS is viewed as a school that is constantly in the process of strengthening its capacity as a healthy setting in which an individual can work and learn.

According to the Australian Health Promotion Association (AHPSA, 2008) HPS may be defined as schools which display, in everything they say and do, support for and commitment to enhancing the emotional, social, physical and moral well-being of all members of a school community. The AHPSA (2008) also states that a HPS is one which has an organised set of policies, procedures, activities and structures, designed to protect and promote the health and well-being of students, staff and wider school community members (Australian Health Promotion Association, 2008).

Although international and national theoretical frameworks have influenced the development of HPS in South Africa, the guidelines have arisen primarily from practical experiences of developing HPS and provincial networks in South Africa. There are many examples of specific school projects as well as wider development of networks of schools that value this approach in the development of more effective teaching-and-learning environments (Department of Health, 2000:14).

3.4.2 Principles and conditions of Health Promoting Schools (HPS)

HPS are built on the premise of five core principles: an integrated, holistic, collaborative and co-ordinated approach; quality assurance; capacity building; utilisation of existing resources, ownership and sustainability and equity and redress (Sizanang Centre for Research and Development, 2006:6).

An integrated, holistic, collaborative and co-ordinated approach implies that HPS' concepts are integrated into existing relevant policies and that those holistic, comprehensive programmes are developed.

Furthermore, inter-sectoral collaboration needs to take place. Quality assurance refers to the fact that political commitment and involvement to promote accountability at all levels be implemented, and that Health promoting programmes be informed by research. In addition monitoring and evaluation needs to take place at all levels (St Leger, 2005; Lebesse, 2009:1). Capacity building and the utilisation of existing resources requires that capacity building be built into HPS and that international experience, local expertise, existing material and human resources be utilised wherever possible. With regard to ownership and sustainability, active participation of teachers, parents, learners, community organisations and people in health promoting programmes or projects is imperative. Finally, equity and redress demand that HPS' programmes address equity and redress needs wherever possible (Department of Health, 2000:16).

Coulson, Goldstein and Ntuli (1998:5), Kirsten and Viljoen (2002:11), and Anderson and Ronson (2005:24) suggest that additional guiding principles be employed in order to establish a HPS. Firstly, strong support from school communities is crucial in the initial stages. It is of the utmost importance that one gain an active commitment from regional and/or district education bodies as well as school principals and senior teaching staff who can legitimise and endorse proposed programmes. Secondly, schools need to be provided with a school-specific, data-based profile of the health status of the learners and current health promoting actions. Such information represents an important vehicle for demonstrating the need for intervention and hence, the potential for action. The third principle is related to the identification of key individuals in school communities who are interested in as well as motivated to become involved.

These individuals should facilitate the process of initiating Health promotion actions. Principals should be encouraged to facilitate the involvement of the aforementioned key individuals by allocating them time during work hours where they are able to meet with health workers and plan to carry out Health promoting actions. The fifth principle pertains to a minimum set of actions that should be developed in order to assist people who serve as liaisons in a given school. Actions and accompanying resources should also be introduced to schools one at a time, with schools advising on their suitability and suggesting how to implement actions. Moreover, schools should be provided with feedback on their progress in achieving a set of minimum actions on a regular basis as a means of reinforcing their efforts and maintaining motivation for further action. In addition to the set of minimum actions for schools, the project management team should undertake a range of supplementary activities across all schools, including running workshops, providing regular newsletters and quarterly reports, as well as information resources. Finally, someone on the management team should be in regular contact with the school liaison officers to monitor their progress as well as assist in problem solving and overcoming barriers (Coulson *et al.*, 1998:5; Kirsten and Viljoen, 2002:7; Anderson and Ronson, 2005:25).

Table 3.1 provides an indication of the core conditions for an enabling school level environment, characterised by Health promotion (Dines and Cribb, 1993:65; Kirsten and Viljoen, 2002:11; Deschesnes, Martin and Hill, 2003:389). According to De Jong (in Kirsten and Viljoen, 2002:13) the six areas (shaded in Table 3.1) conditions represent the six core school level conditions that signal development as a priority in the majority of South African schools.

Table 3.1: Core conditions for an enabling school level environment (Adapted from Kirsten and Viljoen, 2002)

Areas	Core Conditions
Physical Environment	<ul style="list-style-type: none"> • Safe and secure • Intact buildings and facilities • Clean
Psycho-Social Environment	<ul style="list-style-type: none"> • Respectful, caring and friendly relationships between all sectors • Safe forum for expressing feelings and opinions
Management	<ul style="list-style-type: none"> • Decentralised • Participatory
Leadership	<ul style="list-style-type: none"> • Innovative and transformational • Participatory
Critical Thinking	<ul style="list-style-type: none"> • Self-reflection and enquiry • Understanding self and school organisation • Problem solving skills
Identity	<ul style="list-style-type: none"> • Shared educational philosophy and vision • Involvement of all stakeholders • Sense of ownership
Planning	<ul style="list-style-type: none"> • Goal setting • Strategic approach
Resources	<ul style="list-style-type: none"> • Inclusive • Sufficient material resources available • Sufficient human resources available
Development	<ul style="list-style-type: none"> • Ongoing staff development

In addition to the aforementioned principles of HPS, it is necessary that various elements be incorporated into such institutions. Firstly, a supportive government or local authority for HPS needs to be developed, whereby schools are able to embrace the

concept of Health promotion. This in turn, could lead to policy adaptation at national level. Secondly, administrative and senior management support needs to be achieved, since HPS adopt a whole-school approach. As such, HPS need to have ongoing support and commitment from head teachers or school directors and managers. Thirdly, it is helpful if small group activists including teachers, students, parents and community members are created. These activists would then serve the purpose of leading and co-ordinating health promoting efforts.

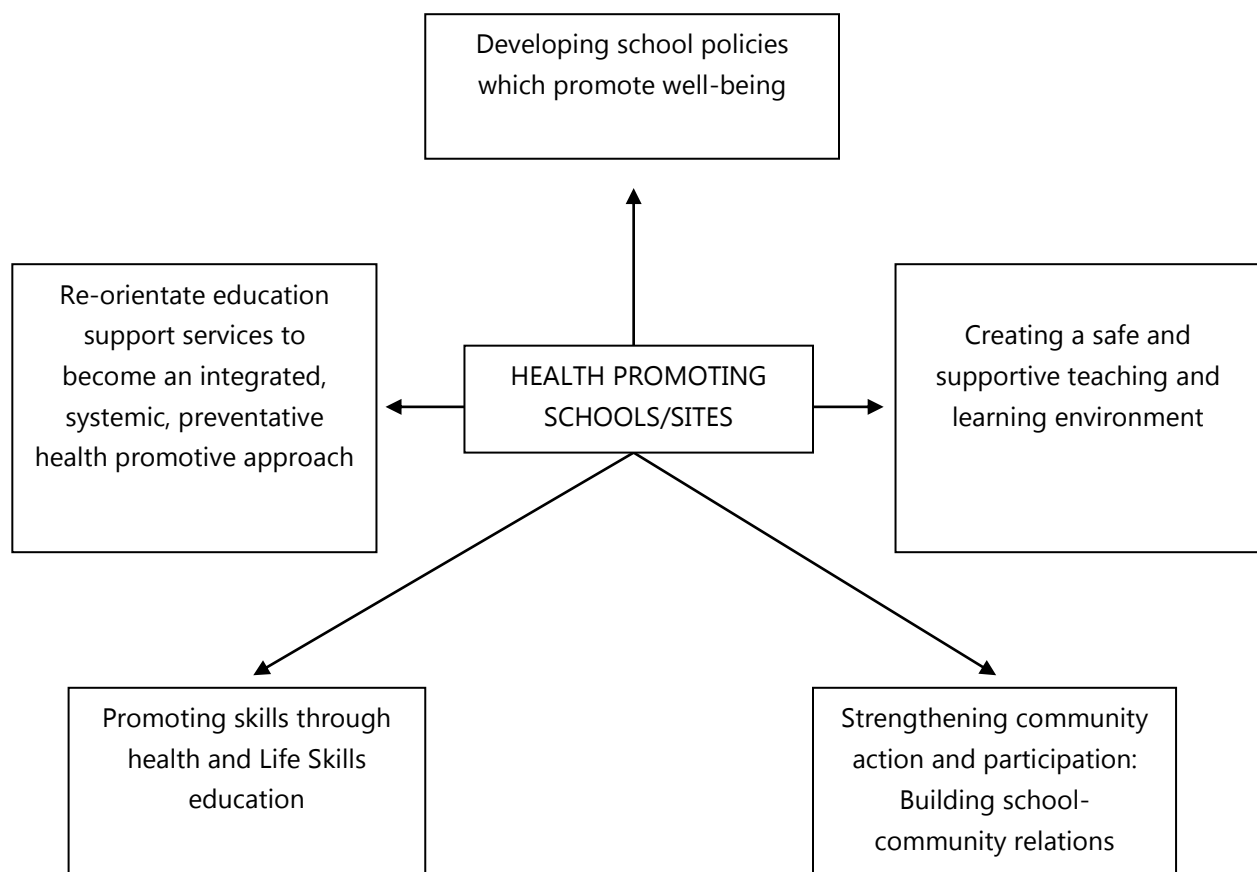
3.4.3 Objectives and core components for the development of Health Promoting Schools (HPS)

Within the context of the Ottawa Health Charter (WHO, 1986:2; Coulson, 2000:2), the following key objectives provide direction for the development of HPS to:

- build education and school policies which support health and well-being;
- create safe and supportive teaching and learning environments which include the creation of human rights;
- strengthen community action and participation through enhancing and expanding the relationship between schools and the community;
- promote personal skills of members of the learning community, with a particular emphasis on influencing health knowledge, attitudes and practices through a culturally appropriate health and life skills curriculum, and encouraging healthy physical activity and recreation; and
- provide access to and re-orientate health and education support services towards an accessible, integrated, systemic, preventative and health promotive approach, with a particular focus on reducing the number of learners affected by learning impairment or experiencing barriers to learning and development, reducing the incidence of disease or injury and addressing all factors that place learners at risk.

The National Guidelines for the Development of Health Promoting Schools/Sites in South Africa (Department of Health, 2000:1-48), compiled by the Department of Health in collaboration with the Department of Education and Welfare, outlined five key components in health promotion. The aforementioned five components of health promoting schools are highlighted in Figure 3.1.

Figure 3.1: Five components of Health Promoting Schools/sites in South Africa (Department of Health, 2000:8)



3.4.3.1 Developing education and school policies which support well-being

The first component, *Developing education and school policies which support well-being*, entails analysing and engaging in the developing of education at all levels of the education system (Havlinova, Kopriva, Mayer and Vildova, 1998:2; Doyle and Ward,

2001:89; Anderson and Ronson, 2005:26). This implies that strategies need to be secured at national, provincial, district/regional and institution/site level, in order to ensure that they support the development of health and well-being of all members of the learning community (Department of Health, 2000:20). Governing Bodies of education institutions have collaborative responsibility for implementing and developing education policy at site level. They therefore have a key responsibility in developing HPS (Deschesnes *et al.* 2003:389).

3.4.3.2 Creating supportive teaching and learning environments

The second component, *Creating supportive teaching and learning environments*, links directly to the educational need to develop a culture of teaching-and-learning, learning and services in schools. Implied in this, is the need to provide a safe and supportive environment where teaching-and-learning can occur (Department of Health, 2000:22). This includes the challenge of developing an inclusive environment, where members of the teaching and learning community respect and accept one another, all human resources are valued and utilised in the teaching and learning environment, all learners, teachers, parents and other community members feel welcome and where a culture of human rights and responsibility presides (Havlinova *et al.*, 1998:4; Kirsten and Viljoen, 2002:10; Konu and Rimpelä, 2002:80). This includes ensuring that historically marginalised members of the community can participate fully in the teaching-and-learning community (Department of Health, 2000:22).

3.4.3.3 Strengthening community action participation within the education context

The third component, *Strengthening community action participation within the education context*, focuses on empowerment through community action and participation, and may be regarded as the cornerstone of South Africa's commitment to democracy

(Department of Health, 2000:23). This component is also clearly reflected in health, welfare and education policies in South Africa. Within the Health promotion context, this links to the need for members of the community to take control over their own health and lives. Within education settings, this entails optimising the involvement of role-players in the development and provision of education, and the development of strong relations between schools and communities for the purposes of promoting community ownership (Department of Health, 2000:23). This commitment to community action and participation in education is highlighted in the Call to Action (Department of Education, 1999a:17). The emphasis is on the development of community-based support services, with the inclusion of parents and community organisations and leaders being of particular importance (Konu and Rimpelä, 2002:80; Anderson and Ronson, 2005:27).

3.4.3.4 Developing personal skills within the education context

Within the context of developing HPS, the challenge of developing personal skills includes (Department of Health, 2000:17):

- the development of the compulsory implementation of health and Life Skills education for learning;
- capacity development of teachers and other members of staff to promote their own and the learners' health and well-being;
- peer education/child-to-child training to learners to support and implement health promotion and prevention strategies;
- capacity development of parents and the broader community to promote the well-being of the family and community; and

- capacity building for service providers to provide relevant Health promotion and Life Skills education support to sites of learning.

The specific content of Life Skills education will be determined by local needs and demands, within the context of the Life Orientation and other Learning Areas of Curriculum 2005, although national and local priorities are likely to dominate these programmes (Department of Health, 2000:23).

Health education and human movement is located within the broader Life Skills education programme, and, as has been highlighted previously, Life Skills education is one of five components of the development of HPS. This location is important for the purposes of proper co-ordination, but also for the purposes of locating health issues within an integrated intersectoral Life Skills framework. This is a strategy that has been recognised as being necessary for effective implementation and outcomes (Department of Health, 2000:24).

3.4.3.5 Providing access to and re-orientating of support services

Education support services comprise a number of health (physical and psychological), welfare and learning support services which need to work together in a co-ordinated and collaborative framework at all levels of service delivery (Department of Health, 2000:24). While psychological and learning support services, and some health services (such as therapists), fall within the Department of Education support structures, most of the health and welfare workers are employed under the Department of Health (in particular school health services) and the Department of Welfare (in particular school social work services) (Lazarus, Davidoff and Daniels, 2000:23; Konu and Rimpelä, 2002:81). As many of these services are not formally or organisationally located within the Department of Education structures, there is a need for intersectoral structure that

facilitates appropriate collaboration between relevant government departments to provide comprehensive support services to schools (Department of Health, 2000:24).

The Department of Education's Education White Paper 6 of 2001 on Special Needs Education (Department of Education, 2001) proposes the development of an integrated, community-based support system, with a two-prong approach which focuses on a) the prevention of barriers to learning and development through curriculum and institutional development, and b) the provision of additional support to address barriers to learning and development where they occur in the system. This integrated, community-based two-prong approach reflects a 're-orientation' consistent with the fifth strategy within the Ottawa Health Charter (WHO, 1996:3), as it reflects a systemic, preventative, health promotive and community-based partnership approach.

The above mentioned development of an integrated community support system proposes a three-tier structure for education support services in South Africa (Department of Health, 2000:12; Department of Education, 2001c):

- *National and provincial departments:* Providing a policy and management framework within which support needs can be identified and provided where needed in the country and region concerned;
- *District support teams:* Comprising people with the competencies to provide the support needed to sites of learning in the area concerned. The major task of this team is to assist schools to develop their capacity to identify and address local barriers to learning and development, and to identify and 'match' needs with resources within the district concerned. District intersectoral committees could be set up to direct and manage this work;

- *Site-based support teams*: Comprising primarily of teachers, learners and parents within a particular school, as well as other professional and community resources when needed. The major task of these teams would be to identify and address local barriers to learning and development.

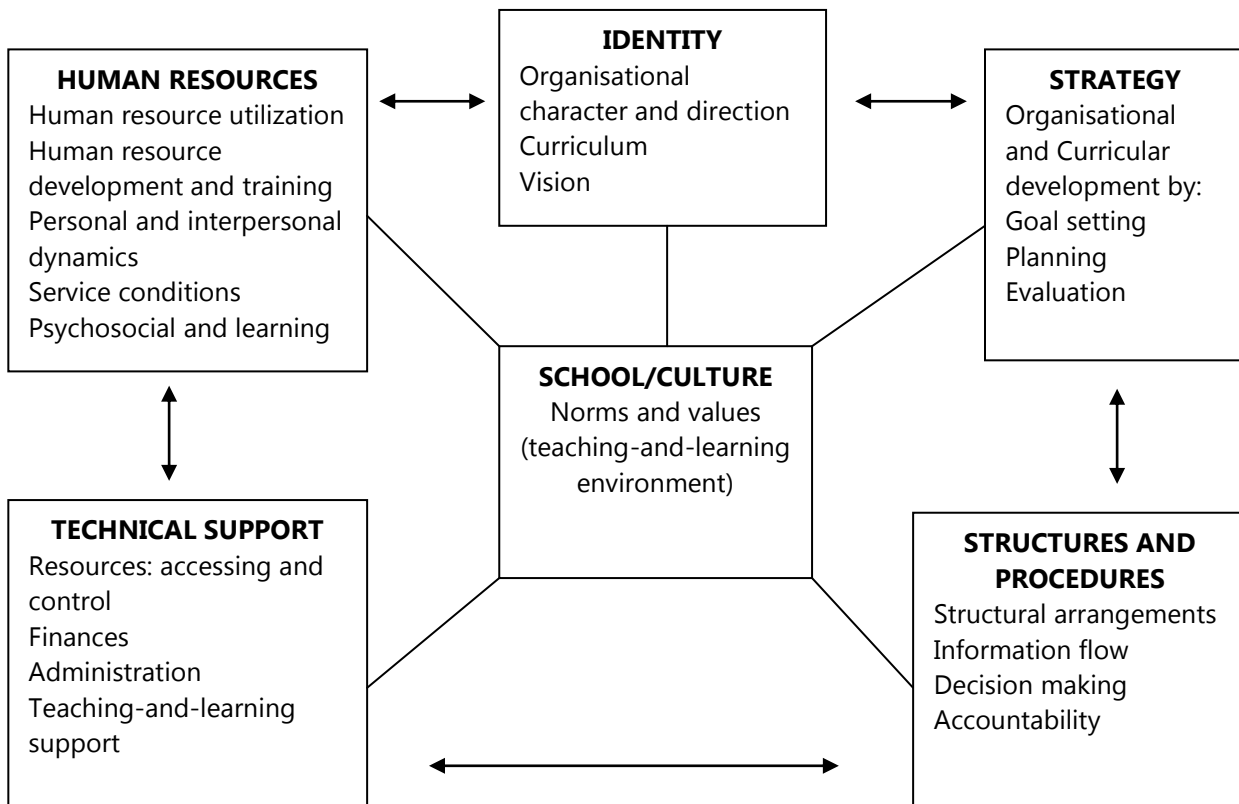
3.4.3.6 Integrating the use of various strategies within the context of Health promotion

As outlined by the Jakarta Conference (WHO, 1997b:2) comprehensive approaches that use combinations of strategies are more effective than a single strategy. Within the education setting, this implies that the key components of Health promotion need to be located within the context of whole school/education institution development. It is necessary to adopt a whole school approach to health in which a broad health education curriculum is supported by the environment and ethos of the school. This approach encompasses three areas: health education having specific time allocation in the formal curriculum through topics, subjects and cross curricular themes; health should permeate the 'hidden curriculum' including caring relationships between home and school and a health physical environment; and third, the HPS recognises the importance of the role that public health plays in the community in which it exists, and develops appropriate links with the wider community to support this role. The holistic outlook which is recommended through the development of a whole school approach has been endorsed by the Health Strategy for England, '*The Health of the Nation*', which has set targets reducing mortality and morbidity from several major chronic diseases, and recognises the importance of multi-sectoral working (Bradley, Sweeny and Waterfield, 1999). The Health Strategy for England also supports healthy alliances and work across different settings; the school is an important setting within the wider system of the local environments for a community.

The idea of implementing a whole school approach also links with a second priority programme, Tirisano (Department of Education, 2001), which focuses on the development of effective schools. The challenge of developing inclusive schools or sites, as highlighted by the Department of Education's Education White Paper 6 of 2001 on Special Needs Education (Department of Education, 2001), also needs to be located within this framework.

Exploring the development of Health promoting and inclusive schools within a whole school developmental framework in the South African context, may be understood through a generic framework outlined by Lazarus *et al.* (2000). This framework may be useful in understanding schools which show the various elements of organisational life which make up a given school. This framework is also used as a basis for understanding the strengths and limitations, as well as the dynamics of a school. Furthermore, it serves the purpose of illustrating organisational and curriculum development. The elements identified include: the school's culture; the school's identity; strategies relating to organisation and curriculum development; structures and procedures; technical support; human resources; leadership, management and governance; and the micro, macro and global context. Figure 3.2 provides an overview of the aforementioned framework.

Figure 3.2: Elements of a school as an organisation (Adapted from Lazarus *et al.*, 2000)

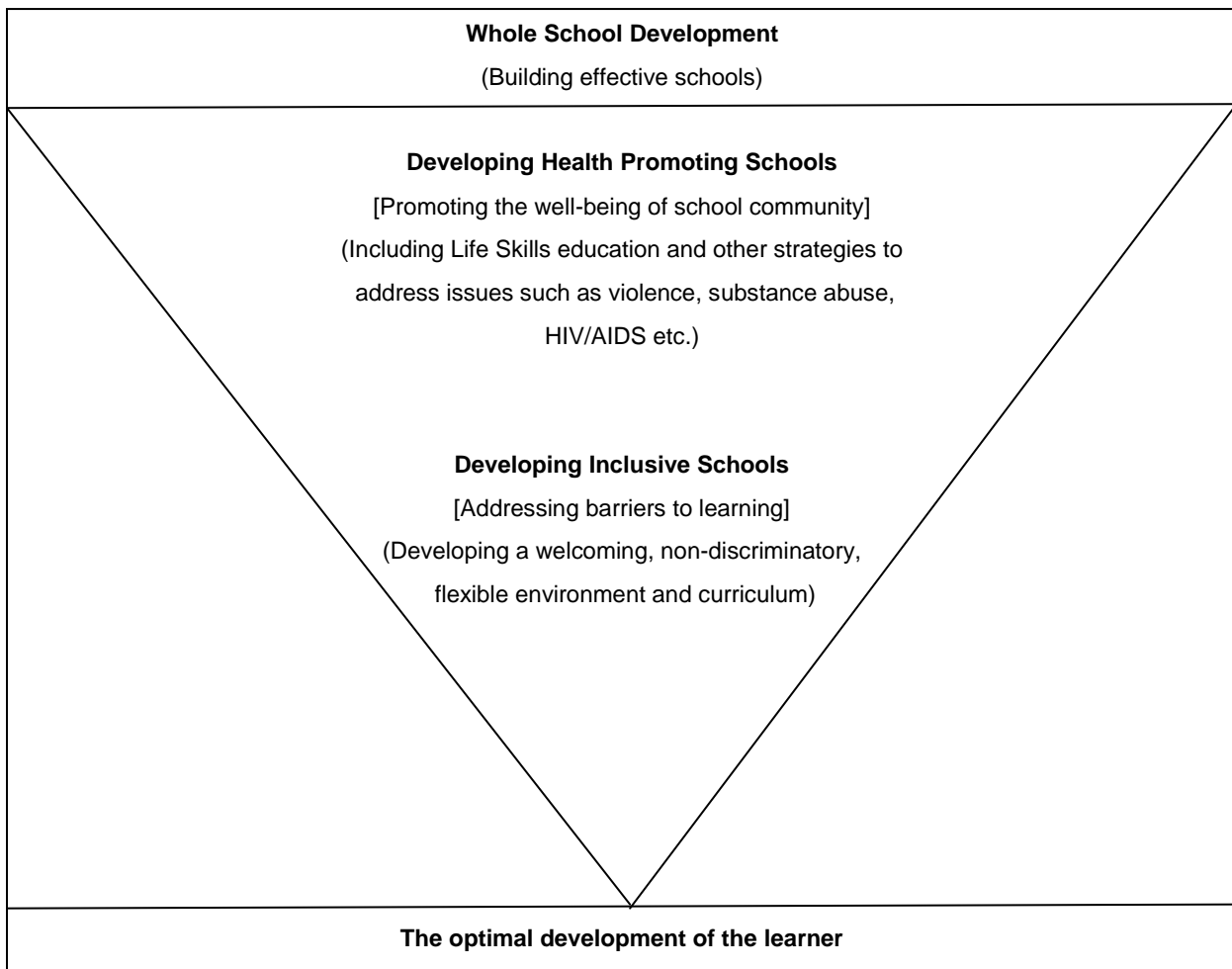


The school developmental framework outlined in Figure 3.2 provides a broad frame for the development of a school. The HPS perspective would therefore be located within this (or an alternative) framework, thereby ensuring that all elements of school life are taken into account and developed accordingly. The HPS perspective therefore provides on lens through which the school’s overall development can be viewed. To achieve a holistic and co-ordinated approach to school development, this view would need to be directly linked to other values, principles, policies and practices in the pursuit of school development.

Figure 3.3 shows this graphically. This figure highlights firstly, that the HPS perspective should be located within a broader strategy and vision to building an effective school.

Secondly, Life Skills education should be located within the HPS' framework, and thirdly, that the inclusive school perspective could also be located within this framework, with the principle of inclusion being one key value, principle and strategy for promoting well-being. This perspective focuses particularly on issues of diversity and discrimination, with an emphasis on developing a welcoming, non-discriminatory and flexible environment and curriculum where access to learning is facilitated through addressing barriers to learning and development in all elements of school life (Department of Health, 2000:21).

Figure 3.3: Developing Health Promoting Schools within whole school development (Department of Health, 2000: 21)



What stands out most regarding the incorporation of the Health promoting and inclusive schools perspective in the whole school development are the values that are emphasised. This includes the values of promoting well-being through empowerment of all members of the school community, and a commitment to the development of a supportive, welcoming and inclusive ethos which respects diversity and addresses all forms of discrimination (Engelbrecht, 2006:34). These are not new values within the context of recent policies in South Africa, but are given more substance around issues that place so many learners at risk of experiencing learning breakdown or exclusion.

3.5 HEALTH PROMOTING SCHOOLS (HPS) IN SOUTH AFRICA: AN OVERVIEW

Since the end of the Apartheid era and the beginning of democratic government in South Africa in 1994, an increasing process of change has occurred in all sectors of government (Swart and Reddy, 1999:47). The change process was directed by a policy framework outlined in the Reconstruction and Development Programme (RDP) of the African National Congress, the majority party in government. These changes led to government departments, non-government organisations and professional associations questioning their role and function, and to change their policies and practices (Swart and Reddy, 1999:47).

3.5.1 The Health Promoting School (HPS): a new beginning

Until approximately 10 years ago, the traditional model of school health was practiced in most schools. Some elements of the model include screening for visual and auditory impairments, growth monitoring, assessment of nutritional conditions, health education and follow up examinations. School health services and health education practitioners experienced many hurdles reflecting inequities of years of discriminatory practices such as the previous provision of services along racially segregated lines, disproportionate personnel-to-student ratios, financial constraints, and inadequate training to staff.

Consequently, issues such as health in schools did not enjoy the high priority it deserved. Various reports from international agencies, government and non-governmental bodies highlighted the need to address child and adolescent health (Yachan and Tollman, 1993:1043; Flisher and Reddy, 1995:1; Shisana, 1996:19).

The concept of HPS was first introduced in March 1994 at a workshop organised by the British Council in Swaziland. Two years later, in January 1996, South Africa's first National Health Promoting Schools Conference was held at the University of the Western Cape (Coulson, 2000:1). This conference was held as a result of the fact that continuous calls were being received from various groups and individuals in order to address health issues with which South African children were confronted, through the education system in a co-ordinated way. Various delegates urged that further action be taken to develop the concept of HPS in South Africa (JICA, 2007:4).

Since 1996, a variety of national workshops on the development of health promoting schools have been hosted by the Health Promoting Directorate of the Department of Health as well as the Medical Research Council (MRC) (2010). During this period, there has been ongoing debate and sharing of experiences. During 1999, most of the workshops revolved around the development of the national guidelines for the development of HPS in South Africa (Swart and Reddy, 1999:47). The aforementioned National Health Promoting Schools Guidelines are still in the process of being drafted, and await further consultation (JICA, 2007) in 2013.

The national policy for Health promotion practice in South Africa is based on the principles and approach of the 1986 Ottawa Health Charter (WHO, 1986:3) for Health promotion, and therefore aligns itself with international policy on Health promotion. It establishes five key areas (five-pronged approach) for Health promotion practice (Marx and Wooley, 1998:89; Coulson, 2000:1; St. Leger and Nutbeam, 2000:257):

- **To promote safe environments for people to live and work in.** Many of the health problems facing South African communities are caused or made worse by living and working in poor conditions. For example, having poor water and sanitation facilities or working in dangerous conditions without any safety measures;
- **To develop healthy public policy.** This is legislation and policy that protects health. For example, this can range from tobacco control through to ensuring that housing policy protects the health of people by ensuring that, for example, it provides for adequate ventilation or sanitation facilities;
- **To promote community action.** Health problems are often tackled best through community action. This could include community clean up campaigns or setting up an HIV/AIDS support group in a community;
- **Develop personal skills.** It is essential that each person is equipped with the information and skills to promote their health. For example, in South Africa, everyone needs to know about AIDS, and young people need to learn how to negotiate safe sex or how to say no to sex; and
- **Re-orient the health services.** Often the health services do not act in the best interest of people's health. Clinics are often not open in the early evening when it may be easier for working people to get to them and environmental health officers may over-emphasise the role of inspections and law enforcement rather than education for food traders.

One outcome of this five-pronged approach is that it is often more effective to promote health outside the health sector. For example, the government AIDS partnership strategy acknowledges that people are best reached through all channels in society, as opposed to just at a clinic. The HPS project is a good example of a programme of health action outside the health sector. However, this does not mean that the health sector does not

have a critical role to play in Health promotion. The role of the health sector in Health promotion is to provide leadership strategy, ensure there is adequate research and training capacity in the country, to set targets and guidelines for the practice of Health promotion by health workers and to ensure the development of all five approaches to Health promotion at the national, provincial and district level (Marx and Wooley, 1998:89; Coulson, 2000:1; St. Leger and Nutbeam, 2000:257).

Another outcome of the five-pronged approach is the emphasis on the environment rather than on personal behaviour change. The environmental health service has huge potential to meet these goals. A fundamental reform of the scope of practice of environmental health officers, revised legislation and curricula at technikons will result in the service being focussed on Health development, Health promotion and environmental management and away from the old model of inspection (Coulson, 2000:1; Wolfgang, Markham and Aveyard, 2003:1209).

The South African Department of Health (2000:1) states clearly that the vision of HPS in South Africa is to create a culture of effective teaching-and-learning through the holistic development of schools and other learning sites which will promote the optimal well-being of all members of the teaching-and-learning community through the implementation of the Health Promoting Schools Initiative. In light of this, the key components of Health promotion need to be located within the context of whole school/education institutions development (Meyer, 2005:40). Lazarus and Reddy (2001:20) argue that the combination of healthy policies, a healthy physical and social environment, health education in the classroom, early detection of problems which can affect health and learning and ongoing programmes to treat, remediate and provide care for children with problems is all part of Health promotion. The people who should be involved in HPS are school principal, school executive and governing body; cleaning staff, outdoor staff, tuck shop staff and volunteer safety staff; all teachers, especially

those involved in health education; health professionals from government and non-governmental organisations and school health nurses, psychologists, speech therapist, social workers and occupational therapists (Department of Health, 2000:31).

A school setting provides the opportunity for all members of the school community to work together to provide learners with integrated and positive experiences and structures that promote and protect their health (Lazarus and Reddy, 2001:20). The connection between a learner's health and education is a powerful one. Just as health exerts a powerful influence on the ability to learn, so too is regular school attendance one of the essential means of improving health. The school itself – through its culture, organisation and management, the quality of its physical and social environment, its curricula and teaching-and-learning strategies, and the manner in which a learner's progress is assessed – has a direct effect on self-esteem, educational achievement, and therefore the overall health and well-being of the learners and staff (Meyer, 2005:45). The physical state of schools is also regarded as an essential component of the HPS, so that pleasant, aesthetically pleasing, safe surroundings are present. It is essential to improve the internal and external environment (Dixey, 1996:53). Thus schools are effective as health-promoting environments only to the extent that they are healthy as organisations. The HPS initiative provides a comprehensive vision and a multi-disciplinary approach that considers people in the context of their daily life, in the family, community and society (Kirsten and Viljoen, 2000:5; Mũkoma and Flisher, 2004:364). More and more people are becoming aware of and are developing sensitivity towards the immense challenges that face South African society. There is a growing consensus, that, if people are really concerned about creating a winning nation, everybody should get involved on all levels of society (Meyer, 2005:48).

At a landmark conference dealing with HPS at the University of the Western Cape, priorities such as the following were identified: poverty, racial prejudice, suicide,

substance abuse/misuse, nutrition, gender issues, traffic and other injuries, tuberculosis and other forms of infections, social diseases and violence – all issues that directly impact on health in its broadest sense. The WHO (1996:8) states that creating a HPS means applying a new way of thinking. It means finding opportunities to develop policies, practices and structures that include Health promotion in everything done by the school and community (Meyer, 2005:48).

Ten years since the establishment of the HPS concept in South Africa, most provinces appear to have implemented some health promotion initiatives within their respective schools. However, it would seem that progress thus far has been challenging in that many barriers seem to slow down the process of implementation (Sizanang Centre for Research and Development, 2006:10; JICA, 2007:4). At the time when Health promotion first entered the South African health system, old style health education and family planning advisors and others were deployed into new health promotion services (Coulson, 2000:1; Department of Health, 2000:14). The result of this deployment was that many people entered this new service without any formal training in Health promotion, and without a clear picture of what Health promotion could offer South Africa. The aforementioned recruits were also not aware of how Health promotion was different from its predecessor, health education (Coulson, 2000:1).

To some extent this confusion has continued. For example there are still very few training opportunities for South Africans in Health promotion, although there is now a national initiative through the Department of Health to establish a programme of Health promotion training in tertiary institutions in South Africa (Coulson, 2000:1). However, the slow development of training opportunities has led to a service capacity gap in Health promotion in South Africa today. There are too few people in the health services who are adequately qualified to provide leadership in Health promotion (Coulson, 2000).

The African Safety Promotion: A Journal of injury and violence prevention (MRC-UNISA, 2008:2) highlights the need to identify structure and processes in schools which maintain and promote health if schools are to be used for health promotion. Thus the Medical Research Council, in collaboration with UNISA (MRC-UNISA, 2008:2) developed an assessment tool which aligns itself with more recent theory, and pioneering research, of health promotion by exploring the structural issues that shape and influence the behaviour of learners. The development of this instrument has promoted inter-sectoral collaboration, sensitised the broader community to the advantages of action-based research, built the capacity of teachers, nurses and others, since it has made participants more aware of the HPS concept and has also lead to the development of a localised instrument developed by the school community for use in the community (MRC-UNISA, 2008:2). Amongst the benefits of the employment of this index are the following aspects: assistance in monitoring the level of Health promotion in schools, assistance to schools in evaluating programmes and practices, consolidation of the understanding of the concept HPS, highlighting the need for school health to be approached in a comprehensive manner, encouragement of positive health behaviours and raising awareness of health, educational and developmental issues within the community.

Information generated by this instrument will provide data for (MRC-UNISA, 2008:3):

- schools and teachers to aid in planning e.g. development of a health programme based on need;
- professionals interested in establishing areas of need for interventions in schools e.g. school health medical officers;
- policy makers to identify gaps in the provision of services; and
- researchers wishing to establish baseline information for evaluation purposes e.g. longitudinal studies involving changes in structure and practice in schools.

3.5.2 The Health Promoting School (HPS) and international collaboration

Recently, the Government of the Republic of South Africa, through the National Department of Health, requested technical co-operation from the Government of Japan through the Japan International Co-Operation Agency (JICA) with the HPS concept (JICA, 2007:2). The National Department of Health identified the Gauteng Province as the target area that requires improvement in the area of community health.

This co-operation was aimed at facilitating the implementation of elements of the HPS concept in fourteen pilot primary schools in the Gauteng Province. Promoting health through schools is an innovative approach to respond to the health needs of learners, teachers and communities (Sizanang Centre for Research and Development, 2006: 12). This strategy concentrates on community education and development rather than having a policy function. It is accepted that to achieve their potential, the school community should be healthy, attentive and emotionally secure.

The aim of this initiative was also to assist in assessing the current situation at the fourteen selected schools for detailed planning and effective, efficient interventions of this project. As such, it was intended that the initiative would offer baseline data on the 'before intervention' situation at each of the schools and identify the outcome and impact after the project had been completed. Each school was assessed separately. Issues dealt with related to aspects affecting health at a school, such as nutrition, sanitation, physical activity, safety, as well as tobacco and substance abuse (Sizanang Centre for Research and Development, 2006:12). A detailed account of the various schools will be given in Chapter 5.

3.5.3 National Department of Health

The National Department of Health indicated that the HPS' initiative is a major component of their overall Health promotion programme. It is regarded as one of the priority programmes and has established a dedicated unit to oversee this initiative's implementation. The Department envisions the improvement of the health status of learners and communities through the implementation of the HPS programme (Sizanang Centre for Research and Development, 2006:15).

The strategic plan of the Department reflects HPS as one of the key programmes and the school is considered as one of the major settings for promoting health (Department of Health, 2000:23). The improvement and further development of the National Policy for HPS, currently in draft format, is envisaged to be finalised by the end of 2012. The Department considers health promoting schools within the broader context of promoting healthy lifestyles and decreasing the burden of disease in South Africa. The Department acknowledges buy-in from other relevant departments such as Education and Social Development (Sizanang Centre for Research and Development, 2006:15).

The Department's approach to HPS is based on the WHO model, with considerations given to the uniqueness of the South African context (Department of Health, 2000:24). In line with this, different provinces have adopted different approaches to HPS. The Eastern Cape, for example, has opted for an 'issue-based' approach, taking nutrition as a key issue or entry point. Other provinces adopted a 'problem-based' approach, focussing on problems such as vandalism, drugs, etc. "Problem-based" approach is a Health promotion approach in which complex health related problems serve as the context and the stimulus for health promotion interventions. Learners are expected to work in teams to solve health related problems e.g. drug abuse. They develop skills in collecting, evaluating, and synthesising resources as they first define and then propose a solution

to a multi-faceted problem (Sizanang Centre for Research and Development, 2006:16). The teacher facilitates the learning process by monitoring the progress of the learners and asking questions to move them forward in the problem-solving process. Unlike traditional health education the learners play an active role in developing solutions to health problems at hand (Sizanang Centre for Research and Development, 2006:16).

The Department is in the process of finalising a manual for auditing HPS, based on the WHO auditing principles. This serves as a 'toolkit' to assist and prepare provinces and schools to implement the HPS programme successfully. Provinces will be able to adapt this 'toolkit' according to their uniqueness and local needs (Department of Health, 2000:24). The Department is aware that there is currently no formal monitoring and evaluation indicators and they still need to be developed. They are establishing a database to keep record of the progress made with regards to the implementation of HPS in South Africa (Department of Health, 2000:24).

Positive strides are being made with regard to inter-sectoral collaboration both internally and externally. The 'Intradepartmental Committee' on youth affairs at a national level has been established to ensure that different programmes e.g. oral health, nutrition, violence and environmental health collaborate and co-ordinate activities. A Forum has been established to ensure that inter-sectoral collaboration takes place. Other critical role-players such as the Department of Social Development, tertiary institutions, the MRC and the private sector support this initiative (Sizanang Centre for Research and Development, 2006:16).

Senior management highlights the following enabling factors in the implementation of HPS: political support from the Minister of Health and Provincial MEC for Health in promoting the health of children, e.g. the Minister launched 'Healthy Environments for Children' in September 2005; health promotion and HPS is regarded as a priority for the

National Department of Health, thus enabling the Directorate to get the necessary financial support needed to implement the programme and a new Health promotion unit is being established within the National Department of Education and areas of collaboration are being identified at a national level to compliment the work of various departments (Department of Health, 2000:24).

However, the Department also highlights some challenges impacting on the implementation of HPS: the creation of a shared vision at a department level, co-ordination and collaboration between Departments of Health, Education and Social Development, as well as other relevant stakeholders and securing enough capacity, interest and commitment from role-players (Department of Health, 2000:25).

In relation to the implementation within the various provinces, different levels of progress are being observed. Some provinces have allocated considerable resources for HPS implementation e.g. the appointment of health promoting schools co-ordinators. There are also instances of effective interaction with the Department of Education (Sizanang Centre for Research and Development, 2006:17).

Examples given of HPS programmes include prevention of waterborne diseases in the Eastern Cape, the involvement of four schools in a community driven nutrition programme in collaboration with the Food Garden Foundation in the Eastern Cape. This specific programme is currently being rolled out to three other provinces – Free State, Northern Cape and Limpopo and tobacco prevention in schools has also received some attention. This MRC has completed their third survey and educators have been trained to create awareness with regards to tobacco in schools and the dangers associated with lead poisoning in paint also received some attention and is seen as a priority for the Department (Sizanang Centre for Research and Development, 2006:17).

The Department of Health's impression and view with regards to the pilot programme in Gauteng was positive and it is believed that it will add value to HPS experience and models in South Africa. The need for a continuous consultative process and skills transfer was highlighted (Sizanang Centre for Research and Development, 2006:18).

3.5.4 National Department of Education

The National Department of Education displayed a positive attitude, commitment and enthusiasm towards the concept HPS. This is also reflected through the efforts to address HPS at a national level. According to the educators, all schools should become advocates for a healthy lifestyle (Sizanang Centre for Research and Development, 2006:18).

HPS are regarded by the Department as a vehicle to get schools and communities to improve health; through the implementation of various health initiatives. The concept HPS is already a component within the current school activities within the Department (Department of Education, 2000:7). Though, it was made clear that schools are not necessarily labelled as HPS by the Department. Also, high rates of poverty are experienced, which have an adverse effect on health of communities and learners therefore schools are seen as "centres of support" for providing care and not merely for educational purposes (Sizanang Centre for Research and Development, 2006:18).

Within the National Curriculum, Health promotion forms part of the 'Life Orientation' programme and Outcomes, with Health promotion being Learning Outcome one (Department of Education, 2000). Health promotion should be incorporated in all learning areas, e.g. Mathematics Learners Support Materials are being developed at a national level to support teachers. 'Safe schools' and nutrition programmes were highlighted as part of the "basket" of HPS activities currently running at schools. It was

emphasised that the education sector is not only dealing with HIV/AIDS, but also with many other issues, e.g. head lice, scabies, etc.

The Directorate 'Health and Education' is currently realigning themselves towards the five Health promotion elements in order to address health and wellness issues in schools (Sizanang Centre for Research and Development, 2006: 19). According to teachers the schools must be able to prevent minor ailments and be able to assist with or refer major ailments.

The Department of Education reiterated that there are drives towards ensuring co-ordination between Education, Health and Agriculture at a national level to ensure the implementation of the HPS' initiative (Department of Education, 2000:8). For example, forums and structures exist for inter-sectoral collaboration at a national level, although it was reported to be a slow process. Head-committee sub-committees are advising on policy with regards to health, wellness and education (Sizanang Centre for Research and Development, 2006:19). At a provincial level, curriculum information sessions inform district level and the health committees or School Based Support Teams (SBST) are involved at a school level.

Senior management at the Department of Education showed enthusiasm towards the possible success of the implementation of the HPS concept. They felt that the following could be enabling factors: the new curriculum paves the way for the implementation of the concept, collaboration between the national departments and the active development of policies in line with common health conditions detected amongst youth (Sizanang Centre for Research and Development, 2006:19).

The Department of Education has listed a few constraining factors: lack of human resources, insufficient financial resources, time constraints and ensuring continued collaboration and co-ordination (Department of Education, 2000).

The National Department of Health (2000) affirmed that the HPS programme is a strategic objective for the department (Department of Health, 2000:9). The vision of the Provincial Department for HPS is to see a reduction of health problems in the schools. It was emphasised that learners' health behaviour can still be modified; due to the fact that they are still impressionable. Senior management highlights the importance of healthy lifestyles, physical activity, healthy eating and school health services (Sizanang Centre for Research and Development, 2006:20).

The Gauteng Department of Education's (2000) vision is to provide learning environments conducive to teaching and learning and to address barriers to learning and development by creating opportunities for learners to connect with, for example, programmes and interventions relating to health (Department of Education, 2000:11). The senior management believe that Health promotion is a key principle of curriculum integration within the curriculum statements (Sizanang Centre for Research and Development, 2006:20).

The Gauteng Department of Education feels that there is a need to acknowledge what is already happening in the schools with regards to HPS and existing health initiatives need to be complimented. Various initiatives addressing Health promotion are in place e.g. '*Banopele*' which was launched on Children's Day 2005. It is a school enrichment programme aimed at addressing the opportunities and challenges thereby ensuring that the neediest schools get the full basket of services such as exemption of school fees, school uniform, referral to social grants, nutrition etc. (Department of Education, 2000:12).

Different sections within the Gauteng Department are involved in the implementation of health related activities including school safety, school nutrition, early childhood development and special programmes, among others (Department of Education,

2000:12). The Gauteng Department considers the district teams as the first line of support to schools. Although the Provincial Department is responsible for developing learning-and-teaching support material, teachers are also expected to develop their own teaching aids (Sizanang Centre for Research and Development, 2006:20).

Some of the enabling factors mentioned by the Gauteng Department included existing health promotion programmes and structures in schools and that the curriculum framework is already providing a framework for the implementation of the HPS programme (Sizanang Centre for Research and Development, 2006:20).

However, the constraining factors were lack of capacity, the late transfer of the budget, lack of clear targets, lack of co-ordination and collaboration and overcoming procedural and intergovernmental systems barriers (Sizanang Centre for Research and Development, 2006:20).

In the following paragraphs an overview will be presented of HPS in the Gauteng Province of South Africa. More detailed information will be given pertaining the group of HPS that were part of the empirical investigation (Chapter 5).

3.6 THE IMPLEMENTATION OF THE HEALTH PROMOTING SCHOOLS (HPS) CONCEPT IN THE GAUTENG PROVINCE

3.6.1 Introduction

In the province of Gauteng, an assistant director had been placed in the Department of Education in order to develop and implement the HPS concept. The development and implementation of HPS has thus been a strategic objective for the Department of Education as the Health promotion directorate develops HPS operation plans on an annual basis. At present, the Health Promotions Directorate has a written guideline for the development and implementation of the HPS concept (Motlatla, 2007:61).

At school level, there are HPS committees as well as in some of the Gauteng districts. Currently, the Health promotion team is planning the establishment of a provincial HPS committee as well as similar committees in all of the Gauteng districts. With regard to collaboration with the Department of Education, it appears as though the Health promotion team is currently engaged in meetings and workshops with the department. Although it is evident that there is some degree of collaboration and co-ordination with the different relevant sections of the department, the Health promotion team reports that it feels as though there is still a great deal of room for improvement. With regard to collaboration and co-ordination at provincial and district level, there does not appear to be any formal relationship with other governmental departments. Despite the lack of relationships with other relevant departments, good relationships are maintained with NGOs at provincial and district level (JICA, 2007:62).

3.6.2 Health Promoting Schools

Currently, the Gauteng province boasts with 14 primary schools which are considered HPS. These schools are involved in projects pertaining to school safety, life skills regarding HIV/AIDS and teenage pregnancy, nutrition and physical activity as well as tobacco control and substance abuse. Although the majority of schools in the Gauteng province are not considered to be HPS yet, it would appear that approximately 66% of Gauteng schools at the very least have access to school health services. In light of this, it appears as though the Gauteng Department of Education is currently in the process of initiating the implementation of the HPS concept in various other schools not yet considered to be health promoting (Motlatla, 2007). The discussed health services can be regarded as assets in that they provide good co-ordination and collaboration with other sectors and employ a good referral system. However, some of these health services lack transport in various districts and are short-staffed (JICA, 2007:62).

At present HPS in the Gauteng province in South Africa have been able to establish a good working relationship with the Department of Education and have secured the commitment of Japan International Co-operation Agency (JICA) in order to fund the implementation of the health promoting concept in Gauteng province. A baseline study was conducted by JICA in order to determine the degree of implementation of the HPS concept in the various schools.

3.6.2.1 Characteristics of the schools and surrounding communities

Amongst the fourteen pilot schools are four farm schools. Some of the schools are situated in informal settlements, such as the Diepsloot area and Soshanguve, whereas other schools are situated in urban areas such Chiawelo and Soweto. Generally, the majority of the surrounding areas of the schools are impoverished, even though the surroundings range from informal settlements to urban settings (Sizanang Centre for Research and Development, 2006:28).

The school principals highlight high levels of parents' unemployment and poverty in the surrounding areas. In most instances grandparents or guardians care for a majority of learners, due to HIV/AIDS-related deaths and migration to larger urban areas in the search for employment (Sizanang Centre for Research and Development, 2006:28).

School buildings and structures range from very old (100 years old) to new buildings (two years old). In one school, shipping containers are temporarily being used as classrooms, since their new premises are under construction. In other instances informal structures are being used. Accessibility to schools has been highlighted as a concern, as learners are travelling long distances using public transport such as busses and trains (Sizanang Centre for Research and Development, 2006:29).

3.6.2.2 School budgets

School funding norms influenced by poor 'quintile indicators' determine the school budget transfers, with quintile one being the poorest schools incurring the highest total expenditure. The quintile system, which determines the amount of funding for individual schools, was implemented in post-apartheid South Africa as the government's commitment to redress and distribution in the education sector. The poverty score of a school, or quintile rank, is based on the poverty level of the community in which it is located. The score is calculated using national census data; weighted household data on income dependency ratio (or unemployment rate) and the level of education of the community or literacy rate (Human Sciences Research Council, 2009). This is further divided into section 21 schools and non-section 21 schools (or section 20 schools) (Sizanang Centre for Research and Development, 2006:29).

Nine of the fourteen pilot schools are categorised as section 21 schools. They are self-governing schools and their School Governing Bodies (SGBs) deal directly with suppliers and contractors for the relevant budgeted items in accordance with standard procurement procedures. The school will receive a total amount of money per learner and they are expected to buy their own supplies needed for the academic year, whereas section 20 schools are schools that are not yet on the section 21 list, and have therefore not been granted approval to procure their own goods and services. These schools inform the Gauteng Department of Education of their needs and an order is placed on their behalf. Such schools are only informed of their school budget, but never physically receive money. This will prepare them to understand actual costs of running their school and improve their capacity to join the section 21 list (Sizanang Centre for Research and Development, 2006:29).

3.6.2.3 Medical check-up statistics

Various directorates in the Department of Health are currently promoting the implementation of the School Health Policy Guidelines in order to improve the health status of school-going children through early identification and appropriate referral of all identified defects during schools visits at all districts in Gauteng (Sizanang Centre for Research and Development, 2006:30; Motlatla, 2007:10).

Currently all districts are providing phase one School Health Services, which include hearing and vision assessment, gross motor impairment detection and a referral system. Phase two has all the aspects of phase one, but includes oral health assessments. During 2005, phase one and two School Health services were provided to 117228 learners from 613 primary schools. A total of 16 347 learners with defects were identified and referred appropriately (Sizanang Centre for Research and Development, 2006:31).

Health education sessions are also provided to learners and teachers by school health nurses on eye care, preservation of hearing, teenage sexuality and other relevant topics as identified by teachers during school visits, also health guideline booklets are distributed (Department of Health, 2009).

3.6.2.4 Principals' ratings of the school environment

The principals of the HPS raised the following with regards to the schools' conditions (Sizanang Centre for Research and Development, 2006:34):

- the farm schools in particular, raised the need for more and improved sanitation facilities. Mobile toilets supplied by the Department of Education are not sufficient and are only serviced once a week;
- one of the informal settlement schools indicated that they experience water interruptions for at least two days per week;

- safety issues such as broken fences are of a concern for farm schools. Some of the schools indicated that they have been burgled in the past;
- possible water pollution is a concern for some farm schools;
- schools reported insufficient playgrounds as well as playgrounds regarded as unsafe for children;
- the majority of the schools mentioned the lack of sporting facilities; and
- exposure of learners to possible child abuse was a concern, due to the locality of some schools.

3.6.2.5 Current Health promotion activities implemented at schools

Principals indicated that the following activities are being implemented as part of Health promotion initiatives: HIV/AIDS programmes, vegetable gardens and nutrition programmes, visits from school nurses, sport activities and personal hygiene programmes (Sizanang Centre for Research and Development, 2006:36).

Within the Learning Areas 'Life Orientation' and 'Arts and Culture', teachers are dealing with health aspects.

3.6.2.6 Health policies at schools

The majority of schools are currently implementing the Gauteng Provincial Department of Education's health-related policies. Ten of the fourteen schools have developed their own HPS policies, which are in line with the Gauteng Department of Education's policies. Various policies such as HIV/AIDS, health and safety policies, a school feeding policy and a special needs policy are being implemented at various schools (Moolla, Lazarus and Reddy, 2007).

Five out of fourteen schools indicate that they feel the policies are well-implemented at school level. Reasons for the various schools' stance regarding implementation at school

level include regularly reviewing implementation policies and health committees which support implementation and teamwork (Sizanang Centre for Research and Development, 2006:37).

3.6.2.7 Health-related services rendered at schools

The majority of the pilot schools (67%) are visited by school health nurses. Among the services which school nurses provide are (Department of Health, 2009):

- conducting vision and basic hearing screenings;
- conducting height and weight checks on Grade R/1 learners and using the intermediate or low prevalence school for malnutrition. Appropriate nutritional interventions are then be planned accordingly;
- checking for gross loco-motor problems;
- conducting oral health examinations;
- performing initial counselling for children with emotional or psychological problems where required and then referring them for appropriate further intervention and management;
- undertaking health promotion activities;
- assisting schools to stock, maintain and use first aid kits;
- advising teachers on child health issues including the management of children with acute and chronic conditions;
- being able to institute appropriate responses for ad hoc problems such as disease outbreaks in schools;
- advising learners with chronic diseases and disabilities on self-care; and
- knowing the referral resources in the district.

Learners are also referred to social workers when problems are experienced. A minority of schools indicated that social workers visit their school, and when this is done, it is mainly to check on learners under foster care. A few of the schools (25%) have remedial teachers available. The SBST usually assists in this regard. For occupational therapy, some of the schools indicated that they access these services at district level. Health services include school health nurses, community health workers, regional health promoters, social workers, learning support and occupational therapy (Department of Health, 2000).

3.6.2.8 Involvement of external organisations

The majority of the Health Promoting Schools (eight) indicate the involvement of external organisations in schools. Some churches are involved in counselling of learners and others use the classrooms for church services during weekend. One church offers its facility as a classroom for the Grade R learners (Sizanang Centre for Research and Development, 2006:38).

NGOs involved in schools include Food Gardens for South Africa and Soweto Mountain of Hope. Other involvement stems from Pikitup, City Parks, BMW, Rand Water, political parties and mines.

Parents are involved in schools, especially when they are invited to parent meetings. Some parents are even involved in the food gardens, while others in some of the schools assist with clearing toilet facilities and preparing meals for the feeding scheme (Sizanang Centre for Research and Development, 2006:38).

3.6.2.9 Access of learners to nutritious food

The majority of HPS principals indicate that the meal that learners receive at school is the only meal they receive per day, and that the majority of learners only eat again at school the next day. Only two schools indicated that learners bring their own 'healthy lunch boxes' to school (Sizanang Centre for Research and Development, 2006:38).

Only two schools have tuck shops, but all fourteen pilot schools allow informal food traders (usually parents) to sell food during breaks on the school premises. Learners are not allowed to leave the school grounds, however some traders sell their products through the fence. The informal food traders sell items such as chips, polony, atchar, bread, as well as crisps, popcorn and sweets. Traders at schools do not sell healthy food, except for one or two traders who sell pap and meat (Sizanang Centre for Research and Development, 2006:39).

All fourteen schools that were visited form part of the Gauteng Department of Education's feeding scheme. The feeding scheme provides food to learners everyday (mostly to all learners). The meal learners receive as part of the feeding scheme includes two slices of bread, fruit and juice. Some of the schools supplement the feeding scheme by cooking food for learners such as porridge, samp, mielies and soya. The produce from vegetable gardens (for example spinach) at some of the schools is also used to supplement their meals (JICA, 2007:39).

However, the challenge of ensuring co-ordination and collaboration between the province and the various districts remains unsolved. Furthermore, it is apparently difficult to organise meetings and training sessions with teachers during the school working hours and the limited budget which has been provided for the implementation of the health promoting concepts implies many other challenges as well (JICA, 2007:64).

In moving forward, the Health promotion team envisions the strengthening of the co-operation between stakeholders and the implementation of planned activities with JICA's support. Training of teachers and learners at pilot schools and the assistance of schools to develop health policies are also priorities. Finally, the development of teaching materials in order to support the implementation of the health promoting concept is imperative (Motlatla, 2007:64).

3.7 CONCLUSION

The aim of this chapter was to present an overview of the various aspects and perspectives pertaining to the global health initiative, Health promotion and the Health Promoting School. The current setting concerning Health Promoting Schools within the Gauteng Province in the South African context was also outlined.

CHAPTER 4

RESEARCH DESIGN AND METHODOLOGY

4.1 INTRODUCTION AND ORIENTATION

The intention of this chapter is to detail the research methodology utilized for the study. It also describes the research approached used, gives an overview of the research design and outlines the data collection and methods used in the analysis of the data.

Research is the process through which researchers attempt to achieve systematically and with the support of data the answer to a question, the resolution of a problem, or a greater understanding of a phenomenon (Leedy, 1997:157; Silverman, 2005:17). According to Gough (2002:2) there are three common ways in which researchers perceive their work as being distinctive: it adopts a characteristic theoretical stance, it pursues a characteristic research question or problem and it adopts a characteristic method.

Given that the technical and procedural aspects will be discussed later, it is important to convey the theoretical basis for the whole research. It is widely accepted that assumptions play an important role in the whole research endeavour on which theoretical frameworks are based (Swann and Pratt, 2003:3).

Merriam (2006:23), as well as Anderson and Arsenault (2007:57) compare the place of a theoretical framework to the foundation, which needs to be laid before construction of a new building can begin. This implies that the foundation must be solid and stable, so that the building and therefore in this case the research may be well supported, which is a mark of good research.

Cogan and Morris (2001:3) postulate that:

"research is about understanding the world, and your understanding is informed by how you view the world, what you view understanding to be and what you see as the purpose of understanding".

It is clear that research is very subjective and can often be biased; therefore a sound research design must be in place. Research is never completely neutral, that is, research always takes place within contexts. There is a global context as well as a national context, which is again grounded within a certain philosophical context. The researcher is situated in these different contexts, and has a personal paradigm from which he or she works. Post-modernism has alerted us to the fact that scientific research can never a priori be assumed to be neutral (Brewer and Hunter, 1990:72). Therefore, it has to be remembered that while research tools are fairly objective, the hypotheses, experimental designs and interpretation of data are contextual. It is claimed that in the post-modern era science can no longer be seen as offering clear solutions and neat explanations (Veith, 1994:182). It is argued that since every person constructs his or own realities based on own experience, the interactions of people with each other and the material world, no two people can hold exactly the same interpretations of reality.

The paradigmatic perspective of the researcher is thus the experience that defines, for the researcher, the nature of the world, the individual's place in the world and the general view of the world and the range of possible relationships to that world and its parts (Denzin and Lincoln, 1998:107-108).

The paradigmatic perspective from which the researcher in this study approaches the research problem is that of the eco-systemic theory (Bronfenbrenner, 1979; 1994). This is elaborated on by Jordaan and Jordaan (1998). According to this view an individual (read: teacher, learner or parent) is seen and studied as a whole system consisting of five

contexts, being the ecological, biological, psychological, the spiritual and the metaphysical (cf. Kirsten, Van der Walt and Viljoen, 2009:11). All the contexts are holistically involved in the life of the human being. Therefore existence without some other context is inconceivable. The holistic eco-systemic view of health, health promotion in LO, can serve as a frame of reference that contains inherently the assumption that all behaviour is simultaneously contextualised in various contexts. These various contexts can serve as potential sources/contributors to health and health promotion in LO. The impact of health and health promotion in LO can be located in all of the possible contexts. Health and the promotion of health, does not only refer to the biological realm, but it also refers to the psychological, ecological, spiritual and metaphysical environments. Also, health and health promotion can contribute to the development of a holistically healthy school population in the present and in the future in order to maintain and develop teaching and learning.

The aim of this research was to ascertain the role of Life Orientation in the Health Promoting School (HPS). The research questions were:

- What is the role of Life Orientation in the Health Promoting School?
- What does the current scenario concerning Life Orientation in the HPS entail?
- What is the nature of the link between health, Health promotion and the HPS, and how can the HPS be constructed?
- How can Life Orientation practically be implemented in the HPS context?

In this study, conceptualization of HPS refers to the significance attributed to Life Orientation and the way Health promotion is perceived. The practical implication refers to how Health promotion is practically implemented in the Life Orientation Learning Area.

4.2 RESEARCH APPROACH

The study was exploratory, explanatory as well as descriptive and not experiential (Babbie and Mouton, 2001). The theoretical assumptions implicit in this research are discussed in this section.

According to Ivankova, Creswell and Plano Clark (2007:255) there are three recognized approaches for the procedures for conducting research: quantitative, qualitative and mixed methods. Quantitative and qualitative approaches to research are well established in the social and behavioural sciences. The choice of an approach depends on the researcher's philosophical orientation (post-positivist versus constructivist versus pragmatist), type of knowledge sought (objective, factual information versus subjective, personal experiences, or both) and methods and strategies used to obtain this knowledge (surveys and experiments versus open-ended interviews and observations, or both). Each approach has its own purposes, methods of conducting the inquiry, strategies of collecting and analyzing the data and criteria for judging quality (Ivankova *et al.*, 2007).

In this study, the research approach builds on both quantitative and qualitative approaches. Although quantitative and qualitative research differs in how they gain knowledge and research questions they address, they can, according to Ivankova, Creswell and Plano Clark (2007:259), both be applied to study the same research problem. By using a quantitative approach the researcher is looking for relationships between the variables, while by using a qualitative approach the researcher is seeking in-depth understanding of individuals' experiences. With each of these approaches, a specific perspective of the research problem can be gained. While quantitative research allows generalization the results to a whole population, qualitative research seeks an in-depth understanding of the issue (Ivankova, Creswell and Plano Clark, 2007:259).

Furthermore, the sequential mixed method approach was used to employ a survey to first establish knowledge of participating schools towards a topic and then follow up with in-depth focus group interviews to learn about individual perspectives on this topic. Thus, the researcher collects quantitative survey data as well as individual qualitative interview data (Ivankova, Creswell and Plano Clark, 2007:255). This approach would therefore provide the researcher with a better understanding regarding the role and possible implication of Life Orientation in the HPS.

Combs (1995:6) uses the following analogy of a vehicle in describing the qualitative research process: *"Much is said when one travels hopefully; research is no exception to this dictum as we explore roads less travelled and learn how to negotiate one turn at a time. Implicit to this enterprise is understanding what drives our research vehicles"*.

4.3 RESEARCH DESIGN

As already mentioned, the two methods used in this research are complementary. Whereas quantitative research tests hypotheses using standardized instruments and deductive analysis and mainly works with numbers, qualitative research tries to build theory mainly on interviews using inductive analysis and mainly uses logical argument within a school of thought (Leedy and Ormrod, 2001:102).

While the questionnaire used in the quantitative section is more pre-determined, the focus group interviews used in the qualitative section are more open. The more precise data obtained with a questionnaire could act as a control for the data obtained from the interviews that were often less clear, while the interviews could assist the interpretation of the quantitative data. A diversity of approaches allows one to combine different designs, not only to gain their individual strengths but also to compensate for their faults and limitations (Brewer and Hunter, 1990:17). It allows the researcher to evaluate the results of both methods against each other and to see if they correspond. Another

advantage is that the results will be broader and therefore more conclusive than if only one method is used. The researcher will be able to derive a broader perspective (Nieuwenhuis, 2007a:70).

Babbie and Mouton (2001:270) indicate that qualitative research is differentiated from quantitative research according to the following characteristics: research is conducted in the natural setting of social actors, a focus on process rather than outcome, the actor's perspective is emphasized, the primary aim is in-depth descriptions and understanding of actions and events; the main concern is to understand social action in terms of its specific context (ideographic motive) rather than attempting to generalize to some theoretical postulation, the research process is often inductive in its approach, resulting in the generation of new hypotheses and theories and the qualitative researcher is seen as the 'main instrument' in the research process.

This research study was characterized by the above features in the following ways:

Natural setting: the research was conducted in schools, in classrooms and offices of the Gauteng Department of Education as well the Gauteng Department of Health.

Focus on process: events as they occurred were studied, Health promotion as a component of Life Orientation was the focus.

Actor's perspective: an attempt was made to view Life Orientation as experienced from the teachers' viewpoints to try to understand their actions and decisions from their schools' positions.

In-depth descriptions and understanding: the actions of participants in the research were described in detail, with attempts to understand the actions in terms of the teachers' points of view on the Life Orientation curriculum.

Ideographic motive: an attempt was made to understand events, actions and processes in the HPS context.

Qualitative researcher as main instrument and objectivity: as the most important instrument in the study, the researcher aimed to be unbiased in her observations, descriptions, reflections and interpretations.

4.3.1 Quantitative design

In contrast to the qualitative research described previously, quantitative research is best defined as the measurement of the properties of phenomena, which is the assignment of numbers to the perceived qualities of phenomena (Babbie and Mouton, 2001:100). It is thus used in the conceptualization, measurement and analysis of findings (Denzin and Lincoln, 1998:26).

A quantitative approach was used in order to statistically express information gathered at the fourteen health promoting schools in the Gauteng Province. This helped to provide explanations and predictions that could be generalized to other persons and places (Leedy and Ormrod, 2001:102; Struwig and Stead, 2003:5). This is necessary in order to provide guidelines and recommendations concerning Life Orientation in the health promoting school.

In this study educators' responses to predetermined categories were counted and basic statistics calculated. This quantitative approach does lend a measure of reliability and validity to the research. Quantifiable data can be measured numerically, meaning it is more precise (Gray, 2004).

In this study, the quantitative research was done in the format of a questionnaire, using Life Orientation teachers, health coordinators and principals as respondents, to ascertain information about the health practices in the schools.

4.3.2 Qualitative design

A qualitative research design was used because it "*integrates deeply with everyday life*" (Holliday, 2002:24). Being part of the school setting was seen as important for the researcher as it enabled her to listen to personal viewpoints of Life Orientation teachers and health coordinators concerning the Learning Outcomes in Life Orientation and how they see it in relation to Health promotion. The researcher attempted to understand the teacher's perceptions, perspectives, understandings and lived experiences of health and Health promotion within the HPS. The lived experience must be understood from the participants' point of view (Leedy and Ormrod, 2001:153; Struwig and Stead, 2003:16).

In this case the researcher wanted to find out how the Life Orientation teachers view the link between Life Orientation and Health promotion, their stance on the competencies as well as the different stakeholders in HPS. How they view community involvement, access to health services and the effect of the environment on health was also explored. The researcher did not come with a predetermined view about the matter, but rather listened openly to the meanings the Life Orientation teachers assigned to the matter of investigation. This enabled the researcher to look at the qualitative part of the study to gain a better understanding.

The research questions are general and broad, and seek to understand participants' lived experiences with the central phenomenon (Health promotion). The sample size is small, as only four HPS were purposefully selected from those individuals (Life Orientation teachers) who have the most experience with the studied phenomenon (Health promotion as component of Life Orientation).

Qualitative research also aims to provide a comprehensive description of a specific phenomenon and aspire to comprehend situations in their uniqueness as part of a particular context (Adams, Collair, Oswald, and Perold, 2005:67). The purpose of

qualitative research is thus to describe and understand rather than predict and control and allows researchers to treat social action and human activity as text. Furthermore, interviews, focus groups and observational data can be transcribed into written text for analysis (Nieuwenhuis, 2007b:104). Educational and Educational Psychology researchers have found that their research questions, views of the world and the practicalities of their situation are best answered by qualitative research methods (Adams *et al.*, 2005).

Another reason why qualitative methods were used in this study was to enhance the quantitative research. They are useful for ascertaining issues that are not readily quantifiable, such as unstructured interviews and proceedings in focus groups, observations and reflections, which were based on open-ended questions, and teachers' definitions of a HPS. Consequently, qualitative research was used particularly to ascertain teachers' understanding of the health promoting concept within Life Orientation. Additional information was also provided about their teaching methodologies of health promoting aspects in Life Orientation and their attitudes towards the HPS.

4.4 RESEARCH METHODOLOGY

Methodology refers to the strategies, plan of action, processes or designs foundational to the choice and implementation of specific methods, as well as the linking of the selection and implementation to the desired outcomes. Methodology is the corpus of knowledge that describes and analyses methods, including their strengths and weaknesses (Miller and Salkind, 2002).

In this research project a mixed-methodology was used. In the first phase of the project, a quantitative questionnaire was used (see Appendix C), which examined the Health practice assessment in HPS. (The questionnaire will be discussed in detail in Paragraph

5.4.2.2). Secondly, focus group interviews were conducted as part of the qualitative data collection.

4.4.1 Sampling

Sampling plays an important role in any research. The term *sample* implies the simultaneous existence of a population or universe of which the sample is a smaller section or a set of individuals selected from a population (De Vos, Strydom, Fouche and Delpont, 2005:193).

According to Arkava and Lane (in De Vos *et al.*, 2005:194) a sample thus comprises elements of the population considered for actual inclusion in the study, so inherently, the sample is studied in an effort to understand the population from which it was drawn. Generalising the results of a study based on working with such a sample means that it is assumed that any other portion of the same population would yield the same observations. Sampling is done to increase the feasibility, cost-effectiveness, accuracy and manageability of the survey that is conducted (De Vos *et al.*, 2005:204).

Convenience sampling was employed in both phases of the project. Fourteen schools within the Gauteng Province of South Africa, which are identified as HPS, were sampled for participation in the study. For the purpose of the quantitative data collection, the Life Orientation teacher/Health promotion co-ordinator at each school, thus fourteen participants, were requested to complete a questionnaire pertaining to the six health promoting categories implemented at their school. For the qualitative data collection part of the research, four schools were selected to participate.

Gauteng is the smallest province in South Africa, with only 1.4% of the land area, but is highly urbanised, containing the cities of Johannesburg and Pretoria. According to Statistics South Africa (2011:2), Gauteng had a population of 10.5 million people, making

it the most populous province in South Africa. The name "Gauteng" comes from the Sesotho word meaning "Place of Gold", the historical Sesotho name for Johannesburg and surrounding areas.

Gauteng is considered the economic hub of South Africa and contributes heavily in the financial manufacturing, transport, technology and telecommunications sectors, amongst others. It also plays host to a large number of overseas companies requiring a commercial base in, and gateway to Africa. Gauteng contributes 33.9% of South Africa's gross domestic product (GDP) and generates 10% of the GDP of the African continent (Gauteng Economic Development, 2011).

The Gauteng Province is growing rapidly, due to mass urbanisation which is a feature of many developing countries. According to The State of the Cities Report (South Africa Cities Network, 2011), the urban portion of Gauteng – comprising primarily the cities of Johannesburg, Ekurhuleni (East Rand) and Pretoria – will be a polycentric urban region with a projected population of 14.6 million people by 2015; however, AIDS may negate this projection.

The geographical location of the Gauteng Province in South Africa is given in Figure 4.1.

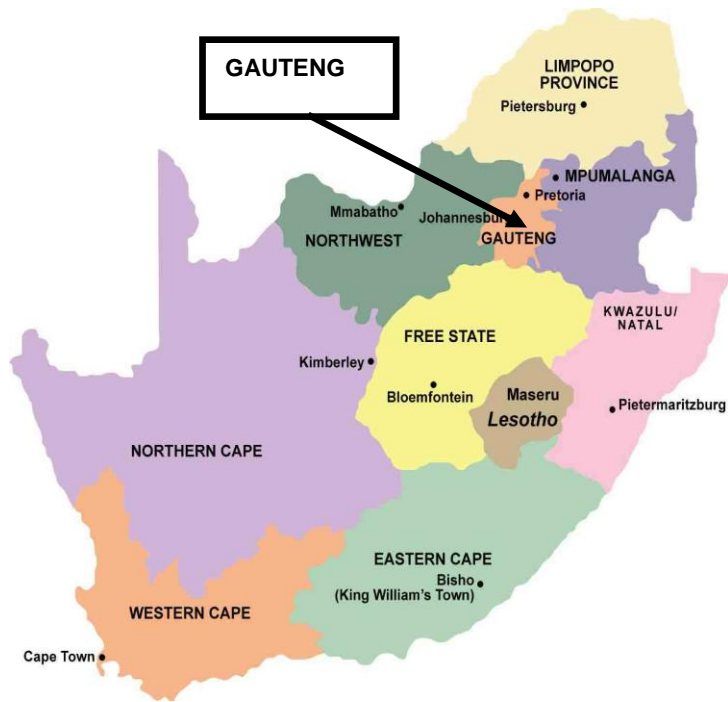


Figure 4.1: Map of South Africa, indicating the location of the Gauteng Province

In the following figure the various education districts in the Gauteng Province is indicated. There are twelve districts with at least one HPS in each one of the districts.



Figure 4.2: Map indicating the location of the various education districts in the Gauteng Province

In Table 4.1 the biographical information of each school which participated in the study, is provided.

Table 4.1: Biographical information of participating primary schools

Schools	Educational districts	Number of Educators	Number of Learners
School 1	Tshwane North D3	19	781
School 2	Tshwane South D4	23	870
School 3	Tshwane South D4	12	416
School 4	Tshwane North D3	36	1400
School 5	Sedibeng D8	8	300
School 6	Sedibeng D7	10	161
School 7	Gauteng North D1	9	380
School 8	Central Wits D11	14	525
School 9	West Rand D2	18	605
School 10	Central Wits D9	20	597
School 11	Ekurhuleni D5	8	610
School 12	Ekurhuleni D6	40	1500
School 13	Central Wits D10	35	1541
School 14	Central Wits D12	10	362

In the case of the focus group interviews at the four selected schools, convenience sampling was used. It means identifying the most convenient schools to act as research schools for the qualitative phase of the study (Robson, 2003:265). All the selected schools are HPS. Life Orientation teachers/Health co-ordinators were selected from different districts of the Gauteng Department of Education which were easily accessible to the researcher. The focus group interviews enable the researcher to compare responses from the different schools. The aim was to get general information concerning the current scenario in the HPS as well as the involvement of the learners in the different health promoting activities.

In two of the four selected schools, the two participants interviewed, were LO teachers as well as Health co-ordinators. One was a man and the other one a woman. In the third school there were two men in charge of LO and one act as the Health promotion co-ordinator. In the fourth school, two women were in charge of Health co-ordinating but were actually LO teachers.

Table 4.2: Biographical information of participating primary schools in focus group discussions

Schools	Educational districts		Number of Educators	Number of Learners
School 1	Tshwane North	D3	19	781
School 2	Tshwane South	D4	23	870
School 3	Tshwane South	D4	12	416
School 4	Tshwane North	D3	36	1400

4.4.2 Data collection

Quantitative data was collected from participants using a questionnaire constructed by the Japanese International Co-Operation Agency (JICA) with the assistance of the Deputy Director Health Promotion of the Department of Health in the Gauteng Province (JICA, 2007). The initial survey coincided with the actual planning of the research study. In this phase the researcher was instrumental in gathering and tallying of the data.

The questionnaire was divided into six categories. Each section dealt with a specific health promoting programme. The six categories were water and sanitation, tobacco use prevention, physical activity, nutrition, safety and protection and health services.

Qualitative data was collected by means of four focus group interviews. The purpose of the focus group interviews was to gain in-depth understanding of the interaction between Life Orientation and the HPS.

4.4.2.1 Initial survey

An investigation in 2007 - by the Japanese International Co-Operation Agency (JICA) with the assistance of the Deputy Director Health Promotion of the Department of Health in the Gauteng Province - as well as the literature survey indicated that Health promotion as a component of Life Orientation was being practised. Therefore the 14 schools in Gauteng were selected for the research as they are in the process of acquiring accreditation of health promoting status by the Department of Health and the Gauteng Department of Education. The data was obtained over a period of four years. The analysis and interpretation of the data led to the formulation of recommendations for more schools to develop strategies in Life Orientation to obtain the status of HPS.

4.4.2.2 Quantitative questionnaire

A questionnaire can be defined as a set of questions on a form that is completed by the respondent in respect of a research project (Silverman, 2005:23; De Vos *et al.*, 2005:166). Babbie and Mouton (2001:233) mention the fact that although the term *questionnaire* suggests a collection of questions, a typical questionnaire will probably contain as many statements as questions, especially if the researcher is interested in determining the extent to which respondents hold a particular attitude or perspective.

The basic objective of the questionnaire is to obtain facts and opinions about a phenomenon from people who are informed on the particular issues. Questionnaires are probably the most generally used data collection instruments of all.

The researcher became involved in the initial stages of the construction of the questionnaire. This was done in co-operation of JICA and the Department of Health in the Gauteng Province.

The questionnaire that was administered was structured as follows (See Appendix C):

- **General information of the school**, the number of teachers and learners as well as the coordinator in the health promoting school programme.
- **Water and sanitation**, including the source of water supply, the condition of the water and programmes to encourage learners to drink water. Furthermore, the state of hygiene and sanitation was explored, as well as waste removal, recycling projects and the school environment in general.
- **Tobacco use prevention and substance abuse policy**, including information about the dangers of tobacco use, signage banning tobacco from the school premise and policies on substance use and abuse.
- **Physical activity**, including questions regarding the condition of the playground and learners' participation in extramural activities.
- **Nutrition**, providing of meals, participation in the National Nutrition School Feeding Programme, information on the vendors as well as the vegetable gardens. In addition, inquiring about the participation in the maintenance of the gardens. Also, the percentage of learners who bring lunch boxes to school and foodstuffs available at the tuck shop.
- **Safety and protection**, appropriate security fencing and proper security measures. Also, the existence of an anti-bullying policy and safety in general was explored.

- ***Health services***, the involvement of school nurses in screening learners for health problems, immunization, as well as the detection of malnutrition. In addition, the number of visits by a health promoter.
- ***Number of educators and learners that have been trained on health promotion.***

4.4.2.3 Qualitative data collection

The basic method in the qualitative data collection was focus group interviews. The purpose of these interviews was to gain in-depth information about Health promotion as a component of Life Orientation.

According to Creswell (1998), focus groups are especially useful when time is limited; people feel more comfortable talking in a group than alone or when interaction among participants may be more informative than individual conducted interviews.

In the focus group interviews, the researcher talked to a group of participants. In this study four focus group interviews were conducted. The teachers/Health promoter coordinators were asked open ended questions and the researcher guided the interview by asking the questions and creating a relaxed atmosphere. The participants were invited to share their opinions and viewpoints on the matter in an informal way. It was ensured that every teacher was given equal opportunity to contribute to the discussion.

Focus group interviews draw on three of the fundamental strengths that are shared by all qualitative methods: exploration and discovery, context and depth and thirdly, interpretation. Thus, focus groups create a process of sharing and comparing among participants. The researcher creates for the participants a well-defined purpose and they produce large amounts of concentrated data in a short period of time – though not the richly textured view of life that comes from participant observation. What distinguishes

focus groups from any other form of interview is the use of group discussion to generate the data (Silverman, 2005:36; De Vos *et al.*, 2005:301).

Morgan (1997:13) affirms that the strengths of relying on focus groups are their ability to produce concentrated amounts of data on precisely the topic of interest. Another strength of focus groups is the reliance on interaction in the group to produce the data. The comparison the participants make between one another's experiences and opinions are a valuable source of insight into complex behaviours and motivation. Focus group interviews were considered to be suitable for this study firstly because putting teachers in groups is more likely to make them feel comfortable so that they will feel free to speak. Secondly, focus group interviews leave room for discussion, which suited the explorative nature of this study.

Focus group interviews were conducted with Life Orientation teachers or Health promoter coordinators of the four selected HPS. In most of the cases the Life Orientation teacher also acts as the health coordinator, assisting the principal to train teachers on the health promoting issues and coordinates all the health promotion activities in the school.

4.4.2.4 Observations

Observation as a research method is a well-known way of collecting data (Denzin and Lincoln, 1998; Silverman, 2005:111). Field notes such as observation and reflective writings, although not used as primary data collection methods in the study, were used to add context to the quantitative data. Observation was employed in this study as a means to enrich contextual information on the schools.

During the site visits the schools appeared to be intact; there was discipline amongst the learners; the teachers were busy with various tasks; the relevant policies were available

on question; the gardens were attended to; the school buildings were also neat and well-kept; safety was an important issue for most of the schools; the fences were well-kept, the overall impression was positive and welcoming.

These field notes assisted the researcher in remembering and exploring the process of an interview. It also helped the addressing the gaps in data and therefore provide more depth to the final research report. One advantage of observation is that it allows the researcher to document behaviours as they occur and note events as they take place.

4.4.3 Data analysis

An analysis of data was undertaken to ascertain the link between Life Orientation and Health promotion in the 14 selected schools in the Gauteng Province.

Both sets of data (quantitative and qualitative) were analyzed separately after which the results were compared and integrated. A literature control was also done in order to verify the results within the context of research already done in this field.

4.4.3.1 Quantitative data analysis

According to De Vos *et al.* (2005:218), analysis means the categorizing, ordering, manipulating and summarizing of data to obtain answers to research questions. The purpose of analysis is to reduce data to an intelligible and interpretable form so that the relations of research problems can be studied tested and conclusions drawn. Descriptive statistics were used during data analysis in the quantitative phase. The researcher interprets the research results for their meaning and implications.

Each school had to complete a health practise assessment questionnaire which consisted of the following aspects: water and sanitation, tobacco use and prevention, physical activity, nutrition, safety and protection and health services.

The researcher compiled a tally in collaboration with the Department of Health in the Gauteng Province. All data from questionnaires were recorded into Microsoft Excel. This recording enabled the researcher to describe the actual situation in relation to key health promoting sections.

4.4.3.2 Qualitative data analysis

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

After the focus group interviews the recordings were verbatim transcribed immediately. After all interviews had been transcribed the formal analysis began. Open coding was used in the analysis. Creswell (1998:102) and Smith, Flowers and Larkin (2009:82-101) provided the guidelines that was followed in the data analysis.

The first stage was to read and re-read the transcriptions of the interviews and to listen to the audio recordings of the participants. The main focus here was to search for information that was salient and that could be noted.

The second stage involved the initial coding. The challenge was to search for key words, phrases and constructions by the teachers and principals of Health promotion and the possible relation with Life Orientation. The manner in which the participants used language to share their perceptions and constructions about Health promotion and Life Orientation was also written down.

Stage three involved the development of emerging themes. Salient and highlighted phrases were grouped together with accompanied by the verbatim exploratory

comments and excerpts. From this the researcher made interpretations in order to gain an integrated understanding.

During stage four the researcher was looking for possible connections across the emergent themes. During this action themes were clustered together to reflect the nature of Health promotion in Life Orientation and in the school. The occurrence of a particular theme in the responses of the participants was tabulated. Through this action the researcher was able to identify the relevant emerging themes.

Finally, the findings of the qualitative analysis were supported by means of a literature control.

Groups of two or three teachers were asked open ended questions. The questions that were asked in the focus group interviews were the following:

- *It is well known that Life Orientation and Health promotion are linked in schools. According to you as a Life Orientation teacher/Health promotion co-ordinator, what is your view on this?*
- *Within Health promotion as part of Life Orientation there are competencies that one can focus on in terms of both the learners and educators. What is your view on this?*
- *Within Health promotion as part of Life Orientation stakeholders play a role. What is your view on this?*
- *Within Health promotion as part of Life Orientation community involvement and participation have a role to play. What is your view on this?*
- *As a teacher/Health Promotion co-ordinator what is your view on the access to health services as part of Health promotion?*

- *As a teacher/Health Promotion co-ordinator what is your view on the environment as part of the health in the school?*
- *As a teacher/Health Promotion co-ordinator what is your view on policies concerning Health promotion in schools?*

4.4.4 Rigour in qualitative research

4.4.4.1 Trustworthiness

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

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

The second criterion is *transferability*. Transferability refers to whether findings of a study can be applied to other participants or in different contexts and relies on the possibility that data may be representative of the broader population (Babbie and Mouton, 2001).

The third criterion is *dependability* which means that if the study were repeated with the same participants and the same methods similar results would be achieved. In order to

ascertain this as far as possible, the researcher described the data collection and analysis process in some detail (Shenton, 2004:71).

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

4.4.4.2 Member checks

Member checks refer to the process where the researcher validates emerging themes and findings with the participants (Henning, 2005:36-37). The researcher often validated her findings with the participants with whom she had follow-up verification interactions on Life Orientation and Health promotion in schools.

4.4.4.3 Using a co-coder

The supervisor of this research project acted as an independent overseer of the research process, the methodology that was utilized, the analysis of the data, the codes and themes that were identified as well as the interpretation of the phenomenon of Life Orientation in the HPS.

4.4.4.4 Triangulation

The concept of triangulation is based on the assumption that any bias inherent in a particular data source, investigator and method would be neutralised when used in conjunction with other data sources, investigators and methods (Struwig and Stead, 2003:18-19; De Vos, Strydom, Fouche and Delpont, 2005:361). In this research project both quantitative and qualitative methods were used to gain a clearer understanding of the nature of Life Orientation in the HPS.

4.4.5 Ethical considerations

When conducting research it is important to consider the project from an ethical perspective. According to Mitchell and Jolley (2001:24) the following rules should be adhered to: Participants should volunteer to be in the study. Participants should be given a general idea of what will happen to them if they choose to be in the study. Participants should be told that they can withdraw from the study at any point. Investigators should keep all answers confidential. Investigators should inform participants of the purpose of the study. Investigators should make sure that all people working for them behave ethically. Researchers should get approval from appropriate committees.

In South Africa, mental health practitioners and researchers are under the obligation of adhering to follow specific ethical procedures while conducting research (Health Professions Act, 2006).

In the following paragraphs key aspects around the ethical practice of this research endeavour, are presented.

4.4.5.1 Informed consent

Informed consent is one of the numerous ethical guidelines that need to be abided by. Two main activities are relevant here: participants need to understand the full nature of the proposed research, and they should voluntarily agree to participate in the project. Before the research project started, the participants were visited at the schools where they are teaching. A full explanation was given to the participants about the proposed project and they could ask any question about the project. During these discussions the participants remain anonymous. Discussions went on until all possible confusion and/or lack of information was cleared up.

4.4.5.2 Right to anonymity

Throughout the research it was kept in mind that health promotion issues in schools can be a very sensitive if not handled anonymously. Therefore the names or identities of all the participants in this project were omitted.

4.4.5.3 The storing of qualitative data

It was decided that the transcriptions and all other related data will be stored for a period of five years. Only the researcher will have access to this material. All the data gathered during the research project will be kept under lock and key in the archives of the University.

4.4.5.4 Permission to conduct the research

Formal permission to conduct the study project was obtained from the Department of Education in the Gauteng Province (see Appendix A). During the interactions with the Department of Education it was agreed that a final copy of the research report will be made available to the department.

4.5 CONCLUSION

The chapter discussed the research design and methodology that was utilized to explore teachers'/Health promotion co-ordinators' understanding and construction of Life Orientation and Health promotion in the HPS. The questionnaire and focus group interviews that were used to generate the data and data analysis were discussed. The chapter concluded with the ethical considerations that were taken into account in the execution of the research. The empirical investigation into Life Orientation in the health promoting school will be presented in Chapter 5.

CHAPTER 5

LIFE ORIENTATION IN HEALTH PROMOTING SCHOOLS IN THE GAUTENG PROVINCE OF SOUTH AFRICA

5.1 INTRODUCTION AND ORIENTATION

Life Orientation (LO) in the HPS has a very distinctive role to play. In addition to its official assignment as a subject within the array of school subjects, LO also has a special focus on health and Health promotion. This fundamental focus forms an integral part of the whole school curriculum (cf. Paragraph 3.7.2). Educationally speaking it is therefore to be expected that, within the context of a HPS, LO will, without any question, be instil with opportunities to gain knowledge, develop skills and values related to health and Health promotion.

One of the objectives of this research project is to investigate Life Orientation in the HPS. In this endeavour the aim is also to explore and describe the nature of the link between health, health promotion and the HPS (cf. Paragraph 1.5.2). The purpose of this chapter is to empirically explore how LO as a Learning Area is being perceived and constructed by teachers/Health promoter coordinators within the context of the HPS.

The chapter commences with a brief overview of the research methodology that was utilized (cf. Chapter 4 for a detailed discussion) in the empirical research; then a quantitative data analysis and discussion follow, and lastly the qualitative data analysis with a related discussion conclude the chapter.

5.2 RESEARCH METHODOLOGY

5.2.1 Research approach

Because of the nature of the specific research topic, it was decided to use both quantitative and qualitative methods, the main reason being that it was desired to obtain both numerical data as well as the teachers' or health promoter coordinators' views, experiences, perceptions and constructions regarding the state of LO, health and Health promotion in the HPS. The two approaches being used were seen as complementary to one another.

A quantitative method was used to gather numerical data in order to describe the trends and explain the relationship between the variables (Ivankova *et al.*, 2007:255). A semi-structured questionnaire was given to teachers and health promoter coordinators in order to gain quantifiable knowledge about the key sections of a HPS (cf. Paragraph 4.4.2 and Appendix C). The first topic was *water and sanitation*, with specific focus on how many schools have access to clean water and functioning ablution facilities. *The prevention of tobacco use* was another important topic since the use of tobacco by teenagers is estimated to be 85% and the researcher wanted to know how many schools have an anti-tobacco policy and whether learners are informed of the dangers of smoking. The third section was *physical activity* and the questions were centred around the state of the school grounds and extramural activities. The fourth section dealt with the *nutritional* needs of learners and the schools' ability to feed needy learners. The fifth section was on *safety and protection*, and the final section dealt with *health services*.

The qualitative method was used in this study to enhance the exploration concerning the link between Life Orientation and Health promotion, the competencies of both learners and teachers, the role of stakeholders and community involvement and participation. Further aspects to be explored were the access to health services; how

teachers viewed the environment and its impact on health, and their understanding of the health promoting policies in their schools. According to Woods (2006) a qualitative research approach seeks to discover the meanings that the participants attach to their behaviour, how they interpret situations and what their perceptions and experiences of a particular phenomenon are. The overall reason for engaging the qualitative research approach was thus to explore and describe the teachers' views on Health promotion in their schools.

5.2.2 Sampling

As it is normally impossible to study a whole population, a sample is usually drawn from a larger population, to conduct research on. A sample can be described as a subset of the population selected to obtain information concerning the characteristics of the population (Mack, 2005). However, there are different types of sampling techniques that can be used during a research project. The purposive sampling technique was used in the present case. Purposive sampling is a method that involves selecting participants who will yield results that will adequately address the research question. The researcher used purposive sampling based on her knowledge and her expertise concerning the field of education and Health promotion. The sample used in the qualitative phase in this study consisted of teachers/health promoter coordinators from four of the HPS. Four schools also participated in the qualitative data collection process.

5.2.3 Data collection procedures

Since the study called for both quantitative and qualitative research methods, various procedures were utilised to ensure optimal results that would address the research question.

The function of the survey data that was captured can directly be linked to the initial research questions (cf. Paragraph 1.5.2). Put differently: the data gathered in the empirical research assisted the researcher in exploring and describing the link between health, Health promotion, and the HPS.

5.2.3.1 Focus groups

An interview of a focus group is a planned, relaxed, naturalistic dialogue among a small group of people on a specific topic (Israel and Galindo-Gonzalez, 2011). According to Morse and Niehaus (2009:90) focus groups are a very efficient way to elicit opinions or to rapidly develop an initial understanding of an area. Focus groups were used to explore the participants' beliefs, attitudes and opinions concerning the research problem.

Four focus group interviews were conducted at four HPS. Each interview consisted of the researcher and two to three participants, one of which was the Life Orientation teacher. Focus group interviews proved to be appropriate as a method of data collection during this research project since it enabled the researcher to get the teachers' and Health promotion coordinators' views on LO, health and Health promotion in the HPS.

5.2.3.2 Questionnaire

A questionnaire was used to obtain the quantitative data in this study. The advantage of a questionnaire is that it provides data amenable to quantification, either through the tallying of boxes or through the content analysis of written responses (Hannan, 2007:101). A questionnaire, "*Health practice assessment in health promoting schools*", (cf. Appendix C) was distributed in 14 schools. The questionnaire was constructed by the Deputy Director of Health promotion at the Department of Health with the assistance of JICA, who funded the health promotion project in Gauteng (JICA, 2007). The 14 schools

were visited with JICA and the Department of Health during 2008. The completed questionnaires were collected and the responses were tallied. In addition to using the quantified data for the purposes of this study, the data were also presented to JICA.

5.2.3.3 Field notes: Observations

Observations are done to help the researcher understand and learn more about other perspectives held by the participants. In the empirical study, some observations were made during the focus groups and during informal conversations and interactions with the participants. These observations assisted in the comprehension of the views held by the participants.

5.2.3.4 Literature control

A literature review is an account of what has been published in relation to the topic of research. According to Leedy and Ormrod (2005:65) the literature review describes theoretical perspectives and previous research findings regarding the problem being studied. Therefore a literature review was undertaken to corroborate the findings of the empirical study.

5.3 RESEARCH RESULTS

5.3.1 Quantitative data analysis

The data gained from the questionnaires formed an important foundation in this research (See Appendix C). The purpose of the questionnaire was to obtain background information about the only 14 health promoting schools, at that stage, in the Gauteng Province. From the 14 participating schools various teachers (LO teachers, Health coordinators) formed teams to fill out the detailed questionnaire.

The data obtained from the questionnaire will now be presented, followed by a discussion of the findings.

The first section in the questionnaire dealt with water and sanitation.

5.3.1.1 Analysis of section 1: Water and sanitation

All fourteen sample schools indicated they obtained their water from taps; twelve schools were supplied by the municipality and the other two had boreholes. The participants were questioned about water they used for drinking, for washing and for other purposes. Table 5.1 is a summary of the source of water used for various purposes.

Table 5.1: Water sources

Source	Drinking	Washing	Other purposes
Taps	86%	86%	86%
Borehole	14%	14%	21%
Rainwater tanks	0%	0%	7%

When asked about the quality and quantity of their **drinking water** it emerged that 100% of the schools were satisfied with the quality but only 79% with the quantity. Ten schools (72%) encouraged learners to drink water. The dissatisfied schools noted three problems: the taps constantly broke due to the large number of learners per tap, there were not enough taps, and one school noted their borehole was too shallow and was located far from where water is needed. Regarding water for **washing**, 100% were satisfied with the quality while only 79% were satisfied with the quantity; the reason was low water pressure. When talking about water for **other purposes** it emerged that 100% were satisfied with the quality and 86% with the quantity. The dissatisfaction was due to limited water availability for irrigation of large vegetable gardens, and to low water pressure.

Adequate water supply is directly related to hygiene and sanitation. The researcher inquired whether **hand washing facilities** are available to learners. Only eleven schools (79%) have such facilities, and of those eleven only seven provide soap. Two participants complained, stating that basins are inadequate and facilities are *“insufficient and not the required standard”*. The second question related to hygiene regarded the number of taps available for hand washing.

It is evident that although all fourteen schools were within the jurisdiction of the Gauteng Department of Education, there are huge discrepancies in the provision of taps. The range varied from 47 learners per tap to a shocking 610 learners per tap. The average among the sample schools was 148 learners per tap.

The water supply of a school is closely related to its ablution facilities. The researcher firstly inquired about the state of the toilets. Of the fourteen schools, only one school described the facilities as *“excellent”*, four schools used *“clean and hygienic”*, *“average”*, *“satisfactory”* and *“reasonable”* respectively. Two schools noted the state of bathrooms as *“terrible and bad”* and *“poor”*. Table 5.2 is a summary of responses:

Table 5.2: State of ablution facilities

Description	No of schools	%
Terrible	1	7%
Poor	1	7%
Reasonable	1	7%
Average	1	7%
Satisfactory	1	7%
Good	5	37%
Clean	3	21%
Excellent	1	7%

5.3.1.2 Analysis of section 2: Prevention of tobacco use

When it comes to tobacco and substance use prevention, the distributed questionnaire posed four questions related to this topic. The first question was whether the school had an anti-tobacco policy in place. Nine of the fourteen schools (64%) had this policy in place. The second question was: *"Are the learners informed about the dangers of tobacco use"*. 100% of the 14 schools had at some stage disseminated information regarding the adverse effects of tobacco use. The third question related to signs banning tobacco use, and six schools (43%) declared the school premises a smoke-free zone. The last question inquired about the schools' policy on substance use and abuse. Ten schools (71%) had a clear policy which banned substance and alcohol use on the school premises.

Five of the schools (36%) answered "yes" to all four questions and have a comprehensive approach to combat tobacco, substance and alcohol use on the school yard. Table 5.3 is a summary of their responses:

Table 5.3: Tobacco and substance use policies

Type of policy	% of schools
Anti-tobacco policy in place	64%
Informed about dangers	100%
Signs banning smoking	43%
Policy on substance use and abuse	71%

5.3.1.3 Analysis of section 3: Physical activity

The researcher found that thirteen schools (93%) had a designated playground area for learners to utilise during breaks, while one school (7%) had no such area. When questioned about the state of the play area, six schools (43%) were of the view that their grounds were well-maintained. Two of the schools were very positive and elaborated that the grass is cut regularly and flowerbeds are well kept. Another two schools

attributed the good state of the grounds to their efforts to prevent littering. These two schools encourage learners to pick up papers during breaks and had a timetable where each class was responsible for cleaning the play area for a week.

Eight schools (57%) responded negatively. Four schools (29%) attributed the poor state of the play area to the ground surface some participants stated that the *"ground is rocky"* and *"uneven ground not suitable for use"*. Another noted *"learners are exposed to dangerous substances like stones"*.

Of the remaining four schools, one associated the poor state of the playground to the lack of a security fence while another noted overcrowding as the reason for improper play areas. The last two schools simply noted the ground was *"not in a good condition"* and *"poor" respectively*.

Another method to encourage physical activity among learners is their involvement in extramural activities. All fourteen schools (100%) offered learners the opportunity to participate in such activities. Four schools (29%) noted they offered one or more of the six sporting codes (rugby, soccer, netball, cricket, athletics and hockey). Two schools elaborated and said they allowed learners to play on the playground during Life Orientation and Art and Culture lessons. One school's participant replied pessimistically and said the sport facilities *"need urgent attention"* while another noted there were no athletics tracks.

Another way to promote physical activity is membership of sport clubs and organisations. Ten schools (72%) indicated their learners belonged to such organisations and noted the most popular activities were soccer, netball, dancing and gymnastics. When asked what percentage of learners enjoyed membership of an external club the responses varied vastly, ranging from 5% to 80% of learners.

Of the remaining four schools, participants from two schools (14%) were not aware of learners belonging to organisations while another two participants (14%) did not answer the question at all.

5.3.1.4 Analysis of section 4: Nutrition

The value of nutrition in promoting health and well-being and productive learning cannot be overstated. Accordingly, the researcher investigated the nutrition status of learners in the studied schools. All fourteen schools (100%) participate in the National School Nutrition Program (NSNP). However, only seven schools (50%) have proper storage facilities to keep food from spoiling.

The first question was what percentage of learners brought lunch to school. Table 5.4 summarises the responses.

Table 5.4: Percentage of learners who bring lunch to school

% of learners per school	Number of schools
30%	3
5 %	3
10%	2
70%	1
60 %	1
40 %	1
20 %	1
15 %	1
3 %	1

The second area of inquiry related to the provision of lunch from the schools’ own budget. Participants were asked if the school provided lunch to learners. It emerged that nine schools (64%) provided lunch while five schools (36%) did not.

Of the nine schools that supplied lunch, seven schools (50%) did it five times a week while the other two schools only provided lunch three days per week. Unfortunately, one school did not indicate how many times a week.

When questioned about the type of food served, the common foodstuffs were porridge, samp, beans and bread. Only two schools (14%) used vegetables from their own gardens while three schools (21%) said they used the menu set by the Department of Education. One school (7%) received fruit from a chain store while another relied on a donation of milk from a dairy farmer in the area.

Another important factor contributing to the nutritional status of learners is the opportunity to purchase foodstuffs and beverages from vendors and tuck shops. When questioned about this it emerged that learners from eleven schools (79%) bought consumables from vendors while learners from three schools (21%) only bought snacks at the schools' tuck shops. There are two schools (14%) where learners purchased from both vendor stalls and tuck shops.

The participants were asked if they had a policy whereby vendors were forced to also sell fruit and vegetables during school events or extended school activities. Twelve schools (86%) had an influence on what vendors supply during those activities. Only eight schools (57%) had complete control over what vendors are selling.

Vendors providing snacks and beverages at ten schools (71%) had not received any training and according to the participants they were not registered. When it came to the hygiene of vendor stalls, only nine schools (64%) monitored the standard of hygiene.

The participants were required to indicate the type of consumables that were sold on or around the school property. The most common foodstuffs were sweets and salty snacks – learners at twelve schools (86%) had access to them. Fizzy drinks were available at ten

schools (71%) while fatty fried foods were available at nine schools (64%). None of the schools sold bottled water or 100% fruit juice. However, eight schools sold fruit and vegetables.

A source of much fresh produce at the studied schools was vegetables harvested from the schools' own gardens. Eleven schools (79%) have their own vegetable gardens. Only one of these eleven schools had a set budget for the upkeep and labour. Of the three remaining schools that did not have a functional vegetable garden, one described their garden as a "*neglected vegetable garden*" while the other stated that their vegetable garden was recently destroyed by a fire. One school did not have a vegetable garden. The size of the functioning gardens varied from 24 m² to 1675 m².

Of the eleven schools with functioning gardens, six sold harvested vegetables to members of the community while nine schools used the produce as ingredients for meals cooked for learners. Six schools utilised produce for both cooking and selling.

The participants were asked about the resources used for upkeep and labour in vegetable gardens. At nine schools (64%) the teachers assisted in gardening. At seven (50%) schools the learners participated and ten schools (71%) relied on help from parents and members of the community.

Lastly, the researcher inquired about nutrition-related activities as part of the curriculum. Thirteen schools (93%) noted they integrated nutrition into the Life Orientation lesson plans. Participants from six of the thirteen schools linked nutritional activities directly to Life Orientation while five stated nutrition was taught in class. The remaining two schools noted that activities such as "*series of hygiene road show*", "*drama*" and "*TV*" promoted good nutrition.

5.3.1.5 Analysis of section 5: Safety and security

The first aspect the researcher investigated was the perceived safety of the school environment. The participants were simply asked: *"Is the school environment safe?"*

Participants from ten schools (71%) were of the opinion that the school environment was safe. When asked why they consider the school to be safe, the responses reflected two factors, namely the presence of a security fence (at two schools) and the school's policy of keeping the school gates locked during teaching hours (at five schools).

Four schools (29%) considered the school environment unsafe. One participant revealed that the school had no fence or gate whatsoever, while another said the fence *"is at the brink of collapse"*. At one school the participant mentioned the broader environment and said the presence of male hostels near the school adversely affected safety. One school did not state the reason for compromised safety.

The second question inquired about appropriate security fencing around the perimeter of the school. From the responses it emerged that only eight schools (57%) had an adequate fence. Four participants (29%) noted the fence was in poor condition while another said the fence was *"unsatisfactory"* to fulfil its role. One school did not have a fence at all.

The next aspect relates to specific safety and security measures schools implement. The participants were presented with seven safety measures and had to indicate which ones the schools had implemented (see Appendix C). Their options were:

- require visitors to report to the main office or reception upon arrival;
- disallow learners from leaving the school premises during schools hours;
- keep school gates locked;
- use staff or adult volunteers to monitor school premises between classes;

- use security cameras;
- employ security guards during regular school days; or
- have partnership with the local policing forums.

The most common measure was disallowing learners to leave the school premises during school hours and it was practised at all fourteen schools (100%). Thirteen schools (93%) require visitors to report to the main office or reception area upon arrival. Two popular measures were locking the school gates at all times and forming partnerships with local policing forums, which appears to happen at eleven of the schools (79%). The least common measure was security cameras which were present at only at one school (7%). Twelve schools have anti-bullying programs / policies in place to prevent or manage bullying.

5.3.1.6 Analysis of section 6: Health Services

The first area of research related to the role of school nurses. Thirteen schools (93%) indicated regular visits by nurses, while one (7%) had no such visit in the last year. When asked about the services the nurses rendered, thirteen schools (93%) mentioned their involvement in immunisation campaigns while eleven schools (79%) said nurses screened for health problems. During screening various components (see Table 5.5) were evaluated, such as vision at 64% of schools, hearing (50%), oral hygiene (50%), growth and malnutrition (14%) and general health (7%).

Table 5.5: Health components evaluated by nurses

Health components screened for		
Health components	Number of schools	% of 14 schools
Vision	9	64%
Hearing	7	50%
Oral hygiene	7	50%
Growth and malnourishment	2	14%
General health	1	7%

The participants had to indicate whether they identified malnourished learners, especially after screening or other health services had been provided. Only seven schools (50%) identified learners who appear malnourished and five of these schools indicated the approximate percentage of malnourished learners. The estimates ranged from 0,6% to 65%. In between were 7%, 30% and 58% of learners respectively (See Appendix C).

Secondly, participants were questioned regarding the immunization status according to the *Road To Health Chart* immunisation schedule and whether the school was aware of the immunisation status of its learners. Only eight schools (57%) identified the number of immunised learners. Only six schools indicated the approximate number of immunised learners (see Table 5.6). The highest was 100% immunised learners, while the lowest was 11%.

Table 5.6: Percentage immunised learners

Schools	Estimated percentage of immunized learners
School 1	90%
School 3	31%
School 7	11%
School 8	13%
School 9	100%
School 13	15%
School 4	No approximate number
School 10	No approximate number

The next question focused on the frequency at which Health Promoters visited the schools. Only two schools (14%) receive visits on a weekly basis. Unfortunately, three schools (21%) did not mention how often the health promoters were visiting, but described it as *"once in a while"*, *"seldom"* and *"very often"*. Another three schools were visited on a quarterly basis and the last two schools were visited once every two months

and four times a year respectively. One school (7%) did not receive any visits from a specific health promoter, but did mention the school got visits from a *“provincial office”*. The participants indicated Health Promoters were mainly involved in activities related to health and mentioned health talks, health activities, food gardens, cleaning campaigns, AIDS activities and monitoring of hygiene in kitchens and storing facilities.

5.3.1.7 Analysis of section 7: Health-promoting school programme

The last section relates to Health promotion implementation. The participants had to indicate the total number of teachers and the number of teachers trained in Health promotion. At four schools all teachers are trained in Health promotion. It is worth noting that three schools do not have any teachers trained in Health promotion. When questioned about the learners who had been educated, all fourteen schools (100%) indicated that all learners had been exposed to the concept of the HPS, since it was part of the Life Orientation Learning Area curriculum.

5.3.2 Discussion of the quantitative findings and literature control

It was revealed from the data analysis that all fourteen HPS had access to tap water. The Department of Education insists on adequate water supply, stating that *“no school is allowed to function without portable clean water”* (Republic of South Africa, 2008:88). In practice however; the Department of Education is still battling to provide water to schools across the country. In 1996, 34,1% of schools had no access to water, and in 2006 it decreased to 12,6% (Republic of South Africa, 2010b:17). Another stakeholder in water supply is the Department of Water Affairs and Forestry (DWAF) who noted they were deeply concerned about the persistent backlogs in particular parts of the country although it has achieved the Millennium Development Goal of *“halving, by the year 2015, the proportion of people who are unable to reach or to afford safe drinking water”* in 2005 (Department of Water Affairs and Forestry, 2008).

The Department of Basic Education (DoBE) has committed itself to ensuring a safe, sustainable supply of drinking water and sanitation at every school across the country by 2014 as part of its Schooling 2025 Plan launched in May 2010 (Nkosi, 2012). According to Mrs Angie Motshekga, Minister of Basic Education, there are currently 450 schools lacking basic water and sanitation facilities in South Africa. She added that this part of the backlog would require R88 billion to address (Nkosi, 2012).

On 10 September 2012, the South African government launched a R30-million project called "*Water for Schools*". This project is led by the International Coca-Cola company and will see water supply infrastructure and sanitation facilities installed where necessary, and improved in other schools (Nkosi, 2012). Another partner is Re-solve Consulting, who recently finished repairing leaks at three schools in Katorus, located on the East Rand, near Johannesburg (Nkosi, 2012). However, the mere provision of water and sanitation infrastructure will not, in itself, improve health. To get the maximum benefit out of an improved water supply and sanitation infrastructure, people need to be supported with information that will enhance these benefits (Council for Scientific and Industrial Research, 2000).

Among the 14 schools investigated, only ten schools encouraged their learners to drink water. In a well developed country like the USA, Sohyun, Blanck, Sherry, Brener and O'Toole (2010) reported that 54% of high-school pupils drink water less than three times a day. They further reported that being obese was significantly associated with low water intake. Lake (2009) from the Children's Institute emphasises that children need reliable access to safe drinking water to prevent illness and promote health and hygiene. She further states that lack of water impacts on children's right to health and that it is vital that children can wash their hands after using the toilet and before touching food.

The Department of Water Affairs and Forestry (2008:100) defines the minimum standards for basic water supply at schools as 15 to 20 litres per learner per day (assuming the use of flush toilets) and one water supply terminal per 130 persons, within 200 meters of the main building. The present research indicates that the number of learners per tap in the HPS varied considerably; four schools (29%) did not comply with this minimum standard, having 150, 199, 260 and 610 learners per one tap, respectively. The best ratio was 47 learners per tap, and the average among the schools was 148 learners per tap.

The United Nation's Millennium Development Goals (United Nations, 2011) are directed at reducing poverty and ensuring sustainable development. Goal number 7, target 10 is the following: halve, by 2015, the proportion of people without sustainable access to safe water and basic sanitation. The data collected by the researcher revealed that twelve of the fourteen schools were satisfied with their ablution facilities, while two schools described the state of bathrooms as "*terrible and bad*" and "*poor*".

Devnarain (2011) conducted a study exploring the consequences of poor access to water and sanitation on the girl learner in South Africa. He stated that inadequate access to water continues to be a serious problem at many South African schools. The study indicated that the effect of inadequate access to water was not gender neutral, and added that inadequate access to water and sanitation significantly diminished learning opportunities for girls at the school. The World Health Organisation (WHO, 2009:12) came to a similar conclusion, stating that girls and boys are affected in different ways by inadequate water and sanitation. For example, a lack of adequate, separate and secure toilets may discourage parents from sending girls to schools. Menstruating girls are particularly affected by a lack of adequate facilities, and menstrual hygiene can contribute to girls missing days at school or dropping out altogether (WHO, 2009b:12).

Mbatha (2011) investigated problems experienced by girls as a result of lack of water and sanitation at two rural schools in Swaziland. Findings indicated that the state of water and sanitation was not satisfactory, and importantly established a correlation between poor access to water and sanitation, and girls' school attendance.

According to Samwel and Gabizon (2009) better management of water and sanitation would prevent over 30 million cases of water-related diseases per year in the European region. The WHO estimates that 88% of diarrhoeal diseases are caused by unsafe water supply and inadequate sanitation and hygiene (WHO, 2011). The aim of hygiene promotion and education is not coercion, but bringing about change in the behaviour patterns of people, to make them aware of the diseases related to unhygienic practises (Council for Scientific and Industrial Research, 2000). When instilling these behavioural changes in children, they are likely to maintain good hygiene and sanitation practises and pass that on to their own children (WHO, 2009b:13).

The HPS thus plays a cardinal role in equipping learners with knowledge and skills to empower themselves with regard to hygiene, sanitation and water behaviours. The World Health Organisation (WHO, 2009:20) identify the school setting as an ideal learning ground, stating that many children learn some of their most important hygiene skills at school level. Learners who have adequate water, sanitation and hygiene conditions at school are more able to integrate hygiene education into their daily lives, and can be effective agents for change in their families and the wider community (WHO, 2009b:12).

Smoking among adolescents is a source of great concern globally. In 2011, Chan and Leatherdale emphasised that prevention of youths smoking should be a public health priority in Canada and further stated that smoking remains prevalent among US youths despite decades of anti-smoking efforts (Chan and Leatherdale, 2011). Researchers in

Bangladesh found that despite the country's tobacco control laws, cigarette smoking in young people, and the magnitude of nicotine dependence among students were alarming (Rahman, Ahmad, Karim and Chia, 2011). In South Africa and other developing countries smoking rates are projected to continue to increase substantially (Resnicow, Reddy, James, Omardine, Kambaran, Langner, Vaughan, Cross, Hamilton and Nichols, 2008). From the present research in HPS it emerged that 64% of the schools had an anti-tobacco policy in place.

The absence of anti-tobacco policies at five HPS is disturbing, since smoking among school-going children rife in South Africa. Madu and Matla (2003) conducted a study among 435 high-school learners in Polokwane (Northern Province, South Africa) and indicated the prevalence of cigarette smoking to be 10,6%. Swart, Reddy, Ruiters and de Vries, (2003) conducted a similar study among 6045 high school learners from all nine provinces in South Africa and indicated that shockingly 23% of participants were currently smoking. It is therefore imperative that all schools have a clear and concise anti-tobacco policy. By understanding the demographics of teenage smokers, schools and the Department of Basic Education can improve their anti-smoking efforts for maximum efficacy. Swart *et al.* (2003) indicated that sex was the strongest contributor to the prediction of current smoking status in Grade 8 to Grade 10 learners. This is supported by various studies across South Africa. Taylor *et al.* (2003) interviewed 901 learners in Kwa-Zulu Natal and state that significantly more males (14,1%) than females (3,6%) smoked. Swart *et al.* (2003) came to a similar conclusion and noted that 28,8% of male adolescents smoke, compared to 17,5% females.

This is in accordance with global trends; for example, in Bangladesh the prevalence of smoking is 12,3% among boys and 4,5% among females (Rahman *et al.*, 2011). Schools should take this into account when planning anti-tobacco initiatives, and ensure they appeal strongly to male students. Resnicow *et al.* (2008) found that the impact of anti-

tobacco campaigns differed by gender and race, suggesting a need to tailor tobacco and drug use prevention programmes accordingly.

Another variable that can be utilised to estimate the relevance and efficacy of anti-smoking campaigns in schools is the age at which learners start smoking. Madu and Matla (2003) state that the mean age of first tobacco smoking to be 14,5 years in Polokwane, Northern Province. Swart *et al.* (2003) however indicate that among 6045 learners from across South Africa, 18,5% smoked their first cigarette before the age of 10 years. The proportion of smokers in a class increases as grades increase. In KwaZulu Natal Province smokers account for 4,3% of learners in Grade 8, 9,8% in Grade 10 and 13,7% of learners in Grade 11 (Taylor *et al.*, 2003). It is imperative that anti-tobacco education should begin at primary school level since many South African learners have smoked already by the time they enrol in high school.

Anti-tobacco policies in schools can further be amended when one is aware of the predictors and indicators for substance use. Gilreath, Chaix, King, Matthews and Flisher (2012) illuminate that an aggregate measure of importance for somebody ever smoking was whether there were school norms of perception that smoking was not wrong, or that smoking was cool, and having friends who smoke. This is supported by Van Ryzin, Fosco and Dishion (2012) who state that parental monitoring and deviant peer association are predictive of substance use in early adolescence. It is worth noting that an association with deviant peers was the only significant predictor in early adulthood (Van Ryzin *et al.*, 2012). King, Gilreath, Albert and Flisher (2011) add that family structure and discipline were significant predictors of adolescent male smoking behaviour. Another predictor is academic achievement. Gilreath *et al.* (2012) posit that there is a strong correlation between recent smoking among South African teenagers and their lack of attendance at schools, with increased levels of academic failure. Madu and Matla (2003) note that high school learners smoke because they are bored, tired or stressed

up or at parties. Anti-tobacco policies should serve a two-fold purpose. Firstly, to prevent youth from smoking, but also to prevent non-smoking youth from becoming susceptible to smoking (Chan and Leatherdale, 2011).

Within the context of the 14 HPS that took part in this research, only six schools (43%) had declared the school ground a smoke-free zone and had signs up around the school. Swart, Panday, Reddy, Bergström and De Vries (2006:3) state that learners in the Southern Cape were willing to participate in anti-tobacco programmes, but that it had to be exciting, fun filled and integrated into their daily lives. The researchers further state that the youth were unaware of smoking prevention or cessation programmes, and they concluded that the most effective form of anti-tobacco campaigns are school-based activities that are supported by out-of-school activities to be held over weekends and holidays. In addition, school-based campaigns should be accompanied by community-based mass media approaches, with the television and print media as the main sources of information (Walker, Walker, Jerling, Rossouw and Lelake, 1999:24; Swart *et al.*, 2006:3).

All fourteen schools (100%) indicated that they had informed learners about the dangers of tobacco use. This is to be expected, since Health promotion is an outcome in Life Orientation and forms part of the LO curriculum. In 1999, Walker *et al.* (1999) conducted a study among 716 high-school learners in Cape Town to explore their attitudes towards tobacco use. The learners were the most familiar with the concept of lung cancer and identified smoking as the chief cause of the disease. However, it emerged that learners were more anxious about unemployment, violence and AIDS than about future health, and health was not perceived by many as the most important goal in life. Resnicow *et al.* (2008) emphasised the need for more intensive intervention, in the classroom and beyond, to further impact smoking behaviour.

Another pressing issue affecting the wellbeing of children in South Africa is inadequate access to nutrition. Labadarios (2000:1) claims that malnutrition among children is one of South Africa's biggest problems, especially in the form of micronutrient disease. The South African National Burden of Disease study showed that underweight contributed to 12,3% in 2007 (Nannan, Norman, Hendricks, Dhansay and Bradshaw, 2007). In 2004 the Western Cape Government noted that malnutrition was a serious problem in South Africa and one of the biggest contributors to childhood illness and death. It is estimated that about 30% of South African children are stunted from a lack of adequate nutrition in the early years of their lives (Western Cape Government, 2004b:2). Malnutrition commonly refers to under-nutrition (poor growth) rather than over-nutrition (Hendricks and Bourne, 2008).

Malnutrition is associated with deficiency of micronutrients – in particular with Vitamin A, Zinc, Iron and Iodine deficiencies. The National Food Consumption Survey – Fortification Baseline (NFCS-FB) found that 64% of children aged 1 to 6 years were vitamin A deficient (Labadarios, 2007). According to the Children's Institute (Berry, Hall and Hendricks, 2011a) children in KwaZulu Natal are most affected, with 88,9% having an inadequate vitamin A status and 44,7% having a vitamin A deficiency. The Northern Cape is the least affected, showing 23,0% inadequate status and 3,8% vitamin A deficiency. Children with vitamin A deficiency carry an increased risk of infection and are more prone to diseases (Berry *et al.*, 2011a). Already in the early nineties, Glasziou and Mackerras (1993) claimed that the improvement of vitamin A status was considered one of the most cost-effective health and nutrition interventions for child survival.

In respect to Iron deficiency, Labadarios (2007:2) found that 25% of children aged from 1 to 9 years were iron deficient. Children in the Free State Province in South Africa were most severely affected, with 18,9% being iron deficient and 11,6% having progressed to iron deficient anaemia (Berry, Hall and Hendricks, 2010). Insufficient iron intake in

children can progress to iron deficiency anaemia, which can inhibit children's cognitive development and increase their vulnerability to infections and cardiac failure (Schrimshaw, 1991:1).

The problem of malnutrition is not limited to South Africa. Globally, maternal and child malnutrition contributes to 3,5 million deaths annually and to 35% of the disease burden in children under 5 years (Hendricks and Bourne, 2008). Malnutrition affects every aspect of a child's life. Poor nutrition will adversely affect a child's physical and mental capacity (Hall, 2010) but also compromises performance and productivity and perpetuates a cycle of intergenerational poverty (Hendricks and Bourne, 2008).

The South African Constitution, in Section 27(1) (b) of the Bill of Rights (Republic of South Africa, 2009), stipulates that *"everyone has the right to have access to sufficient food"*. Besides extending this right to everyone, the Constitution gives children extra protection in Section 28 (1) (c) by providing that *"every child has the right to basic nutrition"* (Republic of South Africa, 2009).

All fourteen (100%) of the HPS that were researched, participate in die National School Nutrition Program (NSNP). In 2004, the Department of Basic Education (DoBE) took over responsibility for the National School Nutrition Program (NSNP) from the Department of Health. The DoBE seeks to ensure that learners in the poorest primary schools and secondary schools have access to nutritious meals. In addition, the DoBE plans to promote sustainable food production in schools to develop skills (Republic of South Africa, 2010a:23). In the *Best of the National School Nutrition Program* released in March 2010, the Department of Basic Education states that *"we know children learn best when they are not hungry or suffering from a nutrient deficient diet"* and claims that *"wherever the programme has been implemented, hunger has been combated and the overall school attendance has improved"* (DoBE, 2010).

Many learners come to school without having the luxury of having eaten breakfast, so providing food in the morning would most improve the energy levels and ability to concentrate (Department of Basic Education, 2010:6). It is paramount that expansion of the NSNP should continue to be implemented at all schools around the country, especially since 3 million children (18%) were living in households where there was child hunger in 2010 (Hall, 2010). The NSNP is only the latest effort in the struggle to ensure adequate nutrition for children, a battle that has been raging for nearly two decades. In 1994, the Department of National Health and Population Development did an anthropometric survey among 97790 primary school entrants selected from 3300 schools across South Africa. The results revealed that 9,0% of learners were underweight, 13,2% were stunted and 2,6% were wasted. Eleven years later, the National Food Consumption Survey – Fortification Baseline (NFCS-FB) showed that 9,3% of children aged between 1 and 9 years were underweight, 18% were stunted and 4,5% were wasted (Labadarios, 2007:3).

Children in the Northern Cape Province seem to suffer most from stunting. “*Stunting*” in children indicates chronic malnutrition. Importantly, it can be used as a proxy for poverty as it reflects the health and nutritional status of children over a long period (Hendricks and Bourne, 2008). In 1994, 19,2% of learners in the Northern Cape were stunted. This increased to 29,6% in 1999 and then slightly decreased in 2005 to 27,7%.

The 14 HPS where the study was done are located in the Gauteng Province, considered a “rich” province as it contributes most to the Gross Domestic Product of South Africa. In 1994, 7,1% of Gauteng learners were stunted. There was an alarming increase to 20,4% by 1999 and a slight decrease in 2005, with 16,8% being stunted (Berry, Hall and Hendricks, 2008). Sadly, it seems that despite government efforts, very little progress has been made with improving the nutritional status of children.

From the data collected it was revealed that eleven (79%) of the fourteen HPS have vegetable gardens. According to the Department of Basic Education (DoBE, 2010) vegetable gardens are the way to go since they have been shown to boost the healthy diets of learners. There are numerous advantages in implementing vegetable gardens. Firstly, fresh produce can be used to supplement the food schools provide. Data from the research indicate the most common foodstuff served were porridge, samp (dried corn kernels), beans and bread. This bland diet often lacks micro nutrients. Only two schools (14%) use vegetables from their own gardens. Secondly, selling harvested food to communities can generate income for the school. The researcher established that six of the schools (43%) sell produce to communities. A primary school in Limpopo has become a centre of excellence in horticulture in that province (DoBE, 2010:24) and also generates income by selling harvests to community members and other stakeholders. Thirdly, learners at schools with vegetable gardens are given the opportunity to acquire practical knowledge (DoBE, 2010:25) and gain life skills such as planting, processing garden produce and understanding entrepreneurship (DoBE, 2010:27).

The acquired skills can be enforced and expanded by incorporating food gardens into various learning areas. For example, in Life Orientation, learners are tasked to identify the types of food nutrients found in different vegetables in the garden. The researcher established that teachers from thirteen of the participating schools (93%) indicated that they integrate nutrition into their Life Orientation lesson plan. In Natural Sciences learners learn about plant production and in Economic Management Sciences learners are taught to calculate profit and expenditure when selling harvest (DoBE, 2010:28). A School Garden Co-ordinator from Limpopo made the general observation that learners who are quiet in class, participate actively in the food gardens, thus improving their communication skills (DoBE, 2010:28).

From the data it emerged that learners at all fourteen HPS purchased foodstuff from tuck shops and vendors. It is worrying that the most popular consumables are sweets, salty snacks and fizzy drinks. Abrahams, De Villiers, Steyn, Fourie, Dalais, Hill, Draper and Lambert (2011) conducted a study among 717 primary school learners in the Western Cape Province and indicate that after monitoring the children for 24 hours, 49% had consumed at least one item purchased from the school tuck shop/vendor. The most frequent foodstuff bought was potato crisps ("chips"). Interestingly, they found that learners who ate food from tuck shops/vendors had a lower standard-of-living score but had higher dietary diversity. Temple, Steyn, Myburgh and Nel (2006) indicate that among 476 high school learners, 69,3% purchased from tuck shops/vendors. Of those, 70% purchased no healthy items and 73,2% purchased two or more unhealthy items. This study further revealed that only 47% to 61% of learners knew that fizzy drinks, samoosas (small turnovers of Indian origin filled with vegetables or meat fried and served hot) and pies were less healthy options. The HPS thus have a twofold purpose: Firstly, to educate learners about healthy food choices and assess this outcome properly in Life Orientation, and secondly, to exert control over the foodstuff sold at school. The research data revealed that only eight schools (57%) had complete control over what vendors were selling and only 9 schools (64%) monitored the standard of hygiene at vendor stalls. However, twelve schools (84%) did have a policy in place to compel vendors to sell fruit and vegetables during school activities, such as athletic meetings.

School children are also affected by the physical school environment, and their perceived safety and security at school. The Department of Basic Education (DoBE) identified school safety as one of the challenges facing the department, stating that too many schools are plagued by violence, crime and deviant behaviour (DoBE, 2011:8). This means that these school environments are not safe for learners and teachers. The

Department concludes that safe environments are essential for effective teaching and learning to take place (DoBE, 2011:8).

The data revealed that 10 schools (71%) considered the school environment to be safe. One of the main contributors to perceived safety was the presence of a security gate. The researcher established that only eight schools (57%) had security fences surrounding the perimeter. In 2006, only 5,5% of assessed schools included in the National Education Infrastructure Management System (NEIMS) had a functional gate or fence. In the proposed "National Minimum Norms and Standards for School Infrastructure" (Republic of South Africa, 2008:80), the Minister of Education indicated that as a bare minimum a school should be provided with an appropriate fencing around the school outbuildings and sport fields, with the minimum height of 1,8 metres (Republic of South Africa, 2008:80). In the same document, the Minister of Education further mentioned that all schools should be provided with a form of security; the basic minimum was burglar-proofs in all educational structures. The optimum would be an alarm system and guards (Republic of South Africa, 2008:80). It is therefore paramount that all HPS have sturdy and effective walls on the perimeters or fencing with a school gate that can be securely locked.

Prinsloo (2005:5) defined a safe school as one that is free of danger and where there is an absence of possible harm and explained that a safe school is therefore a healthy school. Indicators for safe schools include the presence of certain physical features such as secure walls, fencing and gates. Squelch (2001:137-149) suggests that safe schools are also characterised by good discipline, a culture conducive to teaching and learning and professional teacher conduct. Stevens, Wyngaardt and van Niekerk (2001:313) added that safe schools are free of intimidation and fear of violence, while Netshitahame and Van Vollenhoven (2002) claim that if learners and staff do not feel safe, education often takes a back seat. In this regard, both the government and

teachers have an important role to play. The government is compelled, under The South African Constitution and Bill of Rights (Republic of South Africa, 2009) to provide a safe school environment. Section 24 states that everyone has the right to an environment that is not harmful to his or her health and well-being. This means that learners have a constitutional right to receive education in a safe school environment (Prinsloo, 2005:8).

Teachers are compelled to ensure safety in terms of the common-law principle, *in loco parentis* (Oosthuizen, 1998:209). This principle enforces the 'duty of care' of educators: Firstly, the duty of care, which implies looking after the physical and mental wellbeing of learners, and, secondly, a duty to maintain order at a school (Maithufi, 1997:260-261). The teachers at HPS need to be informed of their duty of care, since protecting learners from harm is a legal obligation (Prinsloo, 2005:9). The principals play a paramount role in ensuring school safety. Netshitahame and van Vollenhoven (2002:313-314) conducted a study in the Limpopo Province and indicated in most cases that the schools had inadequate and/or badly maintained facilities and that most of the principals they interviewed had very scant understanding of, and use for, safety policies in their schools. This was confirmed by Xaba (2006:578) who states that schools in the Vaal Region (adjacent to the Gauteng Province) in fact did have a safety policy, which however was not being implemented. He found that most schools and principals believed that the issue of learner safety is a Departmental responsibility and therefore did not pursue the involvement of the community or other safety stakeholders such the police and neighbouring schools (Xaba, 2006:578).

The Centre of Education Law and Policies (CELP) suggest that school safety can be improved by promoting the teaching of values such as honesty, integrity, mutual respect and human dignity (Bray, 2005:135). Learners should be taught effective and nonviolent methods of managing conflict. CELP puts great emphasis on community involvement, stating that the surrounding community can be involved in patrolling the premises and

assisting in the maintenance of buildings and grounds. Parents can also be educated in matters such as controlling and monitoring violent and unsuitable content to which children are exposed on television and in the printed media (Bray, 2005:135).

The School Governing Bodies (SGBs) also contribute to school safety. Squelch (2001:139) laments the lack of good governance and professional management and names these as factors contributing to the general lack of safety in schools. She further blames the situation on the failure of many SGBs to draw up and implement effective school policies, including school safety policies, and ascribes this failure to the fact that the SGBs in many South African schools are not sufficiently equipped to perform this important function (Squelch, 2001:138).

In 1999 the then Minister of Education, Kadar Asmal announced the "Tirisano: Call to Action" plan, detailing his educational priorities and vision for the next few years. His plan emphasised the need for improvements in the safety and security elements of schooling and in the process of teaching-and-learning (Roper, 2002:68). In June 2001, Minister Asmal painted the following picture of a safe school: "In a safe school, the playgrounds are filled with the healthy noise of happy children. They scuff their knees and scrape their elbows, but they are not afraid of each other or of intruders. The classrooms are clean. The teachers are on time, stand upright and are firm but friendly. There is glass in the window panes and there are books on the desks. These are the schools conducive to effective learning and teaching" (Joubert, 2007:1).

However, in 2007, the South African Human Rights Council (SAHRC) published a report which is in stark contrast to the 'ideal school' described by Minister Asmal. Evidence presented to the SAHRC indicated the prevalence of bullying, sexual violence and violence that stems from racial, gender, religious and language discrimination.

Only twelve of the fourteen HPS have anti-bullying programs in place. Liang, Flisher and Lombard (2007) examined the prevalence of bullying behaviour among 5074 learners at 72 government schools in Cape Town and Durban. The study revealed that 36,3% of learners were involved in bullying: 8,2% as bullies, 19,3% as victims and 8,7% as both bullies and victims. Male learners were more vulnerable to victimisation than female counterparts.

5.3.3 QUALITATIVE DATA ANALYSIS

The data that were obtained in the qualitative stage of the research will be presented in the paragraphs that follow. Themes that emerged from the data will be provided as well as significant excerpts taken from the interview transcripts (See Appendix E). The themes will be cross-referenced with a literature review and discussion.

5.3.3.1 Analysis of question 1

The first question the researcher asked was as follows: *It is well known that Life Orientation and Health promotion are linked in schools. According to you as a Life Orientation teacher/Health Promotion Co-ordinator, what is your view on this?*

- **Main theme: Healthy lifestyles**

This question aimed at understanding better how teachers view the relationship between Life Orientation Learning Area and the concept of Health promotion. All the participants acknowledged the link between the two, and used various topics to explain the relationship. The most prominent theme that emerged from question 1 was the fact that both Life Orientation and Health promotion ultimately aim to promote a healthy lifestyle and equip learners with the knowledge and means to acquire and maintain a healthy lifestyle. The participants mentioned the learners' diet, level of physical activity and the cleanliness of the environment as important components of a healthy lifestyle.

- **Balanced diet**

The participants are aware of the importance of a healthy balanced diet in promoting health: *"Yah, yes, I agree with you on this point and again it incorporates both learners and educators in such a way that we encourage learners to eat a healthy balanced diet"* **(Line 5-6)**.

One participant in particular referred to the specific Assessment Standards (AS) in Learning Outcome 1 of Life Orientation that involve dietary aspects: *"So LO 1 (Learning Outcome 1) AS 1 (Assessment Standard 1) is talking about ways to improve the nutritional value of own personal diet. And we cluster this with AS 4 (Assessment Standard 4) where we describe strategies for living with diseases, including HIV and AIDS, since people with HIV And AIDS must eat healthy food so they can live longer"* **(Line 224-227)**.

Some participants described ways in which they teach learners about healthy diets: *"That's why in Learning Outcome 1, which is Health promotion, we encourage learners to eat four groups, four food groups"* **(Line 6-7)** and *"So learners must eat a healthy balanced diet and in Life Orientation we tell learners what a balanced diet is. So they must write a balanced diet for a day or for a week that includes breakfast, lunch and supper"* **(Line 229-230)**. They further encourage learners to eat healthy food: *"And we try to tell the learners not to buy those Simba chips. Those brown-red ones. And they mustn't drink fizzy drinks, they must drink juice instead. So they should avoid eating colourful sweets, you understand?"* **(Line 232-233)**.

- **Clean and hygienic environment**

The participants indicated that a clean and hygienic environment is another component of a healthy lifestyle: *"My view on the above is that it is good to link the two because the*

school as the environment should always be kept clean. This is mainly because we as the school need to expose the learners to a healthy lifestyle” (Line 501-503). Some participants emphasised the importance of personal and environmental cleanliness: *“We teach them how to be clean and hygienic. Not only to be clean themselves but also to have a clean environment” (Line 355-356).* Another participant made the link between cleanliness and health: *“And if we don’t take care of the environment in which we are living, we might time and again get sick. Especially the toilets, keeping the toilets clean are one of the issues, so hygiene issues are brought into the picture” (Line 18-19).*

- **Physical activities**

The third concept is related to Learning Outcome 4 in Life Orientation, namely physical activity and movement. Although the importance of physical activity cannot be overstated when discussing a healthy lifestyle, only two participants mentioned this: *“As an LO (Life Orientation) teacher I think Health promotion and LO (Life Orientation) are the same because they both teach learners how to take care of themselves, how to eat healthy and the importance of doing some exercises” (Line 354-355)* and *“...also the physical activities in learning outcome 4 deal with obesity...” (Line 9).*

5.3.3.2 Analysis of question 2

Question two asked the following: *Within Health promotion as part of Life Orientation there are competencies one can focus on in terms of both learners and teachers. What is your view on this?*

- **Main theme: Healthy lifestyles**

Once again in the second question the theme of a healthy lifestyle emerged. All the participants viewed the ability of learners to adopt a healthy lifestyle as a key competency.

- **Nutritional competencies**

The acquisition of skills related to diet featured strongly in the responses: *“Learners know how to keep their bodies healthy and how to eat healthy food” (Line 521)* and *“All of them, the learners and educators, need to eat healthy foods and practise a healthy lifestyle” (Line 531).*

One participant viewed a functioning vegetable garden as an important asset: *“They are methods we can use to solve the problem of poverty and malnutrition by making food gardens, so both learners and educators are taught how to do that” (Line 360-361).*

The participants were aware of the negative effect of poor diet on academic performance: *“That is why I think vendors mustn’t sell our children sweets in the morning because they become hyperactive in classes” (Line 242-243)* and *“Yes, we give them breakfast because many children come to school without eating breakfast so they can’t concentrate” (Line 245).* Some participants noted that the schools provide learners with breakfast since many learners from informal settlements come to school on an empty stomach, while learners with financial means are tempted to buy snacks from vendors: *“And when they get porridge they don’t buy sweets and fizzy drinks” (Line 245-246).* Some participants encourage learners to bring food from home to discourage unhealthy habits: *“And learners must bring their lunch boxes so they don’t have to buy snacks” (Line 530).*

- **Personal development skills**

A few participants referred to the competencies in relation to Learning Outcome 3 of Life Orientation, which is personal development: *“In Learning Outcome 3 we implement strategies to enhance own and others’ self image through positive actions, and explain and evaluate your emotions and responses to change. And we teach learners to be a*

considerate person and not hurt others” (Line 239-241). Another participant referred to negotiation and refusal skills: *“We teach learners to say or take ‘no’ as a ‘no’ as to avoid unwanted sexual activity or teenage pregnancy” (Line 364).* Critical thinking skills were also mentioned: *“The learners are able to use critical thinking skills so they do not make wrong choices” (Line 366).*

- **Social development skills**

Some participants referred to the competencies of Learning Outcome 2 in Life Orientation, namely Social development: *“In Life Orientation we teach different types of development, like in learning outcome 2 we teach Social development. We explain how to counter gender stereotypes and sexism” (Line 238-239).*

- **Physical activity**

Only participants from one school mentioned physical activity as a competency. However, the participants spoke passionately about their efforts to encourage physical activities and games and boasted with their good achievements in gymnastics. They explained: *“Yes, again in this one we encourage a healthy lifestyle, especially encouraging learners again to eat healthy food and ensuring that learners are taking part in sport, games and physical activities that are incorporated with learning areas. Like I said, Learning Outcome 4 is where learners are encouraged to take part in different activities” (Line 29-31).* The second participant from the same school added: *“Based on that competency, um, we have ensured that each and every child is given the opportunity to take part in games or physical activities like sport” (Line 36-37).*

5.3.3.3 Analysis of question 3

The third question the researcher asked was: *Within Health Promotion as part of Life Orientation stakeholders play a role. What is your view on this?*

The following themes emerged from the responses:

- **The community as stakeholder**

The participants referred to the members of the community as the most prominent stakeholder: *“And an important stakeholder is the community” (Line 252)* and *“we think our community is a stakeholder in this school” (Line 538)*. The participants mentioned the relationship of reciprocity between them and stakeholders. The participants viewed the stakeholders as a security measure and a source of extra income in return for making the school buildings available for meetings or church congregations: *“Yes, again on that... stakeholders are holding meetings at our school and are responsible for cleaning the school and they take part in cleaning campaigns. They are looking after our school at the same time; they serve as the security because while they are here they are our eyes” (Line 85-87)*. Another participant added: *“So we don’t experience vandalism like other schools where you’ll find that they have stolen the computers. We haven’t had that particular thing because the community are holding their meetings here at school” (Line 110-111)*.

The role of the stakeholders in cleaning and maintenance of the school property was frequently stated: *“We especially need the parents to be involved in the school. We have parents who come to school and clean our classes, especially the unemployed parents, they just come and clean the classes” (Line 252-254)* and also: *“After that the members of the community help us by working in the food gardens” (Line 541-542)*.

- **Importance of stakeholders in the HPS**

The participants commented on the importance of stakeholder involvement in their schools: *“All the stakeholders must communicate correctly, right through from the grounds men to the lady who is cooking – all of them must be considered in everything so*

the school can run smoothly” (Line 249-250). Another participant added: *“I think the sustainability of the health promoting school is to sell it to educators, learners and members of the community so they all help in keeping the school a successful health promoting school because if the stakeholders are negative nothing would be achieved” (Line 369-371).*

- **School nurses**

Some of the participants view school nurses as one of the stakeholders. One participant stated: *“And also the school nurses are available” (Line 89)* and added: *“Normally they spend a week with us here. So since last week they’ve been here screening the children’s ears and eyes” (Line 93).* Another participant commented: *“We have nurses which come to school and do checkups” (Line 554-555).* The nurses also assist to *“check even the vendors, the type of food they are selling to the children” (Line 101).*

- **Private companies**

Participants from one school mentioned private companies who support them. It was BMW South Africa: *“BMW, which is next to us at Rosslyn here, they introduced the food garden and provide us with seeds to plant” (Line 542-543)* and Nestlé South Africa which had a rural development competition in which the school won R50000 **(Line 546-547).**

- **Government Departments**

One participant mentioned the involvement of government departments. Firstly, the Department of Agriculture hosted a competition in which the school won R40000. Secondly, the Department of Social Welfare assist the school in obtaining grants for learners: *“They help us a lot to fill in the documents when we maybe have a learner that doesn’t earn a grant. We just invite social welfare, they help us to fill in the forms” (Line 558-559).*

5.3.3.4 Analysis of question 4

The fourth question posed to the participants was: *Within Health Promotion as part of Life Orientation community involvement and participation have a role to play. What is your view on this?*

The participants agreed on the importance of community involvement in the school: *“So we cannot initiate anything here at school that excludes the feeder community. The community and the school must be linked, they must be one thing” (Line 572-573)* and *“Educators or the school as a whole should work with the community” (Line 381)*.

- **Cleaning, cooking and gardening**

The majority of participants described community participation in terms of the help they get from community members in three key areas. Firstly in preparing and serving lunch for learners: *“Here at our school we have parents who help prepare food for the learners, they cook the feeding scheme food. Parents serve the learners during breaks and around half past one when the learners go home they give them fruits” (Line 575-577)*. Secondly, community members assist in keeping the school clean: *“The community helps by cleaning our school” (Line 386)* and *“there are parents who clean the children’s classrooms, especially in the Foundation Phase (Grade R to 3), they clean for the children because they are too young to clean” (Line 262-263)*. Thirdly, the community work in the vegetable gardens: *“They also work in the food gardens where they plant seeds for vegetables to that our learners can eat healthy food” (Line 261-262)* and another participant stated: *“...and then they are also involved in how to reduce malnutrition by working in our food gardens” (Line 387-388)*.

- **Participation in health awareness**

Members of the community are involved in health awareness campaigns at various schools: *"They are involved in health activities in our school like health awareness, most of the times when we have health awareness campaigns, they are involved"* (Line 386-387) as well as: *"... and they also teach learners about the danger of HIV, they usually come to school and help with HIV awareness"* (Line 123).

- **Security**

Many participants viewed community involvement as a type of security and believed that community participation would reduce vandalism and dumping around the school buildings: *"Even over weekends, if the parents are around I don't think there will be any break-ins or vandalism"* (Line 383-384). Another participant stated: *"They serve as security and make sure there's no dumping. So they are looking after the school and also come and teach the learners about the values and norms of our society"* (Line 118-119).

5.3.3.5 Analysis of question 5

The question posed to the participants was as follows: *As a teacher or health coordinator what is your view on the access to health services as part of Health promotion?*

- **School nurses**

All the participants view nurses as the most important health service the school is receiving: *"Yes, let me give you a scenario, the background of the health promoting school. We cannot deal with the health promoting school without the nurses"* (Line 596-597). The nurses fulfil various functions: *"The school nurses come to our school regularly to check on learners' health, for example immunize them or to check their eyes, ears and teeth"* (Line 396-397). Another participant noted: *"If a nurse says the learner is seriously*

ill they take the child to the hospital" (Line 281). One participant added that the nurses provide information regarding diseases: "Yes it does help us when there are referrals, and like I said the nurses can advise us in time how a disease is treated..." (Line 146) and "they play an important role because they inform the learners about their health" (Line 601). Some participants indicated that nurses are required to write a referral letter when learners are taken to hospital: "Before we can refer them to the district clinic, the nurses must write a report to give the background of the learner like the social life and health status" (Line 598-599).

- **Private companies**

The company "Always" is a manufacturer of feminine hygiene products and contributes to the wellbeing of girls: "... again in Life Orientation, there are people from 'Always' that come and lecture the Grade 7's about menstruation and supply them with 'Always' sanitary towels" (Line 298-299). This is an important donation since "... most of the parents can't afford afford to buy those sanitary towels for the girls" (Line 301-302).

According to one participant, BMW, the car manufacturers, indirectly contribute to the health of learners: "Yes and then BMW supply us with seeds to plant in our food garden" (Line 289) and "... they provide us with seeds to plant so that we can cook healthy food for the children" (Line 290-291). The participant concluded: "So we give learners healthy food because their diets must be balanced" (Line 296).

- **Government assistance**

Two participants referred to the Department of Social Welfare: "Some of them they don't have parents, they are child-headed families, so we invite social welfare to come here, they help them to fill in the forms, they issue the forms for them, they do everything so that the child can get, um, a grant" (Line 612-613). Another participant noted: "... and then we

have social development... um... those people supply our learners with uniforms, especially the needy learners” (Line 283-284).

5.3.3.6 Analysis of question 6

The question posed to the participants was: *As a teacher, what is your view on the environment as part of the health in the school?* There was one overwhelming response that all respondents mentioned, namely cleanliness of the school environment.

- **Cleanliness of the school environment**

Cleanliness of the environment is clearly a factor that all participants view as important in their approach towards teaching: *“Yes we believe in cleanliness” (Line 155)* and further that cleanliness is included in the scope of health promotion: *“Yes, health promoting must see to it that school grounds are clean” (Line 306).*

Some participants mentioned the link between the state of the environment and teaching: *“I think the environment is very important because better teaching takes place in a cleaner school” (Line 411)* and another stated: *“You are also the environment so if you or the environment in which you find yourself is not clean, gradually one way or the other it affects teaching and learning” (Line 626-627).* This participant views cleanliness as a component of a healthy lifestyle: *“Because if the school is not clean, we cannot promote healthy living” (Line 627-628).* One participant gave a detailed response: *“We believe in teaching the learners that in a clean environment the learner is free. We believe that the school... um... the school firmly believes that nothing yields better results than learning in a clean and safe environment which contributes to sustainable development and livelihood” (Line 155-157).*

Participants also linked the environment to health: *“We have a problem with the cleanliness of the toilets and that could make one sick if it stays dirty” (Line 415-416).*

The participant elaborated on the cleanliness of the ablution facilities: *"We teach learners that cleaning reduces sickness. They should be provided with soaps and other cleaning materials to clean their classrooms and the toilets so learners are safe"* (Line 419-420).

5.3.3.7 Analysis of question 7

The last question posed to participants was: *As a teacher or health coordinator what is your view on policies concerning Health promotion in schools and what kind of policies do you think we are talking about?*

Two policies were mentioned by all participants, namely a substance abuse policy and a safety and security policy.

- **Substance abuse policy**

Many participants indicated that drugs, alcohol and tobacco are covered under the substance abuse policy. Some participants merely mentioned the existence of such policies: *"We also have a teenage pregnancy policy as well as a drug abuse policy"* (Line 639) while others elaborated further: *"I think learners must be aware of the substance abuse that is all over all schools now"* (Line 482) and continued: *"They must not take drugs and alcohol. We have a substance abuse policy about that"* (Line 484). Two participants noted anti-tobacco policies: *"We talk about the tobacco policy... um... drug policies and and also the environmental policy"* (Line 205) and *"there is the learner pregnancy policy and the anti-smoking policy"* (Line 323-324). One participant mentioned that the anti-smoking policy is applicable to teachers too: *"That is not only for learners but also for teachers who smoke. They know they are not allowed to smoke wherever they want"* (Line 326-327).

- **Safety and security**

All participants mentioned the safety and security of learners to be an important policy. Some participants mentioned aspects of their safety policy: *"Um, we have the learner safety policy, the health care policy and the teenage pregnancy policy"* (Line 637) and elaborated that: *"The safety and security policy teaches learners what to do when there is a fire at the school, they know where they are suppose to go"* (Line 661). Another said: *"Um... so we also have a school safety policy which tells us what to do when a learner is maybe raped"* (Line 476-477). One participant was particularly negative towards the safety policy and noted: *"But the safety policy is not working because we are not allowed to search learners when they come to school"* (Line 449). The participant experiences the safety policies from the Department of Education to be conflicting and ineffective: *"They keep on changing, they say they will be searched but there is no security at the gate to search them so learners come to school with knives"* (Line 453-454). However, another participant from the same school had a more positive response: *"And our school safety policy makes sure that learners are safe, like we don't allow weapons at the school"* (Line 488-489). Some participants did not mention the safety policy *per se*, but noted: *"Okay, the policies are basically guided by the National Policy on Safety for Learners"* (Line 320). Another participant gave an example of locking the school gate and concluded in doing so *"...the safety of the school is also promoted"* (Line 214).

5.4 Discussion of qualitative findings and literature control

It was revealed from the data analysis that all participants as Life Orientation teachers were aware of the link between Life Orientation and Health promotion, stating in all cases that both encourage a healthy lifestyle. This is important since the Department of Education (DoE, 2002:5) claims that many social and personal problems are associated with lifestyle choices and high-risk behaviours. Sound health practices, and an

understanding of the relationship between health and environment, can improve the quality of life and wellbeing of learners. Specific aspects of a healthy lifestyle, namely *balanced diet, cleanliness and hygiene and physical activities*, emerged from this study as important aspects for teachers, health co-ordinators and school principals.

The concept of balanced dietary intake features prominently in the responses to this question. According to the assessment standards set by the Department of Education, nutrition is assessed in every school year. For example, in Grade R learners are required to explain basic concepts such as the importance of drinking only clean water and eating fresh food (DoE, 2002:12). In Grade 3 learners must be able to compare healthy and poor dietary habits and describe the effects of such habits on personal health (DoE, 2002:17). In Grade 6 learners should be able to interpret food labels and critically discuss health effects of listed ingredients (DoE, 2002:29).

Sufficient dissemination and proper assessment of the Learning Outcome on nutrition is critical in the South African HPS. The HPS serves a twofold function: firstly, to equip the learners themselves with good nutritional information and, secondly, to utilise these learners as “vehicles” to transmit information taught in class to members of their households and communities. The latter is vital, since the Sombambisana Project (Beeld, 2012) found that the first 1000 days of a child’s dietary habits lays the foundation for further development. Neurological growth takes place the fastest during the first 1000 days, thus malnutrition in infancy compromises a child’s development, especially cognitive development (Beeld, 2012). A learner taught at a HPS can play a role in promoting the nutritional status of younger siblings. According to Beeld (2012) about 20% of children younger than five years in South Africa are affected by malnutrition. Prof. Andrew Dawes, emeritus professor at the University of Cape Town stated that many young children are hungry, and their development is adversely affected by this (Beeld, 2012).

Cleanliness and *hygiene* within the school setting were high on the agenda for teachers, health co-ordinators and school principals. In 2000, deaths in South Africa attributable to unsafe water, sanitation and hygiene were estimated at 13 434 (Lewin, Norman, Nannan, Thomas and Bradshaw, 2007). This accounted for 2,6% of all deaths in South Africa in 2000. Given the morbidity of poor access to water, poor sanitation and poor hygiene, the HPS plays a pivotal role in not only preventing illness, but also enabling survival of children. The HPS is thus the “where” in Health promotion, while the Life Orientation Learning Area is the “how”.

In Grade R, the Life Skills Assessment standards require learners to know steps to ensure hygiene and to demonstrate precautions against communicable diseases (DoE, 2002:12). The easiest and most inexpensive way of improving hygiene is something as simple as hand washing. Pengpid and Peltzer (2012:2) stated that the biggest killers of young children in African countries are respiratory infections and diarrhoeal diseases – both are preventable via hand washing. The National Health Laboratory Service of South Africa (2010) substantiated this claim, stating that proper hand washing with soap has been shown to be an extremely effective intervention, capable of significantly reducing the prevalence of diarrhoea and respiratory infections among vulnerable young children. According to Lewin *et al.* (2007:755) diarrhoeal diseases are the third-largest cause of death in children under five years, and, further, unsafe water and lack of sanitation and hygiene (WSH) are a key risk factor for diarrhoeal and other diseases.

Pengpid and Peltzer (2012) explored hygiene behaviour among 25 760 school pupils in nine African countries and found that only 62,2% reported washing their hands before meals and only 58,4% wash their hands after using the toilet. Only 35,0% used soap. Significantly, the most prevalent hygiene practise was tooth brushing, with 77,3% brushing teeth more than once a day. Pengpid and Peltzer (2012:2) indicate three variables that contribute to optimal hygiene: the level of education, healthy habits such

as eating fruits and vegetables and protective factors such as caregiver supervision. Their study revealed overall sub-optimal hygiene behaviour in all nine countries that they studied.

Promptussananon and Peltzer (2003) investigated the daily activities that 117 South African children perceived as health-related activities. The results showed that the most important health action around healthy eating were washing hands and that keeping clean was achieved by washing body and hair. However, some activities such as brushing teeth were insufficiently mentioned. Researchers conclude that children have insufficient knowledge and understanding about health related activities (Promptussananon and Peltzer, 2003:2).

HPS should utilise the Life Orientation curriculum as a means to eradicate the persistent state of sub-optimal hygiene behaviour among learners. The ideal is that teachers should ensure that every child achieves every Learning Outcome. Life Orientation itself is aimed at guiding and preparing children for a successful transition into adulthood (Department of Education, 2002:7). Teaching young children optimal hygiene and health behaviour would translate into healthier behaviour in adulthood.

Physical activity and movement emerged as a vital precondition to a healthy lifestyle. Physical education was phased out as a stand-alone subject in 2004, and placed in the Life Orientation Learning Area as one of its four Learning Outcomes (Draper, de Villiers, Lambert, Fourie, Hill, Dalais, Abrahams and Steyn, 2010). Mamabolo, Kruger, Lennox, Monyeki, Pienaar, Underhay and Czapka-Matyasik (2007) investigated the physical activity and body composition of 313 adolescents residing in North West Province. Obesity was prevalent in 8,6% of learners, and learners showed a decrease in levels of physical activity with advancement in maturity. The study concluded that children who were more active were likely to have less fat deposits (Mamabolo *et al.*, 2007:3).

When participants of this study were questioned about *competencies* one can focus on in Life Orientation, the theme of *healthy lifestyle* again emerged. The participants mentioned personal developmental skills, which is Learning Outcome 3 of Life Orientation. In this Learning Outcome learners should be able to use acquired life skills to achieve and extend personal potential in order respond effectively to challenges in their world. Learners are in the process of self-concept formation, and require opportunities to develop positive self-esteem. Peer relations are increasingly important as learners tend to compare themselves with others (DoE, 2002: 25).

According to Prinsloo (2005) it is important to facilitate a child's eagerness to explore and learn, especially the development of problem solving, since it enhances learners' ability to cope with life issues. Personal development of skills is enjoying attention globally. In Northern Ireland, for example, *Personal Development and Mutual Understanding* is a recently introduced requirement of their revised curriculum in Life Orientation. Their rationale for introducing this was to empower young people to develop their potential and to make informed and responsible decisions throughout their lives (Partnership Management Board, 2007:3).

The role of the Life Orientation in the HPS is to teach learners to get to know themselves, to develop a sense of self and self-esteem. A very important aspect of personal development in South Africa is assertiveness. The Human Rights Watch World Report published in January 2010 (Human Rights Watch, 2010) stated that South Africa has the highest rates in the world of rape reported to the police. Personal development skills such as assertiveness, refusal skills, negotiation skills and conflict resolution skills can better equip learners – especially girl learners – to be better prepared to deal with domestic violence, intimidation, rape, abuse and bullying (Human Rights Watch, 2010:2).

The *role of stakeholders* in the HPS is another important aspect that enables the school community. According to the National Guidelines for the development of the HPS in South Africa, stakeholders and their roles can ensure sustainability of the HPS (Motlatla, 2007:1). Four stakeholders are described. The school staff brings health promoting concepts into the classroom and assess Life Orientation competencies. The learners participate in health promoting projects and learn health promoting skills, such as peer education and first aid. The parents can contribute by helping in hosting school activities, inviting non-active parents to participate and linking learners and teachers together. The community seems to be another stakeholder that can advocate for health promotion in the community, offering services such as cooking, cleaning and working in the garden (Motlatla, 2007:15). In a 2000 draft compiled by the Department of Health, in collaboration with the Departments of Education and Welfare, the role of teachers, learners and communities are to identify and address local barriers to learning and development (Department of Health, 2000:25).

As stakeholders, the health care workers, especially *school nurses*, play an important role in the HPS. The level of development of a country is measured by the health status of its children. Although South Africa accepted the Convention of the Bill of Rights of the Child in 1996, thereby committing itself to prioritisation of children, the implementation of school health services in South Africa has deteriorated to levels that contravene these rights (Mohlabi, Van Aswegen and Mokoena, 2010:249). Young, St. Leger and Blanchard (2010:4) from the International Union for Health Promotion and Education explained that Health promotion in a school community requires clearly defined documents or practices that promote health and wellbeing.

In the study conducted by Mohlabi *et al.* (2010) barriers to the successful implementation of school health services in Mpumalanga and Gauteng were identified. The following barriers were identified: poor governance and lack of national policy

guidelines, unrealistic nurse-learner ratio, lack of support from management, managers with limited knowledge of the health promoting school initiative and health professionals not including members of the community in school health programmes.

The fact that *governmental departments* should participate in the HPS, underpins the importance of the role that the state can and should play in health promotion in the communities. One school mentioned the Department of Agriculture which hosted a competition to encourage schools to manage their gardens to harvest vegetables to enhance a healthy nutrition. Another school mentioned that they were assisted by the Department of Social Welfare in obtaining grants for learners.

According to Marais (2010), the social grant system in South Africa ranks among the most impressive in the so-called developing world. Marais (2010) stated further that social grants have turned out to be the single most effective anti-poverty tool deployed after 1994. Since 1997 to 2006, the number of beneficiaries of social grants increased from three to almost 11 million, and today a quarter of South African households receive welfare payments. It is important to mention that the political liberation in South Africa has also brought an increase in redistribution through development projects such as the National Reconstruction and Development Programme (RDP) and the Black Economic Empowerment (BEE) grants (Marais, 2010).

Community involvement and participation in the HPS is a key feature in the success of the school. A study in Indonesia by the Human Development Sector Department of the World Bank (2011b) indicates that interventions that reinforce existing school committee structures – grants and training – demonstrate limited impact on learning, while those that foster ties between the school committee and outside parties are successful. The role of communities is increasingly becoming prominent both nationally and internationally. This is clearly evident in the South African context, especially in the

Departments of Education and Health. According to Lamont (2004), the legislative framework in South Africa already encourages this shift, which in education includes a move towards inclusive, eco systemic and whole school developmental perspectives. In health there is a move towards more community-based and universal strategies.

For parents, to be actively involved in basic activities in school like *cleaning, cooking and gardening*, creates an opportunity to participate as one of the main stakeholders. It seems that in some schools parents are directly involved by serving meals to learners during breaks, especially in the Foundation Phase. In this regard, the Department of Basic Education stated in a report on the National Nutrition Programme (2010) that they are providing meals to more than 6 million learners every day. The involvement of Volunteer Food Handlers, who are members of the community, is also mentioned. These members are taking responsibility for preparing and serving food to learners and for cleaning the cooking and eating utensils (Department of Basic Education, 2010:4). Normally, the Volunteer Food Handlers are appointed by the School Governing Bodies (SGBs). It seems that members of the community, teachers, learners and their parents participate in ensuring the gardens bloom and blossom, even during school holidays. At some of the schools, the produce from the gardens is sold to the local community and others who have partnerships with the school utensils (DoBE, 2010:5).

According to research done by Macnab, Kasangaki and Gagnon (2011) in Canada and Uganda, there were apparent benefits of the school communities involved in nutrition and feeding schemes. They stated that these community-based experiences gained through participation enable parents and teachers to understand locally identified health priorities as well as the impact of their involvement on the children and the community as a whole. Another recent study conducted by Watts, Piñero, Alter, Lancaster (2012) assessed the extent to which nutrition education was implemented in selected elementary schools the in New York State. Nutrition knowledge and its

presentation in the classroom were investigated. They concluded that teachers viewed nutrition education as important and that they were willing to teach nutrition and health awareness topics. Over and above this conclusion, they suggested that more efforts should be made to support the integration of nutrition topics, methods of instruction and availability of resources.

The HPS are all involved in *health activities and health awareness campaigns*. Within the South African context, HIV awareness is of paramount importance. As stated by the WHO (WHO, 2006), it can be assumed that HIV/AIDS has its roots in a range of problems that undermine people's health and human rights, such as inequity and discrimination, poverty, social unrest and migration, exploitation and abuse. James, Reddy, Taylor and Jinabhai, (2004) confirm the above notion and emphasize the reorientation of sexuality education to include those elements critical for behavioural change, such as addressing gender discrepancies and promoting skills for communication through planned intervention programmes. A review by Andersen (2012) of the role of schools in supporting HIV-affected children in sub-Saharan Africa concluded that interventions have been successful in implementing health knowledge at schools but limited attention has been given to the psychosocial wellbeing of children and to children's own experiences of school environments. It was suggested that already available resources and involvement of local communities should be sourced to manage support to HIV-affected children in a challenging socio-economic context. The needs of HIV-affected children should be considered on how they experience ways in which schools support them to cope with adversity in their everyday lives.

Community involvement as a type of security to the school and community itself is a fundamental building block to safe living (Pillay, 2011). Vandalism and dumping around the school buildings seemed to be a problem in most of the schools. One school

mentioned that parents are around the school grounds even over weekends and it seems that their presence acts as a protective measure against burglary and dumping.

For the HPS to have *access to health services* are unquestionably one of the most important aspects of a guarantee for health. In the HPS, the teachers view nurses as the most important role players in the school. The current position of nurses in South Africa is challenging. According to Jooste and Jasper (2012), there are an inadequate number of qualified nurses to provide a service that meets the Millennium Development Goals outlined by the Government in 2010. According to Jooste and Jasper (2012:2), 5,7 million people are living with HIV in South Africa, a similar number to those with the condition in India, yet a far higher proportion of the total population. In January 2011, nearly three-quarters (73%) of people living with HIV in South Africa were co-infected with tuberculosis (TB). South Africa has reached the 1 million mark for the number of people on anti-retrovirals. These statistics alone will require a nursing management strategy if targets are to be met. According to their research, challenges arise from fragmentation and a lack of co-ordination in the initiatives of healthcare stakeholders, the developing infrastructure of healthcare provision, initial nurse education and the transformation agenda aimed at combating the effects of the years of the apartheid regime (Jooste and Jasper, 2012:4).

To have a school environment that is clean and hygienic proves to be an important part of the HPS. According to Mathee and Byrne (1996), Health promotion includes environmental and health sustainability, the empowerment of children to become full participants in the community and to support teachers and parents in the promotion of health-enhancing school environments. They further mention initiatives in some schools that include an anti-smoking poster competition and special environmental and health awareness days.

Policies that guide and steer the activities within a HPS, are fundamental in providing a basis from which all activities can be planned and implemented. According to Nsimba and Masele (2012) the majority of initiation to drug use occurs during childhood and adolescence, with adolescence being the greatest risk period during one's life span. Substance abuse policies and prevention activities should focus on adolescents, either as school-based programmes, or as family-based and media-based programmes (Nsimba and Masele, 2012). Sznitman, Dunlop, Nalkur, Khurana and Romer (2012) propose that a positive school climate and student drug testing should be used to reduce substance abuse by learners in schools. According to Boys *et al.* (2001) the functions of illegal substances, identified by 364 drug-using adolescents, were to relax (96,7%), to become intoxicated (96,4%), to keep awake at night while socialising (95,9%), and to alleviate depressed mood (86,8%). Recognition of the functions fulfilled by substance use should help health teachers and prevention strategists to create drug-related health messages that are more relevant and appropriate to general and specific audiences. Targeting substances that are perceived to fulfil similar functions, and addressing issues that concern the substitution of one substance for another, may also strengthen education and prevention efforts (Boys *et al.*, 2001).

In South Africa, substance abuse policies can also help prevent HIV transmission. Morojele, Parry, Ziervogel and Robertson, (2000) explored beliefs and attitudes among South African adolescents, regarding drug use and sexual risk behaviour. It emerged that drug use was considered to exacerbate underlying vulnerabilities to risky sexual behaviour, mainly due to the effects of the drugs on adolescents' inhibitions, rational thinking, and safer sex negotiation skills. They concluded that adolescent HIV intervention programs should address the risks posed by drug use on sexual behaviour (Morojele *et al.*, 2000).

The problem of violence in schools, like the related problem of violence in society, has become one of the most pressing educational issues in schools (Ward *et al.*, 2006). Policies regarding the *safety of learners* should be one of the first issues to be considered in a school (Cross, Monks, Campbell, Spears and Slee, 2011; Russell, 2011). However, one participant considered the safety policy of the Department of Education as ineffective. The participant mentioned that there was no security at the gate to search learners for knives or other weapons. Another participant stated that locking the school gate during school hours was a way to promote safety at school. During research in South African schools in the Eastern Cape Province, Barnes, Brynard and de Wet (2012) state that violence in South African schools has become a general tendency especially during the past decade, which could have a negative effect on progress and development of the learners. Furthermore they stated that this had an influence on the ability of learners to function in a healthy manner both inside and outside the school environment.

Not only learners, but also parents, community leaders and governmental intuitions should become involved in implementing programmes to prevent school violence, based on the institution of a positive school culture and school climate (Barnes *et al.*, 2012). As has already been said above, violence which occurs in schools, the carrying of weapons and the unruly behaviour of learners are a reflection of what is happening in society and the school neighbourhoods. Barnes *et al.* (2012) state that the school and the parent community should therefore work together to create a peaceful school environment.

An increasing number of longitudinal studies in different countries have shown the range of risk factors that predict future offending and victimisation, and those that protect children and young people from such involvement (Shaw, 2004; Prinsloo, 2005; Estévez and Emler, 2011; Ruback, 2010; Ttofi and Farrington, 2012). A national study of

delinquency prevention in the United States observed a recognised need for a long-term strategy. For example, while zero-tolerance policies, expulsion and suspension may bring short-term relief to school staff, they increase the risk of subsequent failure and re-offending. Such policies also merely serve to transfer the cost of responding to those offending students to another sector, namely the police and health and social services (Bennett, Corluka, Doherty, Tangcharoensathien, Patcharanarumol, Jesani, Kyabaggu, Namaganda, Zakir Hussain and De-Graft Aikins, 2012).

Policies for safety, security, and teenage pregnancy were mentioned by two of the participants. Panday *et al.* (2009) stated that one of the most cost-effective interventions that countries can introduce is flexible school policies. In fact, increasing access to second-chance programmes such as high school equivalence programmes in the US has allowed teenage mothers to continue their education, thereby limiting the impact of pregnancy on a range of outcomes (World Bank, 2011b). More progressive policies adopted in sub-Saharan Africa and Latin America after 2000 mean that many more young women can stay in school and complete their education (World Bank, 2011b). According to Panday *et al.* (2009) there are countries in sub-Saharan Africa that have taken steps to protect young mothers' right to education. In South Africa, even before 1994, in the absence of a formal policy, schools allowed pregnant girls to remain in school and to return to school after delivery. In 2007, the Department of Education, motivated by a concern for learner pregnancies in schools, introduced guidelines for the prevention and management of learner pregnancy (DoE, 2007a). It emphasizes prevention as a means of reducing teenage pregnancy, HIV and other sexually transmitted infections. It is clear that this goal can be achieved through sexuality education provided by the Life Orientation Learning Area, health promoting programmes and peer education among learners.

5.5 SYNTHESIS AND CONCLUSION

The objective of this chapter was to empirically explore how Life Orientation is being perceived and constructed by teachers/Health promoter co-ordinators within the context of the Health Promoting School (HPS).

It is clear that the Learning Area of Life Orientation is intertwined with and interrelated to teachers' views and perspectives on health, Health promotion and the HPS. If a school wants to be counted as a HPS, a range of activities and processes (i.e. access to clean water resources; access to health services; HPS programmes that are implemented; policies on Health promotion that are implemented; safety and security measures that are implemented, etc.) as well as a variety of individuals and groups (read: the community, the school nurse, the government, private companies, teachers, learners, parents, etc.), have to synergize themselves around one objective: to promote the health of the school in a holistic manner. Health promotion in the HPS entails positive strives towards a holistic all encompassing state of well-being. Everyone involved should attempt, as a never-ending process, to reach optimal states of functioning. To reach this state of complete physical, psychological, social and spiritual health, an individual, group, school or community must be able to identify and to actualize potential and aspirations, satisfy needs, and change or cope with the environment. In this endeavor a better quality of life is the ultimate aim.

Although health promotion through education is taking cognisance of the un-healthy pathological state/condition of the individual, school or community (lack of proper water resources, lack of proper nutrition, lack in proper safety and security measures, substance abuse in schools, etc.), the central focus should be on a better understanding of the growth, strengths, enablement, empowerment, prevention, protection and enhancement of the individual, school and community. It is to this ideal that the project on health promotion through education is strategically focussed on.

In the following final chapter the research findings, conclusions, limitations of the research and recommendations will be presented.

CHAPTER 6

FINDINGS, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

6.1 INTRODUCTION AND ORIENTATION

The aim of this chapter is to present the findings of the research study and to draw conclusions based on the findings. The limitations that hampered the study are discussed and recommendations for future research on Life Orientation, health and Health promotion and the HPS are provided.

6.2 FINDINGS OF THE RESEARCH PROJECT

The findings of the research study are presented in the subsequent paragraphs. In the presentation of the findings, the focus is on key findings that emerged from the literature review as well as from the empirical study done in HPS of the Gauteng Province in South Africa.

These findings from the literature review as well as the empirical study served the purpose of answering the basic research questions formulated in Chapter 1. The central research question which guided this research was:

What is the role of Life Orientation in the health promoting school?

The sub-questions that also guided this research were:

What does the current scenario concerning Life Orientation in the health promoting school entail?

What is the nature of the link between health, health promotion and the health promoting school, and how can the health promoting school be constructed?

How can Life Orientation practically be implemented in the health promoting school context?

Firstly, attention is given to the insights from the literature review, followed by the findings from the empirical research.

6.2.1 FINDINGS CHAPTER 2: LIFE ORIENTATION IN SOUTH AFRICA: THE CURRENT SCENARIO

The following are findings that emerged from the chapter:

Globally, and especially in developing countries, there is a severe need to equip children and young people with the knowledge, attitudes, skills and values to assist them in making healthy life-style choices. Life skills (LS) and Life Orientation (LO) are possibly among the most important answers to the problems and challenges that the young people are faced with. LS and LO can instil in children positive behaviours that can prevent risk and premature death. In communities where there is a lack in basic opportunities, LS and LO in schools can provide a basis for the youth to acquire the necessary skills to deal with the challenges encountered in their daily lives (cf. Paragraph 2.2.1). Historically viewed, LS and LO changed with regard to focus and content. In the USA they changed from moral education to character education to life skills. In the Baltic and Scandinavian countries the emphasis is on generic life skills as part of a preventative and proactive approach.

The integration of the family and the broader community is also viewed as important. The individual learner's all-round personal development is central. Teacher training in LS and LO is considered to be important in order to engage with the youth at school level.

In Lithuania the focus in LS and LO is on personal, interpersonal, vocational, learning, communication, problem-solving, and critical-thinking skills. In Australia, the learner as a whole person is important as should be developed as such. A learner's well-being is perceived as comprising social, mental, physical and health components. In the United Kingdom LS is seen as a planned programme towards the promotion of physical and mental health; emotional well-being, social and economic well-being, the contribution that the youth make to society and to protect the young from harm and neglect (cf. Paragraph 2.2.2).

Various international role players, with their collaborators, are influential in promoting life skills around the globe. These include: the United Nations, the World Health Organisation and the World Bank. These international organisations, created various key documents, programmes and frameworks with which health related recommendations, to the international arena, are made. One such successful framework is called FRESH (Focusing Resources on Effective School Health) (cf. Paragraph 2.2.2).

In South Africa, Life Orientation replaced and incorporated subjects such as Guidance, Family Guidance, Vocational Guidance, Health Education, Bible Study and Physical Education (cf. Paragraph 2.3.2).

The main focus of LS and LO should be preventative, concentration on the strengths, competencies and development of the young (cf. Paragraph 2.3.2).

Life Orientation as a school subject should prepare and develop learners as productive members of society. Through this endeavour the emphasis should be on the health of the individual within the context of the larger community and society (cf. Paragraph 2.3.2).

Based on the country, programme and context, the concept of life skills is seen as an evolving concept but with a common focus on skills and abilities to cope. In the South African context Life Skills aims to equip students with skills, values and knowledge necessary to adapt, survive and succeed in a constantly changing world (cf. Paragraph 2.3.3).

Internationally there is a dire need for LS and LO. The need for LS and LO is determined by the challenges that individuals, communities and societies are facing in their everyday lives. These challenges include: substance abuse; adolescent pregnancy; bullying; prevention of STI's, STD's, HIV/AIDS; vandalism; anger management; poor nutrition; insufficient access to clean and fresh water; poor sanitation; violence; inadequate access to health services; weapon-carrying in schools; smoking; absence of parents from home; parental alcoholism; passive entertainment; unemployment; peer group pressure; teenage suicide; criminal behaviour at school (cf. Paragraph 2.4).

LS and LO also focus on creating positive concepts and programmes that enhance and promote the health in individuals, communities and society at large. These include topics like: skills in the promotion of self-confidence and self-esteem; skills to improve academic performance and beneficial social adjustment; skills for goal setting, decision-making, problem-solving, resisting peer pressure and stress management (cf. Paragraph 2.4).

In South Africa, there are various risk factors that obstruct, and negatively affect the development and progress of the health of young people. Nationally these risk factors include: HIV/AIDS; substance abuse; teenage pregnancy, depression and suicide (cf. Paragraphs 2.4.1.1 – 2.4.1.4).

As the country with the highest prevalence of HIV/AIDS in the world, South Africa has as a major assignment through schools, to equip learners with the knowledge and skills to

make informed life decisions. It will also be beneficial to reduce discrimination and stigma towards those individuals living with HIV/AIDS and dispel bogus information that can lead to stigmatisation and dishonour (cf. Paragraph 2.4.1.1).

Internationally, life skills programmes contributed towards a decrease in substance abuse among the youth. It is also pointed out that the family play a major role in people's attitudes on alcohol abuse. The media and cultural awareness should also act as a positive complement to the life skills approach (cf. Paragraph 2.4.1.2).

The increasing demand for schooling necessary to qualify for a well-paying job, underlines the importance of finishing one's school education (cf. Paragraph 2.4.1.3).

The lack of a credible source of information concerning sexuality and relationship education is considered to a main cause for teenage pregnancy. There is a steady increase of teenage pregnancy in South Africa. There is also an increase in the rates of abortions in South Africa (cf. Paragraph 2.4.1.3).

Adequate sexual health education can delay and promote safer sexual practices amongst adolescents. The more comprehensive (focusing both on abstinence and contraceptive use) the programmes are, the more successful they are (cf. Paragraph 2.4.1.3).

Teacher education concerning life skills in South Africa is not adequate and therefore not implemented appropriately in schools. Education on sexual health should be incorporated in the training of teachers as early as undergraduate level (cf. Paragraph 2.4.1.3).

Psychological challenges, like depression and suicide under the youth, are a global issue and on the increase. A lack of self-esteem, strong feelings of stress, confusion, pressure to succeed, financial fears, disorientation in society and approval of deviant behaviour

are some of the determinants of suicidal behaviour amongst the youth (cf. Paragraph 2.4.1.4).

Adolescents with depression accompanied by Attention Deficit Hyper Activity Disorder (ADHD) or Conduct Disorder are more likely to engage in criminal activities and suicide than their peers (cf. Paragraph 2.4.1.4).

The seemingly peaceful transition to a democratic South Africa can be ascribed to the fact that people do have certain life skills to deal with the subsequent challenges (cf. Paragraph 2.5.1).

The international agenda pertaining to development had a positive impact on South Africa in the sense that the Millennium Developments Goals also became part of the country's road on development. The Medium Term Strategic Framework is a prime example of this commitment on a national level (cf. Paragraph 2.5.1).

As South African youth are becoming part of the global world, they will face living in an increasingly demanding environment. Within this context LO has a prominent role to play (cf. Paragraph 2.5.1).

Through participating in international developmental agendas (Millennium Developmental Goals), South Africa became part of the global trend towards the enablement of the country's citizens (cf. paragraph 2.5.1).

In a previous educational dispensation, the so-called African schools were severely deprived of Guidance Service (cf. Paragraph 2.5.2).

Various ground-breaking pieces of educational legislation laid the foundation for a competent, holistic and practical implementation of guidance services to the youth. The new approach is aimed at the vocational and general development of learners and

comprises of a variety of activities like group guidance sessions which focused on career, education, social and personal development; programmes such as life skills; psychometric testing; and counseling (cf. Paragraph 2.5.2).

Guidance as a subject was undervalued and under-utilized in schools, mainly because there were not qualified specialists available and guidance teachers were not supported by school managements and fellow teachers. Guidance teachers also had to cope with an unequal workload (cf. Paragraph 2.5.2).

Life Orientation as part of the new vision in education, replaced all other forms of Guidance offered in schools in South Africa. Life skills, health and career education were absorbed as core aspects into the new Life Orientation (cf. Paragraph 2.5.2).

The many years of growing up in an exploitative and suppressive social environment, culminated in major challenges within the context of the individuals, communities and society at large. An endless list of social ills can be compiled in this regard. The most common include unemployment; poverty; lack of infrastructure and access to basic needs; HIV/AIDS, etc., to name but a few (cf. Paragraph 2.5.3).

Life Orientation is seen as one of the most important avenues through which the problems and challenges of a new South Africa can be addressed (cf. Paragraph 2.5.3). Life Orientation makes an irreplaceable contribution to the General Education and Training Band (GET) by contributing towards the enablement of the individual, community and societal life in general (cf. paragraph 2.5.4.2).

The Learning Outcomes of Life Orientation are similar across the 12 Grades at the school level. Within each Grade, the content is supposed to be taught at an age appropriate level (cf. paragraph 2.5.4.2). Health education within the Life Orientation programme is

developmental, promotive and preventative. This visionary approach accentuates the centrality of Life Orientation in the school context (c. paragraph 2.5.4.2.1).

From a Health promotion perspective, the challenges that should be addressed in the Life Orientation programme are nutrition, HIV/AIDS and sexually transmitted infections, safety, violence, abuse and environmental health. Also, issues involving risk factors such as crime, drugs, teenage pregnancy, sexually transmitted diseases (cf. paragraph 2.5.4.2.1).

Further, the following topics are compulsory in the Learning Outcome that deals with Health promotion in the Life Orientation Programme: water and sanitation; tobacco and substance abuse; nutrition; safety and security, and sexual health (cf. paragraph 2.4.4.2.1).

Within the Social development Learning Outcome, learners are taught to become sensitive to other cultures and religions; to value the importance of human rights and peace and to understand the significance of relationships (cf. paragraph 2.5.4.2.2).

In terms of the Personal development Learning Outcome, it was established that the acquisition of life skills is important in the programme so that learners will become independent, creative and critical in solving problems. Also, they should be able to manage emotions through applying emotional literacy skills (cf. paragraph 2.5.4.2.3).

Concerning the Physical development of learners, it was found that aspects like, body image, motivation, locus of control, communication, and team and lifestyle decisions, are prominent in the Life Orientation programme. Although physical education was relegated to a non-subject in the schools, it is currently, slowly but surely, gaining ground across the country (cf. paragraph 2.5.4.2.4).

The World of work is given attention to only in the Senior Phase (Grades 7 to 9) of the school. Through the programme, learners are prepared to make informed choices about a possible career, and to be able to outline a plan for a journey of lifelong learning (cf. paragraph 2.5.4.2.5).

At the Intermediate level (Grades 4 to 6) Physical development gets the highest weighting (33%) in terms of time allocated to teaching, followed by Personal and Social development (27%) and lastly, Health promotion (13%) (cf. paragraph 2.6.1). In the Senior Phase (Grades 7 to 9) the picture changes slightly with "orientation to work" added to the list with a 15% weighting, followed by Health promotion (15%), Social development (20%), Personal development (20%) and Physical development (30%) (cf. paragraph 2.9.1).

Experiential teaching-and-learning approaches should be utilized, by teachers and learners in order to build knowledge, skills and values relevant to their functioning effectively in society. Further, teachers should plan their lessons to be interactive and stimulating focusing on the interest of the learners. Learner's need should be the basis for learning and should be applied for possible practical application in life after school (cf. paragraph 2.6.2).

Attitudes and values form a very important part of LO and should be continuously assessed during the learning process (cf. paragraph 2.6.2). Methods to assess the external actions and behaviors to infer the learners' inner state include: action research, projects, written tasks/tests, practical demonstrations/performances, assignments, debates and role play (cf. paragraph 2.6.2). A rating scale exists with which the assessments of projects and assignments can be assessed. The scale varies from "achieved" on the one end to "not achieved" on the other end (cf. paragraph 2.6.2).

A major shift in assessment in LO, is one from the assessment of disability to assessing the needs and levels of support required by individual learners to facilitate their maximum participation in the education system (cf. paragraph 2.6.2). It is essential that teachers understand that there is a wide range of barriers that are encountered by learners in their quest for education. These include: systematic barriers; societal barriers; barriers rooted in inappropriate pedagogy, and factors that emerge from within the learner because of disabilities (cf. paragraph 2.6.3).

The government is engaging in various inter-departmental activities to counter the identified barriers that can negatively affect the learners' education. The Tirisano programme, the District Development Programme, the Language-in-Education Policy and the HIV/AIDS programme, are all examples of this inter-departmental endeavor (cf. paragraph 2.6.3). In terms of Life Orientation and the Learning Outcomes incorporated, it was found that all the Learning Outcomes have a central bearing on Health promotion. As such it highlights the importance and focus of what should be taught in this particular part of Life Orientation. The various topics are: the ability to make informed decisions; to understand and commit to the constitution of the country; to achieve and extend personal potential; to engage in physical activity, and to make informed decisions about career choices (cf. paragraphs 2.7.1.1 - 2.7.1.2). In terms of the Assessment Standards related to Health promotion in the Life Orientation curriculum, it was found that the following broad themes are covered: water and nutrition; communicable diseases; safety; sexual abuse; physical activity; environmental health, and personal health. Within each of these themes, various ways and means are suggested in order to acquire and develop the necessary skills to promote and sustain Health promotion (cf. paragraph 2.7.2).

6.2.2 FINDINGS CHAPTER 3: THE HEALTH PROMOTING SCHOOL (HPS)

The following are findings that emerged from the chapter:

Health and the promotion of health are fundamental concepts in the understanding of the Health Promoting School (HPS) (cf. paragraph 3.2). Depending on who is asking the question, and in what context, health as a concept can be interpreted, perceived and constructed in many ways. This vagueness and ambiguity in the conceptualisation of the concept, is the root for the misunderstandings, confusion, and misconstruction that are part of everyday conversation in education settings (cf. paragraph 3.2.1). The concept of health denotes the whole wellness of the human being. Health is holistic in approach and represents a state of complete physical, mental and social well-being and not the absence of disease and infirmity.

To maximise the potential of an individual, community and society, is to strive towards the harmonious interaction of the physical, mental, emotional, intellectual, spiritual and the social aspects of one's life (cf. paragraph 3.2.1). The concept of Health promotion denotes a process by which an individual community and society should be enabled to gain increased control over, and to improve their health (cf. paragraph 3.3).

Various international conferences, declarations, resolutions and recommendations over the last three decades, have singled out Health promotion as a strategic concept in addressing the context and meaning of health actions and the determinants that keep people healthy. Internationally, the World Health Organisation (WHO) is playing a pivotal role in promoting health on a global scale. The Ottawa Health Charter is recognised as the blue print for all Health promotion actions around the globe (cf. paragraph 3.3).

The link between the health and well-being of learners and their capacity to benefit from educational opportunities and attain high standards of achievement has been well-established for many years. Healthy children learn well and their ability to attend school is affected by their health. Good health narrows the opportunity gap and has significant positive effects on personal, social and educational achievement (cf. paragraph 3.3).

Schools have been identified as important Health promotion settings since young people spend over one third of their day at such institutions. Schools make it possible for learners to gain the knowledge, attitudes, values, skills and services they need to be healthy and to avoid important health problems (cf. paragraph 3.3). Formal evaluation of the HPS is currently limited. There is currently such a project underway as part of an initiative of the World Health Organisation (cf. paragraph 3.3).

The concept of the Health Promoting School (HPS) can have a major positive impact in South Africa with all the socio-economical and educational challenges that policy makers and educational planners are facing with (cf. paragraph 3.4). A HPS views health as encompassing physical, social and emotional well-being. It strives to build health into all aspects of life at school and in the community. A HPS represents a place where all members of the school community work together to provide learners with integrated and positive experiences and structures that promote their health. This includes both formal and informal curricula in health, the creation of a safe and healthy school environment, appropriate health services and the involvement of the wider community in efforts to promote health (cf. paragraph 3.4). A HPS may be defined as a school that displays, in everything said and done, support for and commitment to enhancing the emotional, social, physical and moral well-being of all members of the school community (cf. paragraph 3.4.1).

A HPS should be built on the following five core principles (cf. paragraph 3.4.2):

- an integrated, holistic, collaborative and co-ordinated approach;
- quality assurance;
- capacity building;
- utilisation of existing resources, ownership and sustainability; and on
- equity and redress.

For a HPS to be successful, strong community support is of strategic importance in the initial stages of the establishment of the school. Further, to have school specific data, and data-based profiles of the health status of the learners, can help immensely in determining the health needs of a particular school (cf. paragraph 3.4.2). To establish a HPS successfully, key individuals in the school community should be identified. These individuals should also have the time available to engage in the necessary activities to establish the HPS (cf. paragraph 3.4.2). For a HPS to create an enabling environment, certain core conditions need to be established. These include (cf. paragraph 3.4.2):

- the physical environment – should be safe, intact and clean;
- the psycho-social environment – respectful, caring, and open to feelings and opinions;
- leadership – innovative, transformational and participatory;
- critical thinking –self-reflection, understanding and problem solving;
- identity – shared educational philosophy and vision;
- planning – proper goal setting;
- resources – sufficient material and human resources; and
- development – ongoing staff development.

A successful HPS also need the support of the local authorities; the support of the administrative and senior management of the school; and a small group of activists

(members from the teachers, learners, parents, and community (cf. paragraph 3.4.2). In the development of the HPS, the following are vital components that should guide the actions (cf. paragraphs 3.4.3 and 3.4.3.1 to 3.4.3.6):

- policies that support health and well-being;
- safe and supportive teaching and learning environments;
- strong community action and participation;
- promotion of personal skills of the learning community; and
- access to and the re-orientation of health and education support services.

The development of the HPS approach should be explored in the context of the whole school development framework. This framework acts as a basis for understanding the strengths and limitations of a given school. The whole school development framework integrates the following elements:

- the school's culture;
- the school's identity;
- strategies relating to organisation and curriculum development;
- structures and procedures;
- technical support;
- human resources;
- leadership, management and governance; and
- their integration into the micro, macro and global contexts.

Compared to other countries in the world, the HPS concept is somewhat new within the South African educational landscape. It is only in the last decade that health, and the promotion of health in and through schools, have become a major theme at all national and international conferences at and in provincial agendas. At an international conference (1996) at the University of the Western Cape, the first foundations were laid for the establishment of HPS in South Africa. At this conference the following priorities

were identified that directly impact on health in the broadest sense: poverty, racial prejudice, suicide, substance abuse/misuse, nutrition, gender issues, traffic and other injuries, tuberculosis and other forms of infections, social diseases and violence (cf. paragraph 3.5.1).

National Guidelines for HPS in South Africa are in the process of finalisation (cf. paragraph 3.5.1). The vision of the South African Department of Health and Education is to create a culture of effective teaching-and-learning through the holistic development of schools and other learning sites which will promote the optimal well-being of all members of the teaching-and-learning community through the implementation of the Health Promoting Schools Initiative (cf. paragraph 3.5.1).

There is some confusion and uncertainty amongst many leading health promoters, trainers and planners, regarding what Health promotion really entails. This incomprehension arose from the fact that a new system is to be managed by individuals from the old system. There are no real new training opportunities and not really people who are adequately qualified to provide leadership in Health promotion in South Africa, especially in South African schools (cf. paragraph 3.5.1).

The Medical Research Council in South Africa developed a localised assessment tool that can be used in HPS. The assessment tool is in synchronisation with recent theory, and pioneering research, of Health promotion by exploring the structural issues that shape and influence the behaviour of learners in schools (cf. paragraph 3.5.1).

The HPS project in the Gauteng Province of South Africa is driven by the Department of Health, the Department of Education and through the assistance of the Japan International Co-operation Agency (JICA). The co-operation is aimed at facilitating the implementation of elements of the HPS concept in fourteen pilot primary schools in the Gauteng Province. The aim of the project is to assess the current situation at the health

promoting schools and gather baseline data to explore possible strengths, limitations and new innovations (cf. paragraph 3.5.2).

The national Department of Health views the HPS initiative as a major component of its overall Health promotion programme. It envisions the improvement of the health status of learners and communities through the implementation of the HPS programme (cf. paragraph 3.5.3). The improvement and further development of the National Policy for Health Promoting Schools is currently under review and will be finalised by the end of 2012. The approach of the Department is based on the World Health Organisation model of HPS (cf. paragraph 3.5.3).

HPS follow different approaches to implement the health promotion framework. These approaches include: an "issue-based" approach where, for example, nutrition will be addressed; or a "problem-based" approach where a particular problem like, vandalism or substance abuse will be addressed (cf. paragraph 3.5.3). The implementation of the HPS framework in the various provinces in South Africa has reached different levels of progress (cf. paragraph 3.5.3). Success stories in terms of the implementation of HPS include: political support from the minister of Health; financial support to implement the programmes, and the establishment of a unit for Health promotion at National level (cf. paragraph 3.5.3).

Challenges in terms of the implementation of HPS, include no shared vision at department level; complications in co-ordination and collaboration between the various departments involved, and a lack in capacity, interest and commitment from role-players (cf. paragraph 3.5.3).

Various programmes exist in South Africa where HPS are making headway in enabling learners to take charge of their health. These include: prevention of waterborne diseases in the Eastern Cape; nutrition programmes in the Eastern Cape; prevention of tobacco use and the prevention of lead poisoning done nationally (cf. paragraph 3.5.3).

There is a positive attitude and commitment from the National Department of Education towards the promotion of HPS in South Africa (cf. paragraph 3.5.4). At Provincial level, curriculum information sessions on the HPS inform district-level health committees and School-Based Support Teams (cf. paragraph 3.5.4). According to the National Department of Education there are enabling factors that foster and promote the health promoting school project. These include the implementation of the new school curriculum; collaboration between the different departments, and the active development of policies in line with the common health conditions detected amongst youth (cf. paragraph 3.5.4).

According to the National Department of Education there are also constraining factors that inhibit the promotion of the HPS project. These include lack of human resources; insufficient financial resources; time limits, and lack of continuity in collaboration and co-ordination (cf. paragraph 3.5.4).

The *Banopele* initiative is one example where the HPS project was acknowledged for its accomplishments thus far in South Africa. It is a school enrichment programme aimed at addressing the opportunities and challenges thereby ensuring that the neediest schools get the full basket of services such as exemption of school fees, school uniform, referral to social grants, nutrition etc. (cf. paragraph 3.5.4).

The District Support Teams is seen as the first line of support for schools in terms of health promoting resources, co-ordination and management (cf. paragraph 3.5.4). According to the Provincial Departments, there are enabling factors that foster and promote the HPS project. These include existing health promotion programmes and structures in the schools and a curriculum framework that provides a context for the implementation of HPS (cf. paragraph 3.5.4).

According to the Provincial Departments there are also constraining factors that inhibit the promotion of the HPS project. These include a lack of capacity; the late transfer of

the budget; a lack of clear targets; a lack of co-ordination and collaboration, and overcoming procedural and intergovernmental systems barriers (cf. paragraph 3.5.4).

The HPS project in the Gauteng Province is well placed within the Department being a strategic objective. With the necessary management structure in place the province has a written guideline for the development and implementation of HPS (cf. paragraph 3.6.1). HPS committees are in place in some schools in the Gauteng Province and planning is on the table to establish a provincial HPS committee (cf. paragraph 3.6.1).

Working relationships between the various governmental departments are not optimal and need improvement. Good relationships are maintained with NGO's (cf. paragraph 3.6.1). The HPS in the Gauteng Province are involved in a variety of health promoting projects. These include school safety, life skills regarding HIV/AIDS and teenage pregnancy, nutrition and physical activity as well as tobacco control and substance abuse (cf. paragraph 3.6.2). The areas where HPS are functioning vary from very impoverished informal settlements to urban settings. In most cases grandparents and guardians care for the learners. School buildings are mostly dilapidated and a major concern for teachers (cf. paragraph 3.6.2.1).

Most of the HPS manage, with the assistance of the School Governing Bodies, their own budgets and deal directly with suppliers and contractors (cf. paragraph 3.6.2.2). School Health Policy Guidelines are currently being promoted in all schools. The aim of this action is to improve the status of school-going children through the early detection and appropriate referral. Phase one school health services (hearing and vision assessment and gross motor impairment detection) are provided (cf. paragraph 3.6.2.3). Where health education is provided by school health nurses where they present education on eye care, preservation of hearing, teenage sexuality, etc. (cf. paragraphs 3.6.2.3 and 3.6.2.7).

Various practical health issues keep frustrating teachers and are a major concern in terms of Health promotion in the schools. These include poor toilet facilities; interruptions in water service; broken fences and a school being burgled; water pollution; unsafe and insufficient playgrounds; a lack of sporting facilities, and exposure to child abuse (cf. paragraph 3.6.2.4).

A range of health promoting activities is being implemented in the schools. These include HIV/AIDS programmes; vegetable gardens and nutrition programmes; visits from school nurses; sport activities, and personal hygiene programmes (cf. paragraph 3.6.2.5). The HPS developed their own policies in line with the Gauteng Department of Education's guidelines. Policies on HIV/AIDS, health and safety, school feeding and special needs, have been developed by schools (cf. paragraph 3.6.2.6). The HPS have a healthy relationship with external organisations that assist them with their tasks. Churches, NGO's and various other private organisations are also involved (cf. paragraph 3.6.2.8).

All the HPS are part of the Gauteng Department's Feeding Scheme and receive food according to a prescribed menu. Co-ordination and collaboration within the department concerning the provision of food are poor (cf. paragraph 3.6.2.9).

6.2.3 FINDINGS CHAPTER 5: LIFE ORIENTATION IN THE HEALTH PROMOTING SCHOOL: THE GAUTENG PROVINCE OF SOUTH AFRICA

The following are findings that emerged from the quantitative part of the empirical investigation:

Concerning water and sanitation at the fourteen sample schools it was found that the water supply to the schools came mainly from taps and that a very high percentage of the teachers were satisfied with the quality as well as the quantity of the water. There is the odd water tap that is not working but, all in all, the schools have access to water.

The ratio of water taps per learner varies quite a lot. Also, a high proportion of the teachers had some reservations concerning the availability of water, to water the gardens properly. Hand wash facilities are adequate with the odd school experiencing insufficient facilities. Most of the teachers are relatively satisfied with the ablution facilities (cf. paragraph 5.3.1.1).

Considering tobacco use and its prevention, this is a challenge high on the health promoting agenda in most of the schools. A high percentage of schools have the applicable policies in place and relevant information is disseminated in all schools. Less than half of the schools have a smoke-free zone. Nearly three quarters of the schools have a policy that ban substance and alcohol use on the school premises. Comprehensive approaches to combat tobacco, substance and alcohol use do exist in less than half of the schools (cf. paragraph 5.3.1.2).

A large proportion of the schools have a designated playground which is well kept but there are challenges concerning the surface of these areas. In all the HPS, learners are encouraged to participate in physical activities and there are an ample number of activities to choose from. Life Orientation, as well as Art and Culture lessons are also used to participate in physical activities (cf. paragraph 5.3.1.3).

All the HPS participate in the National School Nutrition Programme. Half of the schools lack proper storage facilities. The supply of food to the children during the school day varies from five times to three times per week. Apart from the prescribed meals from the Department of Education, some schools provide their own vegetables and fruit, as part of an agreement with the private sector. Food vendors and tuck shops at the HPS sell food, mostly unhealthy foodstuffs to learners. The vendors do not have any training in providing healthy food to the learners. The gardens, developed by the HPS themselves, are healthy sources of food to the learners. Some schools even sell the

surplus vegetables to the local community. In almost all the HPS, nutrition is linked to the Life Orientation curriculum (cf. paragraph 5.3.1.4).

Regarding safety and security, the teachers view a fence around the school, and a gate to be locked during school time, as proper features of a safe school environment. A third of the teachers view schools as not safe. Concerning the measures taken by schools to provide safety and security, learners are forbidden throughout to leave the premises during school hours. Partnerships with the local police forum, as part of the safety and security of the school, are used by a very high proportion of the schools. Anti-bullying programmes are in place in a very high percentage of the schools (cf. paragraph 5.3.1.5).

Visits by school nurses visiting school, are a well-established way of providing health promoting services in schools. They offer screening services in a range of basic physical health needs that learners may have. The frequency of the visits to schools is problematic though. Many learners are suffering from malnourishment. Only half of the HPS can provide evidence of the immunization status of their learners (cf. paragraph 5.3.1.6). Only about a quarter of teachers in the HPS are trained in health promotion. Currently, the themes that are being taught include talks on health, physical activity, food gardens, cleaning campaigns, AIDS, and hygiene in kitchens and storing facilities (cf. paragraph 5.3.1.7).

The following are findings that emerged from the qualitative part of the empirical investigation:

The relationship between Life Orientation and Health promotion in the HPS is characterised by the teachers as one that promotes a healthy life style. Put differently: Life Orientation and Health promotion eventually aspire to promote a healthy lifestyle and equip learners with the knowledge and means to attain and maintain a healthy lifestyle (cf. paragraph 5.4.1). According to the teachers, a healthy life style has three

basic components: a balanced diet; a clean and hygienic environment and engaging in physical activities (cf. paragraph 5.4.1).

According to the teachers, Life Orientation as a subject should, through Health promotion, focus on the following competencies in working with teachers and learners: skills in creating and maintaining a healthy life style; skills related to serve the nutritional needs that teachers and learners might have; personal development skills; social development skills, and skills to engage in physical activities (cf. paragraph 5.4.2).

As part of Life Orientation, various stakeholders play a role in the promotion of health. These stakeholders are the following: the community; school nurses; private companies, and government departments (cf. paragraph 5.4.3). The community as an important stakeholder is involved in Health promotion as part of Life Orientation, in various ways. The stakeholder involvement includes the following: cleaning, cooking and gardening; participation in health awareness and the provision of security at the school (cf. paragraph 5.4.4). Access to health services, as part of Health promotion, is mainly provided through the school nurses and social workers. Private companies make contributions in the form of donations (cf. paragraph 5.4.5).

A part of health promotion in a school setting, the teachers view the environment as a component that should be clean and unpolluted (cf. paragraph 5.4.6). Regarding policies to maintain Health promotion in the schools, only two were mentioned. These included a substance abuse policy, and a safety and security policy (cf. paragraph 5.4.7).

6.3 CONCLUSIONS

In the section below conclusions are drawn based on the findings (literature reviews and empirical investigation) of the research study.

6.3.1 CONCLUSIONS CHAPTER 2: LIFE ORIENTATION IN SOUTH AFRICA: THE CURRENT SCENARIO

Based on the international and national need (i.e. the school setting) that exists amongst the youth, Life Orientation and life skills education as school subjects have an important role to play in providing the necessary knowledge, skills and values to equip individuals, communities and the society at large. Life Orientation and Life Skills education should directly address behaviour that creates situations where the health and well-being of individuals, communities and society at large may be compromised.

Globally, in Life Orientation (LO) and Life Skills (LS), there is a tendency to educate and train learners and teachers to view the person as a whole person. This holistic approach creates opportunities to deal with the various aspects of health. One can therefore assume and conclude that in future society at large will be functioning on a higher level. Teacher training in Life Orientation and Life Skills is of paramount importance in providing well-equipped educators to the world of schools. The contribution of leading international role players and collaborators should be acknowledged and utilised to the fullest possible extent. Success stories about accomplishments concerning Life Orientation and Life Skills should be shared amongst schools, teachers and learners, and learned from.

The fact that Life Orientation incorporates all other variations of Life Skills education is a positive development. This creates a formal basis and standardisation that all teachers can built on. The newly adopted focus of LO and LS on being preventative and concentrating on the strengths, competencies and development of the young, should be supported and promoted. This fits in with new developments brought into the education arena by the Positive Psychology.

Educationally speaking LO and LS should be approached from a contextualised perspective. Put differently, because LO and LS are involved with the lives of the

learners, their practical everyday lives should be taken into account when the lessons are planned. This approach should also inform the methodology and assignments to be completed by the learners. The fact that countries across the globe are facing the same challenges (i.e. substance abuse; adolescent pregnancy; bullying; prevention of STI's, STD's, HIV/AIDS; vandalism; anger management; poor nutrition; insufficient access to clean and fresh water; poor sanitation; violence, among other challenges) suggests more international and national cooperation to find solutions to common problems. Nationally, more could be done by the Departments of Education and Health, to formulate advice on health risks and healthy alternatives.

The current legislative foundation in education should be used in order to successfully implement the policy frameworks concerning health and Health promotion in schools. In this, schools and teachers may need assistance, to be determined from case to case. The fact that the Learning Outcomes of Life Orientation are similar across all the grades in the school, leads to the conclusion that schools have an opportunity to integrate LO throughout all the subjects offered.

The way Life Orientation is conceptualised as part of the curriculum in schools, create the most appropriate opportunity for the teachers and learners to engage around developmental needs that, if adequately addressed, can guide individuals, communities and the society at large, to a meaningful and prosperous life.

6.3.2 CONCLUSIONS CHAPTER 3: THE HEALTH PROMOTING SCHOOL (HPS).

Much of the confusion and misinterpretation about the concept of health can be ascribed to the fact that there is not a common and universal conception of the term. If this situation is not addressed appropriately, it will remain a barrier in the successful planning and implementation of Life Orientation, health and the promotion of health in

schools and communities. Also, it might be a barrier to the effective implementation of HPS in South Africa.

It is clear that the health and well-being of learners influence their ability to learn and to avoid important health problems. In this regard the HPS approach provides the best opportunity for teachers and schools to foster and promote the health and well-being of their learners. The HPS can become the nexus for community development and transformation. In applying the core principles of a HPS, a school can contribute immensely to the community and society at large. Thorough planning should guide the establishment of the health promoting school. In this planning, all relevant aspects concerning health and Health promotion should be incorporated. The whole school development framework should also be included.

The fact that the concept of the HPS is fairly new to South Africa creates an opportunity not to be missed. Teachers, learners and all other stakeholders can engage in an active learning experience. The HPS project in the Gauteng Province of South Africa can serve as an example of the implementation of HPS in a developing environment. Any barriers and opportunities identified in such a project can guide future efforts. Although the various government departments are sometimes visible in the HPS project, there is a lack of in-depth planning, support and participation. This might be one of the key reasons why the HPS project has not yet become nationally sustainable.

6.3.3 CONCLUSIONS CHAPTER 5: LIFE ORIENTATION IN THE HEALTH PROMOTING SCHOOL: THE GAUTENG PROVINCE OF SOUTH AFRICA

The present research shows that Life Orientation has a major role to play in the instilling of knowledge, skills and values that promote health and well-being in schools. Although Life Orientation as a subject has the benefit of being integrated in the school curriculum, the energy and motivation to drive and strategically move schools to

become HPS are often missing. It can be concluded that the basic services of providing water and sanitation at the HPS are generally functioning. The use of tobacco and other substances is still a major challenge within the communities around the school. It is evident that the production of food, through the gardens in the HPS, is a major step in the right direction. The success stories of these endeavours should be communicated to all schools in South Africa. The energy and motivation gained can propel schools and communities to a higher level of Health promotion. Although schools participate in the National School Nutrition Programme, the efficiency and competence of those involved, is not up to standard. Also, food vendors on the doorstep of the school are potentially posing a health risk to the children.

Safety and security measures taken by the HPS are not sufficient. To put it mildly, the measures taken represents an absolute minimum. Although the school nurse represents a form of HPS in the schools, the frequency, range of screening and number of nurses used are probably insufficient. The fact that only a third of the teachers in the HPS are trained in health and Health promotion, presents another challenge. Against the background of the need for health and Health promotion and risk behaviour amongst the youth in South African schools, serious attention should be given to this aspect. The fact that Life Orientation teachers viewed a healthy lifestyle as the link between Life Orientation and Health promotion is a very promising aspect that schools need to build on. In this regard teachers and schools are making progress towards becoming HPS. It indicates a positive move towards a health-oriented approach.

The fact that teachers are able to construct the basic components pertaining to Health promotion in a school is also positive and encouraging. Together with this insight, teachers were also able to provide informed perceptions on the competencies involved in Health promotion. It proves the point that through learning and education a

difference can be made to people's perceptions concerning health and Health promotion.

The fact that teachers considered the various stakeholders as important collaborators in health and Health promotion in the school was encouraging. In this regard recognition of the community as a stakeholder is an imperative in the advancement towards a healthy community life.

6.4 LIMITATIONS OF THE RESEARCH STUDY

Although the research was planned, organised and executed according to sound scientific principles, the following limitations and shortcomings emerged during the course of the study.

The unpredictability in the hustle and bustle of community life created special challenges that the researcher had to deal with. Some of these included: political activities like street protests and rivalry between political parties; boycott and protesting activities against the local municipality; stay-aways and other trade union actions; policing and searches carried out to uphold the peace within the socially unstable parts of the communities.

The researcher had difficulties accessing some of the schools. The schools are spread out over the whole Province of Gauteng, as the most populated province in South Africa. Some of the communities are very densely crowded and the roads are congested with traffic. Travelling and finding the way was a challenge.

To communicate with the schools was also a challenge. It took some time before a proper communication line was established. Quite a few schools had neither functioning telephones nor any other means of communication. Private cell phones of the teachers were used in most cases.

6.5 RECOMMENDATIONS

The following recommendations are made for future research.

It is suggested that the formulation of clear health-related educational policies and guidelines should be investigated that provide opportunities for full participation in critical decision-making. It is suggested that the practice of the implementation of the HPS should be investigated. Future research should also endeavour to provide a basis or benchmark in terms of key health promoting activities. It is suggested that community participation should be investigated in order to better support the HPS.

Child-headed families should be researched with regard to the support and establishment of stronger connections with the HPS. It is proposed that the possible barriers between the various governmental departments to assisting in the implementation of the HPS should be researched. It is proposed that the roles, responsibilities and lines of accountability of the various stakeholders should be studied. It is recommended that work of the school nurse, and all activities involved, should be researched so that this very important aspect can be put on a sound basis.

It is suggested that the role of the community health worker in the HPS should be studied. It is recommended that the role of a social worker in the HPS should be studied. Future research should investigate various ways and means to promote physical activity in schools. Future research should investigate the possibility of establishing a health centre at the HPS. Through structures like these, most probably all learners in South Africa will have access to basic health services. A further benefit is that the parents and caregivers of learners could be reached and trained to fulfil their Health promoting responsibilities and obligations towards their children.

It is also suggested that research should be done into the formal assessment of a HPS. The aim should be to develop an assessment grid, index or criteria that can be used in

the formal assessment. Also, the assessment should focus both on strengths and on areas that can still be developed in the HPS.

The development of the National Guidelines for HPS should be researched in terms of the possible barriers that are hampering their finalisation. Research should be done on the constraining factors that inhibit the promotion of the HPS project. District Support Teams, as the first line of support to schools, specifically the HPS, should be scientifically researched to understand their needs and to develop meaningful ways of supporting them. District and provincial HPS committees should be established to create a communication network through which schools can interact and consult with one another. A provincial data base could be set up where all data are kept concerning health and Health promotion activities. The various case studies, articles, programmes, etc., on HPS should be kept in such a data base with the aim to support schools, school governing bodies, and parent-teacher-associations.

It is recommended that successful HPS should be studied to understand the dynamics of the possible reasons for the success. The results thereof might guide other schools towards similar accomplishments.

6.6 FINAL CONCLUSION

This research confirmed that Life Orientation within the HPS does have a vital role to play in the health and the promotion of health in the school setting.

Various practical key issues in the HPS should be present and attended to. These include proper water and sanitation, policies on tobacco and substance use and proper participation in physical activities to enhance the physical well-being of the learners. It further includes an integrated and functioning nutrition programme, an effective and well-managed safety and security plan to provide a safe environment where teaching-and-learning can occur, frequent and thorough visits by school nurses so that basic health screening with appropriate referrals can be done and schools should have trained

health promoters to oversee and manage the Health promotion programmes in the HPS.

Secondly, teachers (read: Life Orientation teachers/Health promotion co-ordinators) within the HPS perceive and construct a successful school as one where healthy lifestyles are promoted – focusing on balanced diet, clean and hygienic environment and physical activities. Competencies relating Health promotion are endorsed – focusing on a healthy lifestyle, on making healthy choices in food, on developing personal skills, and on engaging in physical activity. Stakeholders play an important role – stakeholders like the community, school nurses, private companies and governmental departments, community involvement and participation is also crucial – engaging in activities like cleaning, cooking, gardening, creating health awareness and contributing towards school security. Access towards health services is available – school nurses, private companies making contributions, and government assistance. The environment is clean and well kept and policies are in place to ensure that there is not substance abuse and that the school is safe and secure.

Finally, Life Orientation within the HPS does have a fundamental role to play in the health and the promotion of health in the school setting. The HPS initiative is both complex and challenging. A successful approach requires the involvement of the entire school, changes to the school's psychosocial environment, personal skills development, participation of the parents and the wide community, and the implementation of health promotion in schools over an extended period.

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APPENDIX A

Letter from the Department of Education



J Roux
P.O Box 99739
Garsfontein
0060
(T) 012 998 5133; (F) 012 998 5133; (Mobile) 084 666 6123
E-mail : jroux@xsinet.co.za

Cc: The Principal and SGB

Dear Madam

PERMISSION TO CONDUCT RESEARCH: J ROUX

Your research application has been approved by Head Office. The full title of your Research: "Life Orientation and the health promoting school: Conceptualisation and Practical Implication". You are advised to communicate with the school principal/s and/or SGB/s of the four schools targeted regarding your research and time schedule.

Our commitment of support may be rescinded if any form of irregularity/ no compliance to the terms in this letter or any other departmental directive/ if any risk to any person/s or property or our reputation is realised, observed or reported.

Terms and conditions

1. The safety of all the learners and staff at the school must be ensured at all times.
2. All safety precautions must be taken by the researcher and the school. The Department of Education may not be held accountable for any injury or damage to property or any person/s resulting from this process. The school/s must ensure that sound measures are put in place to protect the wellness of the researcher and his/ her property.

NB Kindly submit your report including findings and recommendations to the District at least two weeks after conclusion of the research. You may be requested to participate in the Department of Education's mini-research conference to discuss your findings and recommendations with departmental officials and other researchers.

The District wishes you well.

Yours sincerely

Mrs. H.E Kekana
Director: Tshwane South District

1/1

Making education a societal priority

Office of the District Director: Tshwane South District

(Mamelodi/Einsterneel/ Pretoria East/Pretoria South/Aberidgville/Laudium)

265 Pretorius Street, Pretoria 0001

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APPENDIX B

LETTER FROM DR ANNETTE LYONS

Jeanne Roux
Educational Psychologist
PhD Researcher on Health Promoting Schools in Gauteng
PO BOX 99739
Garsfontein
Pretoria 0060
South Africa

You ref: Date: 30th September 2007 Phone: 01392 365254 e-mail: Annette.Lyons@devon.gov.uk
My ref: Please ask for: Annette Lyons Fax:

Dear Jeanne

INVITATION

I am writing to invite you to Devon to visit schools in our Local Authority in order for you to study and observe the healthy schools activities and structured PSHE delivered to our children and young people.

I have arranged for you to visit:

St. Michael's Church of England Primary School
Ladysmith Infant School
St. Luke's Science and Sports College

Visits to these three schools will provide you with the opportunity to observe healthy schools activities for the age range 3 - 16 years.

I look forward to meeting you and developing a partnership between the North West University, South Africa and Devon Education Services in the important area of healthy schools.

Yours Sincerely



Dr. Annette Lyons
Adviser for PSHE and Citizenship

APPENDIX C

HEALTH PROMOTION SCHOOL QUESTIONNAIRE

HEALTH PRACTICE ASSESSMENT IN HEALTH PROMOTING SCHOOLS

Name of School: _____
EMIS Number: _____
Date of Visit: _____
Region: _____
District: Health _____
GDE: _____
HP Coordinator: _____
GDE Coordinator: _____
Number of Educators: _____
Number of Learners: _____

Who coordinates the Health Promoting Schools Programme in this school?

(Please mark one response)

- a. No one coordinates it in this school
- b. School Based Support Team Coordinator
- c. The Life Orientation Coordinator
- d. The School Health Nurse
- e. Health Promoter
- f. Community Health Worker

1. Water and Sanitation

1.1. What is the source of water supply?

- For drinking:

- Washing:

- For other purposes:

1.2. Is the water in good condition?

- For drinking:

-In terms of quantity: Yes No

(Please specify the problem) _____

-In terms of quality: Yes No

(Please specify the problem) _____

-For washing:

In terms of quantity: Yes No

(Please specify the problem) _____

-In terms of quality: Yes No

(Please specify the problem) _____

-For other purposes:

In terms of quantity: Yes No

(Please specify the problem) _____

-In terms of quality: Yes No

(Please specify the problem) _____

1.3. Does the school have a programme to encourage learners to drink water?

Yes_____ No_____

1.4. Does the school have hand washing facilities (including soap)?

1.5. How many water taps for washing hands are available to learners?

() for the total number of learners ().
The number of water taps *The total number of learners.*

1.6. What is the state of hygiene in the toilets?

1.7. Are they all in a safe working condition?

Yes No: () out of () are out of use.
The number out of use *Total number of toilets*

4.6. Has this school adopted a policy stating that, if food is served to learner by food vendors, during school events or extended school activities, fruit or vegetable will be among the foods offered?

Yes

No

4.7. Do learners at the school purchase snack foods or beverages from:

a. Food vendors

b. Tuck shop

c. Others (Please specify): _____

4.8. Does the school have control on what is being sold at the tuck shop and/or by the food vendors?

Yes

No

4.9. According to your school records, how many vendors in your school community area have been trained in preparing and handling food?

- () vendors have been trained out of () registered/listed vendors.

- We do not have any record of the trained vendors ()

4.10. Does the school monitor hygienic standards of food vendors/tuck shop?

Yes

No

4.11. What is sold in the tuck shop or by the street vendors?

a. Chocolate candy

b. Other kinds of sweets

c. Salty snacks such as regular potato chips

d. Snacks that are low in fat

e. Fruits or vegetables

f. Low fat cookies

g. Fizzy drinks

h. Fruit juice that is not 100% juice (sweetened fruit juice)

i. Sports drinks

j. 100% fruit juice

k. Bottled water

l. Full cream milk

m. Yoghurt

n. Fatty fried foods

4.12. Does the school have a partnership with local health department EHPs to check on vendors and their standards?

Yes No

4.13. Does the school have a vegetable garden?

Yes No

If yes, what is the size of the garden?

4.14. Does the school have a budget for this garden?

Yes No

4.15. How many of the following participate in the garden:

Educators: _____

Learners: _____

Other (name them): _____

4.16. What is the programme for the food garden?

Daily: _____

Weekly: _____

4.17. Are the vegetables from the garden?

- Sold to the community? Yes No

- Cooked for the learners? Yes No

4.18. Does the school have nutrition related activities in the curriculum?

Yes No

If yes, what are they?

5. Safety and Protection

5.1. Is the school environment safe?

(If the answer is yes, please explain below)

5.2. Is your school surrounded by an appropriate security fence?

Yes No - Please specify the problems _____

5.3. Does your school implement each of the following safety and security measures?

(Please tick appropriate responses)

- a. Require visitors to report to the main office or reception upon arrival
- b. Disallow learners from leaving the school premises during school hours
- c. Keep school gates locked
- d. Use staff or adult volunteers to monitor school premises between classes
- e. Use security cameras
- f. Employ security guards during regular school days
- g. Have partnership with the local policing forums

5.4. Does your school have a programme/policy to prevent or manage bullying?

Yes

No

6. Health Services

6.1. Do school health nurses visit the school to provide the following health services?

(Mark appropriate response)

- a. Screening for health problems
- b. Immunisation during campaigns
- c. Other

If you marked a: screening for health problems, what are the items included in the screening? Please specify:

6.2. Does your school identify the number of malnourished learners from screening for health problems or other school health services?

Yes

No

If yes, how many learners are currently malnourished? ()

6.3. Does your school identify the number of immunized learners as per RTHC?

Yes

No

If yes, how many learners are currently immunized? ()

6.4. How often does the health promoter(s) visit the school?

6.5. What activities is s/he involved in, at the school?

7. Health Promoting School Programme

7.1. How many educators at your school have been trained on HPS?
()

7.2. How many learners at your school have been trained on HPS?
()

Thank you for your responses

APPENDIX D

QUESTIONS FOR FOCUS GROUP INTERVIEWS

Questions for interviews:

1. It is well known that Life Orientation and Health promotion are linked in schools. According to you as a Life Orientation teacher/Health Promotion co-ordinator, what is your view on this?
2. Within Health promotion as part of Life Orientation there are competencies that one can focus on in terms of both the learners and teachers. What is your view on this?
3. Within Health promotion as part of Life Orientation stakeholders play a role. What is your view on this?
4. Within Health promotion as part of Life Orientation community involvement and participation have a role to play. What is your view on this?
5. As a teacher / Health promotion co-ordinator what is your view on the access to health services as part of Health promotion?
6. As a teacher / Health promotion co-ordinator what is your view on the environment as part of the health in the school?
7. As a teacher / Health promotion co-ordinator what is your view on policies concerning Health promotion in schools? (What kind of policies are we talking about?)

APPENDIX E

EXAMPLES OF RESPONSES FROM QUALITATIVE INTERVIEWS

1 **Interview 1 (School 1):**

2

3 R: It is well known that Life Orientation and Health promotion are linked in schools. According to you as a Life Orientation
4 teacher/Health promotion co-ordinator what are your views on this?

5 T1: Yah, yes, I agree with you on this point and again it incorporates both learners and educators in such a way that we
6 encourage learners to eat a healthy balanced diet. That's why in learning outcome 1, which is health promotion, we
7 encourage learners to eat four groups, four food groups...

8 R: So that's Learning Outcome 1

9 T1: And also the physical activities in learning outcome 4 deal with obesity and learning outcome 2 deals with environmental
10 awareness especially cleanliness and environmental competitions.

11 R: Okay, that's very good

12 T2: Just to add on what Moss has just said, we participate in the launch of competitions just to, you know, motivate even
13 teachers...

14 R: Between the grades?

15 T2: Between the grades as well as, you know, we've got soul buddies, then we've got the Envirocenter and Eduplans. We
16 motivate both learners and educators to take care of our environment, now this is what we can get... without having to work,
17 but just to, you know, take care of the environment then you can achieve a lot of things, and this indirectly affects our health.
18 And if we don't take care of the environment in which we are living, we might time and again get sick. Especially the toilets,

19 keeping the toilets clean is one of the issues, so hygiene issues are brought into the picture. And this it what we are trying to
20 emphasize, so last year we came second in a national competition.

21 R: Really.....

22 T2: ... and another year we came first and won about R75000 and that money is used to improve the environment around the
23 school. We are also participating in BMW South Africa since 1999, which is the seed garden, and for the past two years we
24 have exceeded the school excellence category, we are now in a premium category...

25 R: Mmm... congratulations

26 T2: Thanks

27 R: Oh that is good...okay, thank you Moss. Then question 2, in Health promotion as part of Life Orientation there are
28 competencies that one can focus on in term of both the learners and teachers. What are your views on this?

29 T1: Yes, again in this one we encourage a healthy lifestyle, especially encouraging learners again to eat healthy food and
30 ensuring that learners are taking part in sport, games and physical activities that are incorporated with learning areas. Like I
31 said, learning outcome 4 is where learners are encouraged to take part in different activities. We partnership with other
32 schools and NGO's and we also enter other competitions, especially soccer, netball and so on.

33 R: Oh okay...

34 T1: That's how we make sure that learners are active

35 R: Okay

36 T2: Based on that competency, um, we have ensured that each and every child is given the opportunity to take part in games or
37 physical activities like sport. Our school have been linked with a school in Birmingham...

38 R: Oh Birmingham... In England?

39 T2: Yes, Mavastock, that's right, it's um Mavastock, a College School and our teachers are awarded an opportunity to go over
40 there to learn....

41 R: Have they been there?

42 T2: Yes, Moss is one of them

43 R: Oh... in Birmingham...

44 T2: Yes. Even in Manchester and in Surrey we have schools we work with. And in Birmingham, that school is a sport college. Now
45 our teachers are getting skills and come to implement them here. They were here last time to come and um... come...

46 R: So they visited you?

47 T2: Yes. Now in doing so the British Council is the one that is supporting us. This enables us to be a resource school in terms of
48 sports because under 11 and under 12 years were the champs of Gauteng in Netball and Gymnastics. So we are ensuring that
49 children must... um

50 T1: Take part

51 T2: Take part in sports

52 R: Yes, participation is very important

53 T2: Irrespective of whether we have a good sports field or whatever, it doesn't matter...

54 R: Yes

55 T2: ...they have to take part

56 R: Be part of it all

57 T2: Yes... um like people say "we don't have this and this and this". But what are you doing with that little resources you have?
58 You have to make use of whatever you have. And people will see that you are doing something and they will help you, like
59 NGO's.

60 R: Yes

61 T2: Um...the school is now actually fully resourced with lots of things like Donor South Africa...

62 R: Um?

63 T2: They assisted us to build five classrooms at the back...

64 R: Oh the new classrooms?

65 T2: Yes, and they are bringing three more classrooms....

66 R: Is it those white classrooms in the back?

67 T2: Yes, they are coming this week. And why? It is because of the environment of the school...

68 R: Um

69 T2: ...that actually prompts them to say "we can do something". But if the environment was not welcoming, they would not be a
70 part of the school and help us

71 R: Yes

72 T1: And also we encourage learners to take part in indigenous games, you see, those ones who do not play sports but...

73 R: Ja?

74 T1: At least they can have a chance to do something.

75 R: I can imagine they enjoy it a lot

76 T1: Yes they do, yes

77 T2: Another area that we are focusing on, it is because we've realised that most of the kids at our assembly, faint. They come to
78 school without eating anything, so we have introduced a system because we've realised that especially in winter, learners are
79 coming late at school, so there's porridge, breakfast porridge in the morning.

80 R: Oh okay

81 T2: And breakfast ends at 07:30, so if you come after 07:30 you don't get porridge. So everybody has to be here before then, so
82 the issue of late coming has been reduced because there is breakfast.

83 R: That's a brilliant idea to get them at school early... okay... good. Okay Moss, and then the third question I want to ask you is
84 within Health promotion as part of Life Orientation, stakeholders play a role. What are your views on this?"

85 T1: Yes again on that ... stakeholders are holding meetings at our school and are responsible for cleaning the school and they
86 take part in cleaning campaigns. They are looking after our school at the same time, they serve as the security because while
87 they are here they are our eyes

88 R: Um

89 T1: Yes. And also the school health nurses are available

90 R: Oh the nurses?

91 T1: Yes

92 R: Okay

93 T1: Normally they spend a week with us here. So since last week they've been here screening the children's ears and eyes

94 R: That is excellent

95 T1: Yes and they are accessible also

96 R: Yes

97 T1: We are able to be advised in time when a problem is occurring, like what are the new diseases that we can prevent

98 R: Um

99 T1: They inform us early

100 R: Yes

101 T2: And then they are helping us to check even the vendors, the type of the food they are selling to the children

102 R: So it's good food, healthy?

103 T2: That's right its good food for the children. We are also hosting churches on Sundays...

104 R: On the school ground?

105 T2: Yes on the school grounds. And they pay on a monthly basis and the money is used as fund raising. In return also they buy

106 soap, you know, for the school which can also be used to clean the toilet and to clean the classes

107 R: Yes

108 T2: And we've got political structures, like the ANC in this area, they are holding meetings here at the school

109 R: Okay

110 T2: So we don't experience vandalism like other schools where you'll find that they have stolen the computers. We haven't had

111 that particular thing because the community are holding their meetings here at school

112 R: So you involve the community a lot?

113 T2: That's right

114 R: That's great. Okay um Moss, then the next question I want to ask you: "Within Health promotion as part of Life Orientation
115 community involvement and participation have roles to play. What is your view on this?"

116 T1: In addition to that, you see, we have um people who are looking around the school, especially the neighbouring people here.

117 R: Okay

118 T1: They serve as security and make sure that there's no dumping. So they are looking after the school and also come and teach
119 the learners about the values and norms of our society...

120 R: Okay

121 T1: ...so learners behave accordingly

122 R: People in the community?

123 T1: Yes. And they also teach learners about the danger of HIV, they usually come to school and help with HIV awareness

124 R: Um

125 T1: So they help us in that regard

126 R: Mmm... that's great

127 T2: Yes, for example, every year we hold awareness campaigns ...er... we had a marathon and a walk for the grannies and I think
128 Brennan will tell you that was one of the most successful campaigns this year

129 R: Oh okay, so was it this year?

130 T2: Yes and we got help from Old Mutual because they were here

131 R: Um

132 T2: So all the stakeholders, they come together and we organise a marathon and a walk, you know these big grannies they just
133 walk on...

134 R: Really?

135 T2: They enjoy themselves and drink water and the little ones are running ...er... like a marathon. So at the end of the day there
136 are different depots for screening for high blood pressure, not only for HIV, but also high blood pressure, sugar levels and
137 whatever

138 R: Yes

139 T2: So whenever the community get these services free at a school they tend to respect the school as a health promoting school

140 R: Yes and they want to be part of it

141 T2: And they respect the school because it is not only used for teaching but also for community services

142 R: Yes the school is serving the whole community

143 T2: Yes

144 R: Yes, that is true. Moss and then if I can ask you "as a teacher, what are your views on the access to health services as part of
145 Health promotion?"

146 T1: Yes it does help us when there are referrals, and like I said the nurses can advise us in time how a disease is treated and also
147 what the principal said about the screening...

148 R: Um

149 T1: ...and even when a learner gets injured the nurses are here and they can help

150 R: They can help...

151 T1: So we can get help faster

152 R: Okay

153 R: Then I want to ask you "as a teacher what is your view on the environment as part of the Health promotion in the school?"

154 The environment... I know we have already talked about it a bit

155 T1: Yes we believe in cleanliness. We believe in teaching the learners that in a clean environment the learner is free. We believe

156 that the school... um... the school firmly believes that nothing yields better results than learning in a clean and safe

157 environment which contributes to sustainable development and livelihood

158 R: Yes one can see it here

159 T1: Yes

160 R: The school is very clean and seems friendly!

161 T1: Yes

162 R: The passing learners all greeted us

163 T2: We have this thing of 'mind your space' and each and every child knows the concept of 'mind your space'

164 R: What is that?

165 T2: Learners must ask themselves: 'am I in the right spot?' So when we go to assembly I say 'mind your space'. So the child will

166 look around if there are papers lying around. Or if he or she is in the allowed area at the time because this side of the

167 entrance (*gestures towards gate*) we don't allow learners to enter or walk because the cars move by this side, so it's for their

168 own safety

169 R: Yes

170 T2: And it allows us to detect problems since the learners know where they are not allowed to go. So if there is a stranger that
171 comes into the school yard and walks that side of the gate we are able to detect that it is not a person from the school

172 R: That is an excellent strategy to keep the school safe

173 T2: Yes we also lock all the school gates at all times and only use one gate so that every person coming into the school is clearly
174 visible

175 T2: I am also busy with the... um... evacuation policy. It is a new one so I still have to meet with the teachers about that.

176 R: Oh

177 T2: We are busy working on it but I have drafted it. The secretary... she is typing is now

178 R: Yes

179 T2: This policy is going to help us to realise when there is a danger at school. So I am going to show the teachers and do the
180 demonstration and ring the bell

181 R: Yes

182 T2: So if the bell is rung in a certain way it means there is a bomb or something. So all the kids must go to one specific place and
183 then sit down

184 R: Okay

185 T2: No child should run away and we should get help. So these are the kind of the things we do to ensure that there is safety
186 within the school environment

187 R: Yes and everyone will know the procedure to evacuate

188 T2: That's right

189 T1: I just want to say again that whatever a learners learn at school he or she must be able to practice it at home

190 T2: At home yes, it is a cascade. Like even to start the food gardens, that's why we show the learners that a tyre garden is so easy

191 to do. And making tyre gardens at home is also part of recycling

192 R: Yes

193 T2: Yes they can use the tyres easily and also the tyres are not burned, you see they can use it to plant some seeds there

194 R: This tyre garden is wonderful. And you're also using the other garden?

195 T2: Yes we are using the other garden also

196 R: Yes you have a lot of space for gardens.

197 T2: Yes. And we also have recycling depots and we recycle every little thing like papers, tins, bottles or anything. So if a parent

198 has something at home that can be recycled they must send it to school so we can recycle it

199 R: Okay, so the children bring it to the school?

200 T2: That's right

201 R: Okay. And then the last question Moss: "As a teacher what is your view on policies concerning Health promotion in schools

202 and what kind of policies do you think we are talking about?"

203 T1: Yes okay, the policies bind all the structures and parties within the schools to work towards a common goal

204 R: Um

205 T1: We talk about the tobacco policy... um ... drug policies and also the environmental policy. The principal mentioned the

206 evacuation policy. Those are the one that we have. So all the structures must be able to to work towards a common goal and

207 everybody should be aware of the policies

208 R: Um

209 T2: I think just to add on that, if a school has a policy whereby all the stakeholders have buy in, you know, they have contributed
210 something it is easier to make a success of it. For example the policy of locking the gate, it hasn't been an easy thing to do
211 because the parents queried and said we shouldn't do it. But once we explained why it is safer, they all now agree the gate
212 should be locked

213 R: Yes

214 T2: That is why it is important. And the safety of the school is also promoted

215 R: Yes

216 T2: So as a result, if a policy is actually drafted by all the structures it will be a success because everyone will know why
217 something is happening in a certain way.

218 T2: Yes that's true. Thank you very much for your time

219 **Interview 2 (School 2):**

220

221 R: It is well known that Life Orientation and Health promotion are linked in schools. According to you as a Life Orientation
222 teacher, what is your view on this?

223 T1: Yes, Life Orientation and health promotion coordinate, because in health promotion we take care of healthy lifestyles and in
224 Life Orientation we have learning outcome 1 which is health promotion. So LO 1 (*learning outcome 1*) AS 1 (*assessment*
225 *standard 1*) is talking about proposing ways to improve the nutritional value of own personal diet. And we cluster this with AS
226 4 (*assessment standard 4*) where we describe strategies for living with diseases, including HIV and AIDS, since people with HIV
227 and AIDS must eat healthy food so they can live longer

228 R: Yes

229 T1: So learners must eat a healthy balanced diet and in Life Orientation we tell learners what a balanced diet is. So they must
230 write a balanced diet for a day or for a week that includes breakfast, lunch and supper

231 R: Okay

232 T1: And we try to tell the learners not to buy those Simba chips. Those red/brown ones. And they mustn't drink fizzy drinks, they
233 must drink juice instead. So they should avoid eating colourful sweets, you understand?

234 R: And then the next question: "within Health promotion as part of Life Orientation there are competencies that one can focus
235 on in terms of both the learners and the teachers. What is your view on this?"

236 T1: Firstly I think it will help a lot if not only Life Orientation teachers, but all teachers, are taught about health promotion. That
237 way health promotion can be linked with all learning areas and we will achieve much more. Anyway, health promotion

238 ensures the cleanliness of the environment and self. In Life Orientation we teach different types of development, like in
239 learning outcome 2 we teach social development. We explain how to counter gender stereotypes and sexism. In learning
240 outcome 3 we implement strategies to enhance own and others' self image through positive actions, and explain and
241 evaluate your emotions and responses to change. And we teach learners to be a considerate person and not hurt others.
242 Finally we teach learners how to live healthily. That is why I think vendors mustn't sell our children sweets in the morning
243 because they become hyperactive in classes. So in the mornings we cook porridge for learners

244 R: So their first meal is at school then?

245 T1: Yes, we give them breakfast because many children come to school without eating breakfast so they can't concentrate . And
246 when they get porridge they don't buy sweets and fizzy drinks

247 R: Okay, wonderful. Then the next question: "within Health promotion as part of Life Orientation stakeholders play a role. What
248 is your view on this?"

249 T1: All the stakeholders must communicate correctly, right through from the grounds men to the lady who is cooking – all of
250 them must be considered in everything so the school can run smoothly

251 R: Yes

252 T1: And an important stakeholder is the community. We especially need the parents to be involved in the school. We have
253 parents who come to school and clean our classes, especially the unemployed parents, they just come and clean the classes

254 R: Okay, so the parents are involved?

255 T1: Not only the parents, even the grounds men, we have two grounds men that we employ. But our school is large so a third
256 grounds man in working. He came to school and said he works for the community. So at the end of the month the school
257 gives him food in return for his work at school, he does like maintenance things

258 R: Then question number four: "within Health promotion as part of Life Orientation community involvement and participation
259 have roles to play. What is your view on this?"

260 T1: Parents help in our kitchen and cook for learners. They also work in the food gardens where they plant seeds for vegetables
261 so that our learners can eat healthy food. There are parents who clean the children's classrooms, especially in the foundation
262 phase (grade R to 3), they clean for the children because they are too young to clean. We want our learners to be in a clean
263 environment. We also employ cleaners at the school who clean the whole environment and also the classrooms. We also
264 have projects and initiatives that include parents. Like in Life Orientation we had a project to create awareness about teenage
265 pregnancy and HIV and AIDS. This project took place over a month, when learners came to school and pretended to be
266 pregnant and had to go to the clinic for check ups. And I was the person who took those learners to the clinic for check ups.
267 We have photos of that, we have proof. And after "giving birth", they came to school with dolls which we pretended were
268 their babies. So during a break when the learner was playing, we called her and said her child is crying. So she had to stop
269 playing and come feed the baby. We also involved the parents. We firstly asked their permission when we started the project
270 so that they wouldn't be angry about it. We told the parents this project will show learners they mustn't get pregnant at a
271 young age and when you are child it is not good to be a mother. So the parents went along and woke the children up at 10
272 or 11 o'clock, or even midnight, and pretended the "babies" were crying and the learners had to comfort the doll. So learners
273 saw that it was not fun to be like that.

274 R: That sounds like a great project

275 T1: Yes. But it was also about HIV and AIDS. We told learners about everything, pregnancy, HIV and STD's (*sexually transmitted*
276 *diseases*) for that whole month. It was a good project.

277 R: Oh okay, that's good. Then questions 5: "As a teacher what is your view on the access to health services as part of Health
278 promotion?"

279 T1: School nurses come to school to check our learners – especially their eyes and ears. So they give some of the learners
280 spectacles for free. If a nurse says the learner is seriously ill they take the child to the hospital. Because you know most of our
281 parents are irresponsible, they don't take care of their children until we call them and say: "please take your child to the
282 hospital". And then we have social development ... um... those people supply our learners with uniforms, especially the needy
283 learners

284 R: Is that the Department of Social Development?

285 T1: Yes, they come here every year . They give all the grade 1 learners uniforms and from grade 2 to grade 7 we write the names
286 of the needy of the neediest learners and they give them uniform

287 R: Okay

288 T1: Yes and then BMW supply us with seeds to plant in our food garden

289 R: Oh they are involved?

290 T1: Yes, they provide us with seeds to plant so that we can cook healthy food for the children. We have cabbage, spinach, onions
291 and many other vegetables. Then there are people from the feeding scheme that give us food. Mr. K already mentioned that.

292 We augment donated food with food from our gardens. And after school the learners get fruit so that they can get even
293 more vitamins. We give them fruits like apples, pears, oranges or bananas

294 R: Yes

295 T1: So we give learners healthy food because their diets must be balanced

296 R: Okay

297 T1: And again in Life Orientation, there are people from "Always" that come and lecture the grade 7's about menstruation and
298 they supply them with "Always" sanitary towels

299 R: Okay, the company "Always"?

300 T1: Yes, they supply them with the sanitary towels because most of the parents can't afford to buy those sanitary towels for the
301 girls. They give a box for the school so if a girl has a problem she can come to us and we give her sanitary towels. It is good
302 because some learners have to use tissues or toilet paper or newspapers

303 R: Oh that is good

304 R: Okay, then I would like to know your views on the environment as part of health in school

305 T1: Yes, health promoting must see to it that school grounds are clean. We involve learners and tell them to pick up papers. Here
306 at school we work with the classes from grade 1 to grade 7. It is our monthly procedure, so if this week it is your class, every
307 morning the learners in that class must pick up papers, during and after breaks. They also have to and clean the toilets after
308 school. Though there are ladies who clean the toilets the learners too must learn how to clean it properly

309 R: So you have timetable then?

310 T1: Yes we have a timetable

311 R: Okay

312 T1: And our grade 7's sweep the yard around the classrooms every morning

313 R: So it is so well organised

314 T1: Yes

315 R: And then we have the grounds men who help with the food gardens. Not only in the food gardens, but they also do the

316 maintenance so that we can ensure the school is safe

317 R: Yes okay. And then "as teachers what are your views on policies concerning Health promotion in schools?" Policies about

318 Health promotion and what kind of policies are we talking about?"

319 T1: Okay, the policies are basically guided by the National Policy on safety for learners. We have a code of conduct for learners

320 and an environmental health policy. We have a SBST (*School Based Support Team*) policy

321 R: Yes

322 T1: We have a safety and health policy that include action on communicable diseases. There is the learner pregnancy policy and

323 the anti-smoking policy

324 R: That's interesting

325 T1: That is not only for learners but also for teachers who smoke. They know they are not allowed to smoke wherever they want.

326 R: Okay, and you B?

327 T2: I think the policies are basically guiding us on how to conduct ourselves, especially when it comes to learners' health in

328 classrooms. So it's a guiding tool which always helps us to help the learners. So everybody knows exactly what to do when

329 something happens and there is no panic and chaos. The SBST policy also allows assistance to vulnerable and child headed
330 families.

331 R: Okay

332 T2: These policies, together with Life Orientation, equip our learners with basic skills on how to conduct themselves and how to
333 take care of themselves.

334 R: Oh okay, do you have a policy on discipline?

335 T2: Yes have a code of conduct. We have a system where we use demerits. The system works, but is not popular with the
336 learners. It is sometimes just on paper as a backup plan to scare them. In classes there are no corporal punishment anymore
337 and all the educators know that. Some of the other strategies are letting the learners sweep the class, just doing minor
338 chores in the classroom.

339 R: Do you think it working?

340 T2: Yes

341 R: Do you have problems with discipline in general?

342 T2: No not really. We don't have drastic issues like bullying or instances where learners stab each other

343 R: Oh so you don't have that?

344 T2: No, fortunately there are no such incidences

345 R: I am glad to hear that. Thank you very much for your time

346

347 **Interview 3 (School 3):**

348 R: Okay, thank you T, can I start with you? "It is well known that Life Orientation and Health promoting schools are linked in
349 schools. According to you as the health co-ordinator, what is your view on this?"

350 T1: My views on this are that Life Orientation goes hand in hand with health promotion because they both address the same
351 issues, like the safety of learners and how to live a healthy lifestyle

352 R: Okay, yes

353 R: And A, do you want to add anything about Life Orientation and the health promotion?

354 T2: As a LO (*Life Orientation*) teacher I think health promotion and LO (*Life Orientation*) are the same because they both teach
355 learners how to take care of themselves, how to eat healthy and the importance of doing some exercises. We teach them
356 how to be clean and hygienic. Not only to be clean themselves but also to have a clean environment

357 R: Yes that is important. Thank you. And then, the second question I want to ask you "Within Health promotion as part of Life
358 Orientation there are competencies that one can focus on in terms of both the learners and teachers. What is your view of
359 this? T, your view?"

360 T1: They are methods we can use to solve the problem of poverty and malnutrition by making food gardens, so both learners
361 and educators are taught how to do that

362 R: I saw your gardens on they way in, they are beautiful!

363 T1: Thank you

364 T1: We teach learners to say or take a "no" as a "no" to avoid unwanted sexual activity or teenage pregnancy.

365 R: Okay, and Agnes what do you say about the competencies?

366 T2: The learners are able to use critical thinking skills so they do not make wrong choices. They must always think positively
367 about their health

368 R: Okay T, "within Health promotion as part of Life Orientation stakeholders play a role. What is your view on this?"

369 T1: I think the sustainability of the health promoting school is to sell it to educators, learners and members of the community so
370 they all help in keeping the school a successful health promoting school because if the stakeholders are negative nothing
371 would be achieved

372 R: And does the school and stakeholders have a good relationship?

373 T1: Some, but we are still learning so it will improve

374 R: Yes. And A, what are your views?

375 T2: Um... teachers must always encourage learners to go to the garden and plant some vegetables and teach them the
376 importance of eating healthy food. Teachers are the link between the learners and the parents to promote healthy living
377 between them. Learners pass on their knowledge to the parents so that the families can live healthy at home. And the
378 teachers also give reports to the relevant departments about the health of our school and the involvement of the parents

379 R: Okay that's good. And T, "within Health promotion as part of Life Orientation community involvement and participation have
380 a role to play. What is your view on this?"

381 T1: They have role to play, yes. Educators or the school as a whole should work with the community. For example, invite them to
382 have functions at school or to participate school games, or maybe give them pieces of land in the school yard to make food
383 gardens. This would also help in protecting the school. Even over weekends if the parents are around I don't think there will
384 be break-ins or vandalism

385 R: Okay thank you, and A, what do you say about the community involvement?

386 T2: The community helps by cleaning our school. They are involved in health activities in our school like health awareness, most
387 of the time when we have health awareness campaigns, they are involved. And then they are also involved in how to reduce
388 malnutrition by working in our food gardens. They also cook lunch for the learners. There are also old men from the
389 community that help us, when they harvest their vegetables they give some of it to us to supplement our feeding scheme
390 food

391 R: Okay that's good. Then "as a teacher what is your view on the access to health services as part of Health promotion?" T, what
392 do you say about this....

393 T1: Yes, we have access to health services for example the NGO's come to our school to provide counselling or support services
394 to teachers and learners. We also have a clinic not too far from the school

395 R: Yes

396 T1: The school nurses come to our school regularly to check on learners' health, for example to immunise them or to check their
397 eyes, ears and teeth

398 R: Okay wonderful. It is annually?

399 T1: Um they come several times during the year...

400 R: Oh okay. I saw three nurses today. Are they from the Gauteng Department of Health?

401 T1: Yes

402 R: Okay good. A, and what do you say about the access to the health services?

403 T2: Um... local health services provide us with materials and information about our health, they provide us with some books,
404 magazines, they immunize our learners regularly, we have a first aid kit which is always available for an emergency

405 R: Okay

406 T2: They also provide us with some skills and knowledge about our health, they explain to the learners why their health are
407 important to them, so they can take care of themselves

408 R: Okay that's good. And then T "as a teacher what is your view on the environment as part of the health in the school?"

409 T1: That's a thorny one!

410 R: Yes

411 T1: I think the environment is very important because better teaching takes place in a cleaner school. I do think we need more
412 help from the government, they should send us more cleaners. And learners are always taught not to litter, not to throw
413 papers all around. But many are not taught that at home, so if parents told their children to keep their environment clean it
414 would greatly help us at school. And also if they could be taught toilet manners and to respect their environment by maybe
415 flushing the toilets and not use newspapers in the toilet. We have a problem with the cleanliness of the toilets and that could
416 make one sick if it stays dirty

417 R: A, and from your side?

418 T2: Um, as teachers we must encourage learners to clean the surroundings all the time, um... they must take care of their toilets
419 and they must stop littering. We teach the learners that cleaning reduces sickness . They should be provided with soaps and
420 other cleaning materials to clean their classrooms and the toilets so learners are safe

421 R: Do you have the soap and the cleaning materials?

422 T2: Yes we do

423 R: Oh that's good

424 T2: And then we have two cleaners here, so most of the time we involve our learners when it comes to cleaning. They show them

425 how to clean and then sometimes the learners do it on their own

426 R: That's good, so they are learning all the way.

427 T2: Yes

428 R: Okay and then T I want to know "as a Health co-ordinator – and you are a teacher as well – what is your view on policies

429 concerning Health promoting in schools? And if I can ask you, what kind of policies do you think are we talking about here?"

430 T1: Policies from the government are binding the teachers' hands behind their backs because they restrict them to discipline the

431 learners. For example, if a learner does something wrong, or maybe they leave their books at home or come late every day

432 we are not allowed to give corporal punishment. But I can send the child maybe to pick up papers or take the weeds out of

433 the flower beds, but they will say it is child labour

434 R: Who will say that? The Department of Education?

435 T1: They say it is child labour, we mustn't let learners work

436 R: Oh, did they send you a policy?

437 T1: Yes, yes

438 R: Really?

439 T1: Yes it's long time ago

440 R: So you are not allowed to do that?

441 T1: We are not allowed to punish the children by forcing them to take out the weeds, or to water the garden after school or...
442 they say it is child labour

443 R: Did the Department of Education say that?

444 T1: Yes they sent us a policy

445 R: Okay

446 T1: And then I can say these policies include the discipline policy, maybe if a child does something wrong, maybe fights with
447 another child, and then you need to discipline that child – you must be careful. And then another one its the safety policy

448 R: Yes that is an important one

449 T1: But the safety policy is not working because we are not allowed to search learners when they come to school

450 R: Are you not?

451 T1: No

452 R: According to the rules of the Department of Education?

453 T1: They keep on changing, they say they will be searched but there is no security at the gate to search them so learners come to
454 school with knives

455 R: Okay

456 T1: And we have a non-violence policy...

457 R: Oh the non-violence policy did you receive that from the Department of Education?

458 T1: I don't remember

459 R: Okay but you have that in your file? The policies....

460 T1: Yes they are there. So it's a big problem to us as teachers because we don't know what to do with discipline and violence

461 R: I can imagine

462 T1: "Do this" they say it's wrong and "do this" they say no you can't do that. That is why I say they are binding our hands behind

463 our backs...

464 R: Yes that makes it difficult

465 T1: It's more difficult because learners come to school with cell phones and listen to music in class or show pornographic

466 pictures around when the teacher goes to the bathroom or something

467 R: Oh you also have a problem with that?

468 T1: Yes. And then we don't know what to do with those learners...

469 R: And the principal and deputy principals? Do you involve them with the discipline, like with the cell phones?

470 T1: Yes they know

471 R: Oh

472 T1: Yes they don't know what to do

473 R: Okay

474 T1: We are afraid to discipline or punish the learners

475 R: The principal as well?

476 T1: Yes his hands are tied behind his back as well. Um... so we also have a school safety policy which tells us what to do when a

477 learner is maybe raped. So we take the case to the relevant people, like a social worker and police. But we never get feedback

478 or results from the case that is not good

479 R: Oh, they don't come back to the school?

480 T1: No

481 R: That's so difficult. T, your view on policies concerning the health promoting in schools?

482 T2: I think learners must be aware of the substance abuse that is all over all schools now

483 R: Yes?

484 T2: They must not take drugs and alcohol. We have a substance abuse policy about that

485 R: Yes is it in your SBST file?

486 T2: Um

487 R: Okay

488 T2: And then learners must respect each other and the teachers. And our school safety policy makes sure that learners are safe,

489 like we don't allow weapons at the school

490 R: Um

491 T2: Learners mustn't vandalise any materials

492 R: Do you have a problem with vandalism?

493 T2: Yes, most of the time they break windows and chairs

494 R: And are the parents aware of the policies?

495 T2: Yes they are involved. We tell them and they also know the school policies

496 R: Yes that it good. Thank you very much for your time

497 **Interview 4 (School 4):**

498 R: Thank you so much that we can be here and visit your school. Can I start with the first question, "It is well-known that Life
499 Orientation and Health promotion are linked in schools. According to you as a Life Orientation teacher or the Health co-
500 ordinator, what is your view on this?"

501 T1: Let me start by saying that I am the health coordinator. My view on the above is that it is good to link the two because the
502 school as the environment should always be kept clean. This is mainly because we as the school need to expose the learners
503 to a healthy lifestyle. If we link them together, I think, it is a foundation for subsequent success. If we put Life Orientation
504 aside and put health aside it won't work, both of them must work concurrently. I think our learners are going to grow up with
505 good knowledge about health promotion

506 T2: According to my view it's best to be linked because Life Orientation teaches learners about their bodies, their lives, as well as
507 their health. Health promotion teaches them to live a healthy lifestyle. It concerns their behaviour and their family
508 background; we need to know where they come from. So especially concerning our community, it is a very poor community,
509 you see?

510 R: Yes

511 T2: And most of the learners are more needy...

512 R: Needy?

513 T2: Yes they are needier. So that's why Life Orientation and health promotion is very important

514 R: Okay, do you want to add something?

515 T3: I think she has said a mouthful

516 R: "Within health promotion as part of Life Orientation there are competencies that one can focus on in terms of both the
517 learners and teachers. What is your view on this?"

518 T1: Yes, although it is a little bit complicated, but my view on this is that there are a lot of competencies; learners learn how to
519 grow the vegetables...

520 R: Yes

521 T1: Learners know how to keep their bodies healthy and how to eat healthy food

522 R: Yes

523 T1: And how to be safe within the school ground. Those are the competencies I think. Let me repeat them, learners know how to
524 keep their bodies clean and about their safety. Learners also learn how to eat healthy food at school, I think that is what we
525 have done. When the health promoters came into our school, they said we must teach learners to eat healthy food, and not
526 to eat junk food. We gradually introduced or orientated learners and parents about the health promoting school. Eventually
527 the parents themselves ended up taking the decision that nobody should sell junk food within the school, they should sell
528 only fruits during breaks

529 R: Yes

530 T1: And learners must bring their lunch boxes so they don't have to buy snacks

531 T2: All of them, the learners and educators, need to eat healthy foods and practise a healthy lifestyle. Also safety and security
532 need to be more focused on

533 R: Okay, that is great

534 R: And then the third question, "within Health promotion as part of Life Orientation stakeholders play a role. What is your view
535 on this?"

536 T1: On the stakeholders?

537 R: Yes

538 T1: Yes, we do have a lot of role players in the health promoting schools. We think our community is a stakeholder in this school.
539 They were involved from the onset, in the beginning when we started a food garden at our school. And even the
540 environment at large. For example, when we started our flower garden and vegetable garden here at school we took our
541 community to a botanical garden for a simple workshop to learn skills. After that the members of the community help us by
542 working in the food gardens. BMW, which is next to us at Rosslyn there, they introduced the food garden and provide us
543 with seeds to plant

544 R: Oh that is a nice stakeholder

545 T1: Yes and that is where things started to happen and we find ourselves in a better situation than before

546 R: Yes

547 T1: Yes, because of so many stakeholders like in 2009, Nestlé South Africa had a competition, which is rural development, and we
548 entered that competition and we won R50,000...

549 R: Oh you won R50,000?

550 T1: Yes even two weeks back we won the R40,000 for the MTK...

551 R: What is the MTK?

552 T1: The MTK is the competition from the Department of Agriculture

553 R: Oh Agriculture...

554 T1: That is another stakeholder, there are so many stakeholders involved in the running of the school, so that is that.

555 T2: In our school we have health promoters. We interact with them when we have health problems. We have nurses which come
556 to school and do checkups. For example, if we suspect a learner is pregnant we invite the health promoter to talk to the
557 learner. The we also have social welfare, who help us when we have social problems with learners, especially with orphans.

558 R: Okay

559 T2: They help us a lot to fill in the documents when we maybe have a learner that doesn't earn a grant. We just invite social
560 welfare, they help us to fill in the forms

561 R: That is excellent

562 T2: Then also where we have child-headed families, we invite the health promoters and social welfare so they can go to the
563 family and check what is happening. Then we have a social worker at school, she visits us every day or three times a week

564 R: So the social worker is coming here?

565 T2: Yes she comes every day around 1 o'clock. So if we have problems we just talk to her, then we call the learners so she can
566 talk to them. She even visited some families

567 R: Okay, then I want to ask: "within Health promotion as part of Life Orientation community involvement and participation have
568 a role to play. What is your view on this?"

569 T1: The community where the learners come from is usually, according to my understanding, the feeder community. It's the
570 community that feed the school. They help learners in sports, in arts and culture and environmental issues such as food
571 gardens. This will also help the school to promote the social lives of the learners in general.

572 R: Yes that's important

573 T1: So we cannot initiate anything here at school that excludes the feeder community. The community and the school must be
574 linked, they must be one thing. What we teach learners here they should also do at home

575 R: Okay, and your views?

576 T2: We think it is a good idea to communicate with the parents so that they can be involved. Here at our school we have parents
577 who help to prepare food for the learners, they cook the feeding scheme food. Parents serve the learners during breaks and
578 around half past one when the learners go home they give them fruits

579 R: Okay

580 T2: Then we also have parents who help us by cleaning our school. They come to clean every day...

581 R: Do you pay them or not?

582 T2: At first they were volunteering but now the feeding scheme pay them. They also clean the toilets maybe twice a day. They
583 come in the morning and after school to clean.

584 R: Okay

585 T2: Parents participate in learning outcome four of Life Orientation which is the physical one where they do different sport
586 activities. Also during the school holidays we have a holiday program and we invite learners from our school and
587 neighbouring schools. So the parents help us to host physical activities and games during the week and also during the
588 holidays

589 R: Oh that is wonderful community involvement

590 T2: Some parents are cooking food for lunch during the holiday program too

591 R: So do they play games?

592 T2: Yes different games like soccer, netball, our traditional games, chess, everything

593 R: They must enjoy that!

594 T2: Yes

595 R: Okay. And then the next question: "as a teacher or health co-ordinator what is your view of the access to health services as
596 part of Health promotion?"

597 T1: Yes, let me give you a scenario, the background of the health promoting school. We cannot deal with the health promoting
598 school without the nurses. They come to school on a regular basis to check the learners' eyes, their ears, those who have got
599 learning problems. Before we can refer them to the district clinic, the nurses must write a report to give the background of
600 the learner like the social life and health status

601 R: Okay

602 T1: They play an important role because they inform the learners about their health. When they are needed they are always
603 available

604 R: So they come on a regular basis?

605 T1: Yes, on a regular basis here at school. Last year we had a social worker at that building over there on a full-time basis. I think
606 they were doing their practical from UNISA and we also had two nurses from Medunsa who did their practical work here. The
607 nurses at the clinics around here are part of the school

608 R: Great, and your views?

609 T3: I think it is very good to encourage health promoters to visit our school because their services are highly needed as our
610 community is very needy. Almost all of the kids come from poor families. Some are, they have been left by their... their
611 parents have passed on and they are living with their grandparents. So they don't have enough food and social welfare come
612 here and help them with the applications to get grants

613 T2: Some of them they don't have parents, they are child-headed families, so we invite social welfare to come here, they help
614 them to fill in the forms, they issue the forms for them, they do everything so that the child can get, um, a grant.

615 R: Yes I understand

616 T2: Then we have a committee, the school uniform committee. We have Bhato-pele from the Department of Education

617 R: Oh Bhato-pele?

618 T2: Yes Bhato-pele, they help the children with uniforms. If you find that the learner doesn't have a a uniform we just make an
619 application for those kids. And then we further have a first-aid kit for when someone is hurt. And we also have a sickroom

620 T3: We have two sickrooms, for the girls and for the boys...

621 R: And do you have someone that helps?

622 T3: Yes we have two teachers who help with first aid. Also some of the learners are very poor and especially the girls, they
623 struggle to buy sanitary towels. We help them since there is a company who donate sanitary towels. When learners ask us,
624 we supply them with the products.

625 R: Thank you. And then question six: "as a teacher or Health co-ordinator what are your views on the environment as part of the
626 health in the school?"

627 T1: The environment is the milieu, it's the surrounding and it is part of you. You are also the environment so if you or the
628 environment in which you find yourself is not clean, gradually one way or the other it affects teaching and learning. Because
629 if the school is not clean, we cannot promote healthy living

630 R: Yes

631 T1: The environment must be conducive in such a way that it promotes better teaching and learning at school

632 T2: The environment needs to be clean and safety should always be considered. Our learners are also involved in the garden. When
633 they have a free period they go to the garden and help us to do clean and water it, especially the food garden. We show
634 them how to do a garden so that they can do it at home. They also help us to clean the surrounding of the school. In the
635 mornings and during breaks the learners pick up papers

636 R: Okay. Then I want to ask: "as a teacher or Health co-ordinator what is your view on policies concerning Health promotion in
637 schools and what kind of policies do you think we are talking about?"

638 T1: Um, we have the learner safety policy, the health care policy and the teenage pregnancy policy.

639 T3: I think the policies help us a lot because if we have drawn up the policy we know how to deal with a problem. Our HIV/AIDS
640 policy is concerned with sex education. We also have a teenage pregnancy policy as well as a drug abuse policy.

641 R: Do you have a problem with drug abuse?

642 T3: No we don't have a problem with that. But about the sex education, we need to focus on it because these learners are more
643 active, they are sexually active. Especially due to their backgrounds, there is no privacy since they maybe stay in a shack, a
644 one room shack, so they see everything. When they come to school they want to practice it. That's why during breaks we try
645 to supervise the toilets

646 R: And discipline problems?

647 T3: Oh it is a serious problem, especially since corporal punishment is not allowed

648 R: How do you discipline the learners?

649 T3: We invite their parents and talk to the learners. If we have big problems, we invite the social worker to talk to the learners

650 R: Oh okay

651 T3: And we have adopt-a-cop here at school. We have a serious problem because some learners are trying to steal here at

652 school, especially to open the teachers' bags, you see? Then we invite the adopt-a-cop and they talk to them. We arranged a

653 trip to the Odi prison; learners went there and talked to the prisoners.

654 R: Okay, so any other policies?

655 T3: The first aid policy...

656 R: Oh so you have a policy on that?

657 T3: Yes the learners and parents know about that. Some parents send a learner to school while he or she is sick. So they have to

658 know that we are not going to give any learner any medicine, we just help them. They stay in the sickroom and we call the

659 parents to come and fetch them. Or if the learner is seriously ill, we take him or her to the clinic. We also have a safety and

660 security policy

661 R: Yes that is an important one

662 T3: The safety and security policy teaches learners what to do when there is a fire at the school, they know where they are

663 supposed to go

664 R: Oh like an evacuation policy?

665 T3: Yes.

666 R: Thank you very much.