

A profile of the health promoter in schools in the North West Province

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Declaration

I the undersigned hereby declare that the work contained in this dissertation is my own original work and that I have not previously in its entirety or in part submitted it at any university for a degree.

Signature

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Abstract

To accomplish health for all, a unified approach and effective collaboration by all stakeholders to promote health is essential. Health Promoting schools were conceptualised by the World Health Organisation to achieve better health promotion outcomes. In the process of achieving health promotion status, input from various stakeholders is essential. Health promoters are seen as an appropriate and cost-effective option to help promote health in a setting such as a school. Health promoters working in schools are also a relatively new field in South Africa and in the North-West Province of South Africa. Consequently, limited studies explored health promoters in school settings, and particularly the profile of health promoters. The identity of and function of health promoters when they promote health is particularly important given that national and provincial government depend on health promoters to educate teachers and students regarding health topics and to guide school communities in enhancing holistic wellness. This study therefore aimed to create a profile of the health promoter in the North-West Province, Dr. Kenneth Kaunda District, in order to assist them with social and health challenges they may encounter. Since very little is known about the profile of the health promoter, a quantitative study was conducted involving 13 participants (11 males; 2 females), who are employed as health promoters in school settings in the North-West Province, Dr. Kenneth Kaunda district. The Health Promoter Questionnaire was developed to obtain quantitative data regarding health promoters' biographical information, training and qualifications, work description, way of communication, planning, school visits, transportation, support, barriers, coping strategies and personal health. Data were analysed using descriptive statistics (frequencies) to create a profile of the health promoter in the North-West Province, Dr. Kenneth Kaunda District. Findings revealed that the health promoters are mainly males, relatively young, proficient in two or three languages with matriculation certificates, but no additional formal training or experience in health-related topics. Although the Department of Health provided some form of training, the health

promoters indicated insufficient knowledge in specific health promotion themes such as violence prevention, suicide prevention and alcohol and drug prevention. The need for more training on various other topics such as the handling of conflict, better communication, reporting of misconduct to appropriate individuals and procedures to make referrals to professionals was also identified. Apart from health-related barriers such as HIV/AIDS, violence as well as drugs and alcohol abuse, health promoters also face additional barriers such as unclear job descriptions, insufficient planning such as rotation based plans and follow-up visits to schools, as well as insufficient time spent at schools. Health promoters also receive insufficient support from the Department of Education and Department of Health in addressing these barriers. The profile of the health promoter will therefore assist local and provincial government to create and implement programs and plans that could assist health promoters in the execution of their duties. Additional recommendations refer to the training of health promoters regarding the myriad barriers they face, the implementation of clear job descriptions, as well as relevant support services regarding work and personal problems. As this study is only focused on health promoters in school settings in the North-West Province, Dr. Kenneth Kaunda District, it is suggested that future studies focus on health promoters in other contexts and in other provinces in South Africa.

Key words: descriptive statistics, health, health promoters, health promoting schools, health promotion, South-Africa.

OPSOMMING

In die strewe na gesondheid vir almal, is 'n verenigde benadering asook effektiewe samewerking deur belanghebbendes noodsaaklik. Gesondheidsbevorderende skole is sodoende deur die Wêreldgesondheidsorganisasie gekonseptualiseer om beter gesondheidsbevordering-uitkomst te bereik. In die proses om gesondheidsbevordering-status te bereik, is die insette van verskillende belanghebbendes in skole noodsaaklik. Gesondheidspromotors word beskou as 'n gepaste en kostedoeltreffende opsie om welstand in omgewings soos skole te bevorder. Gesondheidspromotors wat werk binne skole, is 'n relatiewe nuwe veld in Suid-Afrika sowel as die Noordwes-Provinsie van Suid-Afrika. Om hierdie rede is daar 'n beperkte aantal studies beskikbaar rakende gesondheidspromotors werkend in skole en veral die profiel van hierdie werkers. Wie hierdie gesondheidspromotors is, en wat dit is wat hulle doen wanneer hulle welstand bevorder, is veral belangrik. Die nasionale en provinsiale regering is afhanklik van gesondheidspromotors om onderwysers en leerlinge op te lei rakende gesondheidsonderwerpe en ook om skoolgemeenskappe te begelei om holistiese welstand te bevorder. Hierdie studie het dit dus ten doel om 'n profiel van die gesondheidspromotor wat werk in skole in die Noordwes-provinsie, Dr Kenneth Kaunda-distrik te skep, ten einde hulle te ondersteun met betrekking tot die sosiale en gesondheids-uitdagings wat hulle mag teekom. Omdat baie min bekend is rakende die profiel van die gesondheidspromotor, is 'n kwantitatiewe studie gedoen met behulp van 13 (11 mans en 2 vrouens) gesondheidspromotors wat werk binne skole in die Noordwes Provinsie, in die Dr. Kenneth Kaunda-distrik. Die "Health Promoter Questionnaire" is ontwikkel om kwantitatiewe data te bekom met betrekking tot die biografiese inligting, opleiding en kwalifikasies, werkbeskrywings, manier van kommunikasie, beplanning, skoolbesoeke, vervoer, ondersteuning, hindernisse en persoonlike gesondheid van die gesondheidspromotor. Data is ontleed met behulp van beskrywende statistiek (frekwensies) om 'n profiel van die gesondheidpromotor in die Noordwes-provinsie, Dr Kenneth Kaunda-distrik te skep. Bevindinge het getoon dat die

gesondheidspromotors hoofsaaklik mans is met relatiewe jong ouderdomme, twee tot drie tale magtig is met matrieksertifikate, maar geen addisionele formele opleiding of ondervinding in gesondheidsverwante onderwerpe het nie. Alhoewel die Departement van Gesondheid verskeie temas as opleiding aan gesondheidspromotors verskaf het, dui hulle aan dat hul onvoldoende kennis in spesifieke gesondheidsbevorderingtemas soos geweldvoorkoming, selfmoordvoorkoming en alkohol- en dwelmvoorkoming besit. Verdere opleiding is veral geïdentifiseer rakende onderwerpe soos die hantering van konflik, beter kommunikasie, rapportering van wangedrag aan toepaslike individue sowel as prosedures om verwysings te maak na professionele dienste. Afgesien van gesondheidsverwante hindernisse soos MIV/vigs, geweld, asook dwelm- en alkoholmisbruik wat gesondheidspromotors in die gesig staar, het ander bykomende struikelblokke soos onduidelike posbeskrywings, onvoldoende beplanning (rotasie-gebaseerde planne en opvolg besoeke aan skole), asook onvoldoende tyd wat spandeer is by skole na vore gekom. Gesondheidspromotors kry ook nie genoeg ondersteuning van die Departement van Onderwys en die Departement van Gesondheid om hierdie hindernisse doeltreffend aan te spreek nie. Die profiel van die gesondheidspromotor sal dus plaaslike en provinsiale regerings ondersteun om programme en planne te ontwikkel om sodoende gesondheid te bevorder en gesondheidspromotors te ondersteun om hul pligte beter te kan uitvoer. Bykomende aanbevelings is die effektiewe opleiding van gesondheidspromotors met betrekking tot die magdom hindernisse wat hulle in die gesig staar, die implementering van duidelike posbeskrywings, asook relevante ondersteuningsdienste ten opsigte van werk en persoonlike probleme. Aangesien hierdie studie slegs gefokus is op die gesondheidspromotors in skole in die Noordwes-provinsie, Dr Kenneth Kaunda-distrik, word dit aanbeveel dat toekomstige studies fokus op gesondheidspromotors in ander kontekste en in ander provinsies in Suid-Afrika.

Sleutelwoorde: beskrywende statistiek, gesondheidspromotors, gesondheidsbevorderende skole, gesondheidsbevordering, Suid-Afrika.

LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
BMI	Body Mass Index
CAPS	National Curriculum and Assessment Policy Statement
CHW	Community Health Workers
CSHP	Comprehensive School Health Program
DBST	District Based Support Team
DoE	Department of Education
DoH	Department of Health
ENHPS	European Network for Health Promoting Schools
HIV	Human Immunodeficiency Virus
HLS	Healthy Lifestyles Programme
HP	Health Promotion
HPS	Health Promoting School
IEC	Information Education and Communication
ISHP	Integrated School Health Policy
IUHPE	International Union for Health Promotion and Education
NCESS	National Committee of Education Support services
NGO	Non-governmental Organisation
NHPPS	National Health Promotion Policy and Strategy
NSNP	National School Nutrition Program
PHC	Primary Health Care
PSPP	Public Schools on Private Property
RDP	Reconstruction and Development Programme
SBST	School Based Support Teams
SGB	School Governing Body
SHEN	Schools for Health Europe Network
SHS	School Health Services
SIAS	National Strategy on Screening, Identification and Support
SSC	Social Sector Cluster
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational Scientific and Cultural Organisation
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
WSCC	Whole School, Whole Community, Whole Child Model

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INTRODUCTION AND ORIENTATION TOWARDS THE RESEARCH PROBLEM

1.1 INTRODUCTION AND CONTEXTUALISATION OF STUDY

This study forms part of a larger multi-phased research project *Moving towards the Health Promoting School in the North West Province: training the health promoter*, that aims to obtain a profile of the health promoter in the North West Province in South Africa. One of the objectives of the larger project is developing and establishing Health Promoting schools in South Africa. Data for the larger research project was gathered by means of a multi-phase data collection method in which qualitative and quantitative data was obtained. The themes that emerged from the qualitative data were discussed by Terburgh (2015). For the purposes of this study, the profile of health promoters that was obtained by means of quantitative questionnaires will be discussed.

To argue the relevance of the profile of health promoters, it is necessary to first understand the importance of healthy children and consequently school health. Childhood health is of utmost relevance as it can be a significant indicator for future

community wellbeing. Childhood and adolescence do not only lay the foundation for future adult health, but also plays an important role in future economic well-being (Langford *et al.*, 2015). It is also a familiar concept that healthy societies and communities support healthy individuals and families which in turn provides room for the society and the individual to realise their full potential (Centre for Disease Control and Prevention, 2010).

Above mentioned inferences can pose as a great threat for the wellbeing of all South Africans. Health disparities in South Africa's population is evident if physical, social and environmental variables like poverty, unemployment, poor housing, working conditions, lack of social support and water pollution are taken into account (Naidoo & Wills, 2009; Van der Hoeven & Kruger, Greeff, 2012). The health differences in South-Africa are therefore problematic as children in disadvantaged communities have a reduced opportunity to develop into healthy adults. The concept of health in schools should therefore not be taken lightly, as there is a direct correlation between healthy children and better educational outcomes (Michael, Merlo, Basch, Wentzel & Wechsler, 2015; Mukoma & Flisher, 2004) which in turn will have a ripple effect on all other areas of human functioning.

Also, the impact of socioeconomic disadvantages during childhood are well documented and confirms a link towards risky health behaviour and poor mental health (Poonawalla, Kendzor & Owen, 2014; Pikhartova, Blane & Netuveli, 2014; Noh, Kim, Oh & Kwon, 2014; Goosby, 2013). Literature correspondingly indicates that childhood maltreatment (physical or emotional) can lead to unhealthy choices and risks for a variety of problems across their lifespan (Smith, Saddleon, Homish, McKee, Kozlowski & Giovino, 2015; Langford, 2015; Heusser & Elkonin, 2013; Easton, 2012). This confirms the ripple effect of childhood disadvantages on all other areas throughout a person's life. The positive side of childhood health is also documented as Mukoma and Flisher (2004) concluded that healthy children achieve better in school and in return have a direct positive outcome on their health later in life.

Since early experiences have an impact on later life, it is evident that schools play a vital and significant role in future public health. The importance of health promoters working in schools can only be validated by evaluating their role and accomplishments together with the role and accomplishments of the health promoting school movement. Health Promoting Schools has become a progressively popular movement internationally as well as nationally to address the health needs of school communities. In a systematic review on Health Promoting Schools it was concluded that these schools have the potential to offer an all-inclusive, sustainable and effective setting for reaching children (Langford *et al.*, 2015). When it is accepted that all children should attend school, Health Promoting Schools can be seen as a logical option where overall health and wellbeing can be strengthened. Schools will be viewed in this study as a central concept that serves as a working destination for health promoters.

1.2 CLARIFICATION OF CONCEPTS

1.2.1 Health

When referring to health the World Health Organisation's definition of health can be regarded as the most used and well known definition of all. They refer to health as "a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity" (WHO: 1984). Viner and Macfarlane (2005) elaborates on this definition by referring to health as a multidimensional concept that consists of physical, emotional, social, spiritual and intellectual components. These definitions are significant as it challenges the general concept of health as only a physical concept and emphasise holistic health in connection with a person's environment.

1.2.2 Health promotion

Health promotion can be viewed as the discipline or art of assisting people to alter behaviour patterns, be more mindful and create environments to increase optimal health (Viner & Macfarlane, 2005). In the Ottawa Charter (WHO: 1986) health promotion is defined as "the process of enabling people to increase control over, and to improve, their health". More recently, the WHO referred to health as a state of

complete 'social, spiritual, physical and psychological health' through the individual's ability to realise their potential, satisfy needs, motivate and cope with changing environments (WHO, 2009). When referring to health promotion in this document, it is imperative to remember that health is seen as a holistic concept and therefore health promotion consist of much more than just the promotion of physical health.

1.2.3 Health promoter

In the literature, the terms health promoter and health worker are used interchangeably. Various authors define the health promoter as "a health worker or community health worker who educates, motivates, and supports the members of the community in their pursuit of health" (Reichschmidt, Hunter, Fernandez, Guernsey de Sapient & Meister, 2006). According to Reichschmidt *et al.*, (2006) health workers are trained personnel which are familiar with the health care system in order to educate, motivate and support the members of a community to select appropriate health-related behaviours.

1.2.4 Health promoting school

For the purpose of this study a health promoting school is seen as "a place where all members of the school community work together to provide students with integrated and positive experiences and structures which promote and protect their health" (WHO, 1999). A health promoting school will include formal and informal curricula to teach students about health within a healthy school setting; provide health services while involving the whole school and surrounding community to promote health (WHO, 1999).

1.2.5 Stakeholder

According to the WHO (2005) stakeholders are defined as persons, groups or institutions with interests in a project or policy or who may be directly or indirectly affected by the process or the outcome. In this specific research, stakeholders are all individuals, organisations and teams responsible for actions in the health promotion process. This will include teachers, student bodies, all other school staff, School

Governing Bodies, School Based Support Teams, the Department of Education, the Department of Health and the wider community including parents, business owners, community leaders (for example: Church leaders).

1.2.6 Community

An increasing number of programmes that strive to increase health promotion or wellness recognise the importance of community engagement and community empowerment (Prilleltensky & Prilleltensky, 2006; Wallerstein, 2006). Rath and Harter's (2010) research can be seen as an extension of these findings as they identified community as one of the five key elements that influences wellness.

The term community has been a subject of debate for a long time given all the arguments present in literature. Dikeni *et al.*, (1996) concluded that a community could consist of any of the following three characteristics: a spatial unit, an economic unit or a unit sharing social and cultural relations. A spatial unit refers to people living in the same area (Selznick, 1996); economic unit refers to people practising parallel financial actions to make a living (Dikeni, *et al.*, 1996); and the last represents people who share a history, knowledge, beliefs, norms, values and customs (Dikeni *et al.*, 1996).

For the purpose of this study, a school is considered as a community in that it shares above mentioned characteristics. A school community also includes the wider public area around the school as these areas also includes above mentioned characteristics.

1.3 PROBLEM STATEMENT

Although several countries agreed to the policies and plans of the World Health Organisation, many still face a number of challenges in executing effective health promotion. South Africa likewise adapted several policies and bills to support health promotion, but numerous obstacles must still be overcome to ensure that health promotion becomes a priority. To bridge these challenges, the Jakarta Declaration (WHO, 1997) identified several priorities which can be pursued when working towards effective health improvement. These priorities include: the promotion of social

responsibility for health, an increase in the investment of health development, the establishing and extending of partnerships in health, the increase of communal capacity, the empowerment of individuals, and the creation of an infrastructure for health improvement.

Even though these priorities were highlighted, the World Health Organisation identified equitable distribution of resources, human rights and social justice as some difficulties in executing these steps in the future of health promotion (WHO, 1997). With South Africa's history taken into account, it is evident that these challenges regarding distribution of resources, human rights and social justice will also have a significant effect on the promotion of health in the country and consequently the North-West province. Taking into account the major obstacles people in the North-West province face regarding poverty, unemployment, health problems, insufficient access to health care and unequal opportunities, places an emphasis on the importance of health promotion and the work of health promoters. The promotion of health should be of great importance to the government as well as provincial government so that the society is kept healthy and contented on all possible health dimensions. To achieve this goal, all role-players (i.e. the government, health promoters, teachers, society, policy makers etc.) should have individually and jointly, a clear understanding of what the concept of health promotion entails and how the practical implementation of it can manifest itself in practice (Denman, 2002; Blake, Poland, Green & Rootman, 2000).

Most schools in South Africa also experience a wide range of health problems that threaten the well-being of young people. These health problems can have a series of reactions due to the interactive relationships between learners, staff and the surrounding community (Burton & Leoschut, 2012; KwaZulu Natal Department of Health, 2011). HIV/AIDS, malnutrition, insufficient nourishment in poor socio-economic areas, violence, teenage pregnancies, domestic violence, bullying, racism, poor economic circumstances which leads to violence and child-headed households

are just a few problems schools in South Africa encounter daily (Burton & Leoschut, 2012:7; Bureau of Market Research, 2012; Cluver, Bowes & Gardner, 2010; Harrison, Xaba & Kunene, 2001; Harber, 2001).

It is thus apparent that a healthy school environment is necessary, where learners can feel safe and secure, and which enables them to learn effectively. According to Morgan and Deutschman (2003) intensive programmes should be established and maintained so that 'learning' can take place effectively. Programmes which train the learners' parents and the society in which they exist to live a more economical and comfortable life will also be beneficial (WHO, 2013).

Health promoting schools can play a major role in addressing the above-mentioned problems and other difficulties in the education domain. Not only can schools influence numerous children and parents at the same time, but schools are also regarded as a place where knowledge, attitudes and behaviour are learnt which will remain throughout a person's life (Naidoo & Wills, 2009:206; Coulson, 2000). West, Sweeting & Leyland (2004:287) investigated differences in schools' health behaviour and concluded that those schools which have a character to engage learners and therefore use a health promotion model are more effective in establishing health.

As indicated in the concept clarification section (see paragraph 1.2.1), mental health is recognised as a part of health. Barry, Clark, Jenkins & Patel (2013:17) determined that mental health promotion can also be integrated successfully into school programmes. These programmes included community empowerment, poverty reduction, HIV/AIDS prevention, reproductive health and sexual health. Schools are accordingly regarded as the basis of opportunity for the promotion of the health of learners, staff and families and the society in which they exist (World Health Organisation, 1998). Strong family and social relationships should be created so that the environment in which the learners learn, live and develop can be maintained (Department of Health, 2003).

It is thus of paramount importance that all the role players in health promotion should provide their optimal support so that the youth of South Africa may utilise all

opportunities that exist, and succeed (Viner & McFarlane, 2005). Health promoting schools can especially be of ultimate importance in the South African context, where inequality and minimal opportunities in the past placed a great number of learners at risk for unhealthy behaviour.

Nyamwaya (2003) and Tossavainen *et al.*, (2004) asserted that there are a number of challenges that need to be taken cognisance of when moving towards a health promoting school. These included the slow professionalism, lack of coherent theory, the lack of clearly defined responsibilities in the training or education of health workers and the fact that the collaboration between the educational and health sectors in health promotion is unclear. The World Health Organization (WHO: 2008) similarly acknowledges health promoter's lack in knowledge, skills and concept application as an obstacle in the achievement of effective health promotion. Wills and Rudolph (2010) confirmed these findings as they identified the "lack of clarity about associated roles, lines of accountability and gaps in competency, skills and training" as obstacles when creating health promoting environments. Health promoters' lack of expertise can therefore be regarded as an immense problem in the implementation of interventions for health promoting schools.

Kwatubana and Kheswa (2014) as well as Morgan and Deutschmann (2003) recognised health promoting staff training and education as a crucial part for implementing health promotion, particularly in resource-poor environments. Health promoters can consequently be regarded as one of the key participants in the successful implementation of health promoting schools. Although health promoters are key stakeholders in promoting health in schools, Coulson (2005) concluded that health promoters are being employed without the necessary training. Similarly, Motlhako (2008) indicates that the majority of health promoters in South Africa, and more specifically the North-West Province are not efficiently trained for the obstacles they encounter in promoting health. According to Motlhako (2008) these health promoters

have challenges to interpret the problems and have insufficient sources, knowledge, skills and training to implement or develop solutions.

There is currently no clear description of the profile or job description of the health promoter in South Africa. It is therefore essential to first have an understanding of the required role which the health promoter has to fulfil in their professional capacity before adequate and effective training programmes can be developed. If the profile of the health promoter is better understood, improved interventions and strategies can be planned to assist health promoters in developing health promoting schools.

Variables such as the nature and extent of their training and skills also need to be investigated to better equip health promoters in the future. Evidence regarding their training, skills and experience will shed light on the problems they experience when fulfilling their role. Although various researchers identified the role of health promoters as one of the problems in achieving health promoting schools, there is no clear indication in the literature of who the health promoter is or what their profile entail. Naidoo and Wills (2009:51) concluded that there is "no agreed consensus on what health promoters do when they try to promote health".

A further problem when investigating the profile of the health promoter is the numerous terms being used when referring to the health promoter. The following terminology have been used: "health workers", "health promoters", "community workers", "promotores", "promotora", "health promotion practitioner" (McDermott-Levy & Weatherbie, 2012; Brandstetter, McCool, Wise & Loss, 2012; Reischmidt, Hunter, Fernandez, de Sapien & Meister, 2006).

A further problem was identified as some researchers use the term health promoter as a professional occupation in itself, while others indicate that nurses, teachers, researchers and members of the community are also health promoters (Naidoo & Wills, 2009; McDermott-Levy & Weatherbie, 2012; Wills & Rudolph, 2010; Van den Broucke *et al.*, 2010). The central problem which emerges is that no clear description exists on the profile of the health promoter working in schools. The need of a profile

for health promoters will contribute to uniformity in policies of different departments to not only prevent confusion but to also confirm a standard focus.

1.4 AIM OF THIS RESEARCH STUDY

In light of the limited knowledge regarding the profile of health promoters the central research question that guided this project was:

What is the profile of the health promoter in schools in the North West Province?

The above question was divided into more specific objectives in order to give added focus to the research process. These objectives assisted the research project to gain a clearer understanding of the health promoter and related dynamics of promoting health in schools. The following objectives provide an indication of the questions included in the Health Promotion Questionnaire:

- To understand the nature and extent of the training and qualifications of the health promoters in the North-West province;
- To determine if an official job description of the health promoter in terms of the schools exists and a better understanding of work conditions;
- To determine the possible methods of communication and planning that are being utilised by the health promoters;
- To determine the nature and scope of the support needed, and received by the health promoters, in order to execute their health promoting activities in schools, and
- To determine the perceived barriers and challenges of the health promoters that might impact negatively on the execution of the health promoting activities in schools.

1.5 RESEARCH METHODOLOGY

1.5.1 Data collection

In quantitative research, certain features of a phenomenon and not the phenomenon itself are being measured (Delpont & Roestenburg, 2011). The quantitative data collection method that was used for this research was therefore to measure certain properties relevant to the role of health promoters. The method chosen describe abstract concepts in terms of numbers or symbols in accordance with specific rules (Monette, Sullivan & De Jong, 2008). An extensive research questionnaire was developed to achieve this aim. This Health Promoter Questionnaire will be discussed in detail in Chapter 4.

Babbie (2007) defines a questionnaire as “a document containing questions and/ or other types of items designed to solicit information appropriate for analysis”. The objective of the questionnaire was to obtain facts and opinions about the profile of health promoters consisting of the following variables: biographical data, training, training needs, ways of communication, language, work demands, planning, transport, support, barriers and personal health (Delpont & Roestenburg, 2011). The questionnaires were administered individually where each participant completed their own document.

1.5.2 Data analysis

A qualified statistician was employed to provide professional guidance and advice in the proper conceptualisation, design and identification of themes before conducting the research in order to facilitate data analysis. The statistician provided expert advice on selecting relevant instruments and analysis procedures.

Conclusions were made by quantifying the answers of the questionnaire and by using descriptive statistics to obtain a profile of the health promoters. According to Creswell (2012) the literature review and main objectives of a study should be taken into account when analysing data. The literature review provided different themes that guided the design of the questionnaire. Every theme had a number of questions in

order to provide significant/relevant responses regarding the role of health promoters. These themes were used to formulate further investigations and develop possible training programmes for executing effective health promotion strategies in the North West Province. The validity of conclusions that was made was cross-referenced with existing literature.

1.5.3 Reliability and validity

The instruments used in quantitative research are of central importance for ensuring reliability and validity (Nieuwenhuis, 2010). Reliability refers to the accuracy and the consistency with which a questionnaire measures (Polit & Beck, 2010). In order to ensure the face validity and construct validity of the questionnaire the questionnaire was submitted for peer review to confirm that the questionnaire measures what it is supposed to measure (Polit & Beck, 2010). When designing the questionnaire, an expert statistician was employed to ensure that all possible measures were taken to confirm reliability and validity.

1.5.4 Ethical considerations and procedure

Strydom (2011) states that researchers who do not execute research ethically are negligent towards society. Ethics should be taken into consideration throughout the research process (Creswell, 1998; 2009). An ethical code of conduct should apply to the research problem, purpose and questions, data collection, data analysis and interpretation and in the writing and distributing of the research (Creswell, 1998; 2009).

The researcher was very mindful of these ethical considerations throughout the research process. Great care was exercised in assuring ethical conduct by considering the following topics highlighted by (Strydom, 2011):

- By all means avoid possible harm to participants and all other persons involved in the research;
- Ensure that all participants participate voluntarily and that they are aware;
- Acquire written informed consent from all participants;

- Avoiding deception of subjects and/or participants;
- Ensure the privacy and confidentiality of all involved, and
- Ensure that the researchers' behaviour is ethical and that they are competent.

Considering above mentioned ethical guidelines, all stakeholders were informed of the planned research process. The identified participants were being asked for their written informed consent and all relevant information regarding the process, confidentiality, voluntary participation and withdrawal at any given time was discussed.

The participants were recruited through a manager of the Department of Health in the North West Province, specifically in the Dr. Kenneth Kaunda District. Informed consent forms were made available to the participants in order for them to study the consent form and ask any questions if needed. On the data gathering day the researcher informed the participants as to what the research will entail, and what was expected of them before they gave written consent to participate in this study.

It was also explained that the participation in this study will be voluntary and that participants can withdraw from the research at any time without any prejudice. The informed consent form also indicated that anonymity and confidentiality was ensured. The informed consent also indicated that the participants' identifiable information and the data will be kept in a safe place in the Faculty of Education Sciences at the North West University where only the primary researcher and assistants will have access to it for a period of five years. Furthermore, great care was exercised in assuring ethical conduct by all means avoiding possible harm to participants and avoiding any deception of the participants.

1.6 CONTRIBUTION TO RESEARCH FIELD

As indicated by the research problem, it is evident that health promoting schools have an impact on learners, as it enables them to enjoy physical, psychological and social well-being. Stewart and Wang (2012) concluded that health promoting schools are favourable in building school staff and learner's resilience. Health promoting schools

also have a wider impact as it creates parental and community input and support (WHO, 2005). Parents and community members are influenced as they are gaining broader knowledge about local health problems, learning important and new health information and health literacy skills and taking part in their children's education. Although research is available on how to create health promoting schools, the research problem also indicated that there is currently no health promoting schools in the North West Province. This research hopefully will add relevant knowledge to better understand the role of the health promoter and why they currently struggle to create health promoting schools. The research will expectantly shed light on the training needs and other problems that health promoters may encounter. This new knowledge can then be used by the Department of Health and the Department of Education to collaborate to develop training, strategies and policies to support and to manage health promoters in creating health promoting schools in the North West Province.

The National Health Promotion Policy and Strategy (NHPPS) for the term 2015-2019 proposed collaboration with academic and research institutions to integrate research into health promoting programmes as one of their key goals to strengthen and monitor the health promotion initiative (Department of Health, 2014). It is the researcher's opinion that this specific research based on the profile of the health promoter is one of the priorities in this field in order to enhance the effectiveness of health promoters by creating health promoting schools.

The World Health Organization (2000) suggests that health promoting schools contribute to economic development as well as contribute to the guaranteeing of fundamental human rights. When health promoters are more effective, healthy school environments can have an impact on local businesses as more productive employees will be produced.

1.7 STRUCTURE OF REPORT

This research report is structured in five chapters as set out below.

CHAPTER 1: Introduction and orientation towards the research problem

CHAPTER 2: Health, health promotion and Health Promoting Schools

Chapter Two will offer a detailed overview of literature regarding health, health promotion and Health Promoting Schools. This review will include the development of health, health promotion and health promotion schools both globally as well as nationally. The current scenarios as well as movements used in health promotion will also be reflected. In addition, the potential benefits and limitations of Health Promoting Schools will be highlighted.

Lastly, the need for Health Promoting Schools in South Africa will be argued, followed by an overview of the theoretical underpinnings of health promotion.

CHAPTER 3: Health promoters

Chapter 3 will give a review of the current national and international literature regarding health promoters and especially health promoters working in schools. Different studies will be examined for results including individual studies, systematic reviews and meta-analyses.

CHAPTER 4: Research methodology

Chapter 4 presents the methodological framework of this study. An overview of the key methodological and ethical considerations are presented with a clear description of the design and specific methodological approaches.

CHAPTER 5: The profile of the health promoter: a quantitative investigation

Chapter 5 presents the findings from the administered Health Promoter Questionnaire. These findings are collated for purposes of a systematic analysis to identify specific factors within literature about health promoters as well as new emerging data.

CHAPTER 6: The profile of the health promoter in schools in the North West Province: a synthesis

Chapter 6 provides a synthesis of the findings emanating from the research project and summarises the key findings of the profile of the health promoters.

The strengths and limitations of the study are also presented and concludes with some key recommendations for the future research aimed at empowering health promoters.

1.8 CONCLUSION

The main goal of this chapter was to provide an introduction and contextualise of the research project. The aim, research question and objectives of the study were also formulated. Key concepts were clarified and a broad overview of the methodology and ethical considerations used in this study, was given. It also provided an outline of the structure of the research report and what is to be expected. Chapter 2 is the first of two chapters providing a literature review about health, health promotion and Health Promoting Schools.

HEALTH, HEALTH PROMOTION AND HEALTH PROMOTING SCHOOLS

2.1 INTRODUCTION

Health promotion is a worldwide undertaking where an increasing number of policy makers and governments are actively taking part in. The health promotion movement aims to use a comprehensive approach where physical, mental, social and spiritual health of whole communities is being advanced since individuals face ever-increasing health issues. Another growing trend in wellbeing and health of individuals is the acceptance of a school's role in reaching individuals and their families. In order to effectively close the gap in health differences and implement health promotion in schools, a clear understanding of health and health promotion is needed.

The purpose of this chapter is to give an overview of the concepts health and health promotion and to explore the global and national need for health promotion in schools. The current scenario of health promotion in schools in South Africa is outlined by investigating the need and effectiveness as well as challenges in Health Promoting

Schools. The theoretical underpinning of HP is correspondingly examined to get a better understanding of health and health promotion as holistic concepts.

2.2 HEALTH: DEVELOPMENT AND CONCEPTUALISATION

Health is regarded as a concept with multiple interpretations as society ascribes a variety of definitions to health. The World Health Organization elaborated on health by identifying it as a relative concept since people ascribe different meanings to it (WHO, 1985). It is thus of importance to have in mind that people, cultures and professions ascribe their own subjective meanings to what health is for them.

Traditionally, the term health has been defined by medical terms since the medical model of disease prevention and treatment was dominant (Shah & Mountain, 2007). The view of health as only a medical concept led to researchers concluding that the Western science's view of health "leads to narrow analyses of disease causality and limited proposals for prevention policy" (Tesh, 1988).

In the 1970's there was a change in the way policy makers and health professionals treated or thought about health. The shift occurred by moving away from treating diseases through medical practices towards preventing diseases by means of the identification of groups at risk to develop disease (Beaglehole & Bonita, 2004; Naidoo & Wills, 2009). More emphasis was placed on groups and social functioning as the ability to adhere to demands in the social environments as well as the fulfilment of personal potential were acknowledged (Tones & Tilford, 2001).

The WHO emphasised health as a resource with special emphasis on social and personal resources (WHO, 1986). The WHO extended on this movement by identifying the promotion of health as an act that goes beyond health care to the individual's regulation of health (WHO, 1986). As a result, the focus shifted towards educating people on behaviour in order to avoid risks and by making better decisions.

Accordingly, the term "*health education*" is still used when referring to some health promotion interventions (Naidoo & Wills, 2009).

In recent decades there was an even bigger movement towards holistic wellness rather than just defining health as the absence of disease. Viner and Macfarlane (2005) for example, referred to health as a multidimensional concept that consists of *physical, emotional, social, spiritual* and *intellectual* components. The World Health Organisation correspondingly emphasises holistic wellness as they define health as "*a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity*" (WHO, 2001).

However, this definition implies that an individual with less than perfect physical, social and psychological functioning is not healthy (Lucas & Lloyd, 2005). A more inclusive and multidimensional definition is therefore required. Lucas and Lloyd (2005) agree with Viner and Macfarlane's (2005) multidimensional concept as they included all concepts described above into their definition of health. These concepts include physical, mental and social functioning in agreement with a person's potential. The WHO further elaborates on psychological health as *a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community* (WHO, 2001:1).

From the above-mentioned definitions, it is clear that health is a multi-dimensional concept which addresses the person as a whole. These dimensions described below are similarly identified by Viner and Macfarlane (2005) and O'Donnell (2009) as diverse health zones to function in dynamic balance in order for a person to be believed as being healthy:

- **Physical health:** optimal physical wellness includes fitness, nutrition, strength, vitality, medical self-care as well as the responsibility of individuals to take care of minor illnesses and when to seek professional assistance;

- **Emotional health:** this area recognises the need to feel positive and enthusiastic about life while using stress management techniques to maintain balance. It also includes self-esteem, self-control and the management of ones' feelings;
- **Social health:** this dimension encourages active contributions and participation with family, friends and the wider community by building valuable relationships;
- **Intellectual health:** ones' education and development through creative stimulating mental activities to reach individual potential. It also includes the ability to think clearly and logically;
- **Spiritual health:** this dimension encourages love and charity as well as the search for meaning and purpose in life; developing a belief system, values and a world-view. Spiritual health also serves to encourage values such as patience, perseverance, kindness, compassion, hope and joy all virtues important for health (Culliford and Powell, 2005), and
- **Occupational health:** The occupational dimension refers to individual fulfilment and to ascribe meaning towards work by using an individual's own gifts, skills and talents (Hettler, 1976).

Figure 1 illustrates the different health dimensions, nested within an individual's personal potential (Lucas & Lloyd, 2005; Viner & Macfarlane, 2005). The illustration also clearly demonstrates the equal importance of every dimension of health and that no single dimension can be regarded as more important than any other dimension (Viner & Macfarlane, 2005).

Health should thus be seen as numerous factors which enable an individual to achieve their full potential and therefore incorporates all areas of human existence (Lloyd, 2005). The different definitions of health and the inclusion of various dimensions are significant to health promotion. The inclusion of the different dimensions of health challenges the general concept of health as only a physical concept, and emphasises

holistic components in connection with a person's potential and total being. The term health in this study will therefore be viewed as a holistic concept with the emphasis on enabling factors and a person's control over their health (Davies & Macdowall, 2006).



Figure 1: Dimensions of health adapted from Hettler (1976); Lucas and Lloyd (2005); O'Donnell (2009) and Viner and Macfarlane (2005)

2.3 HEALTH IN THE SOUTH AFRICAN CONTEXT

Globally and nationally health is regarded as a basic human right (Constitution of the Republic of South Africa, 1996; Department of Health, 2014). The Department of Health has therefore been mandated to improve and promote health, and adopted an ecological framework to address health differences and to improve health in South Africa. The ecological framework recognises the interrelated relationships and influences between individuals, family, communities and behaviours (Bronfenbrenner, 1979). The National Health Promotion Policy and Strategy (2014) accordingly included the socio ecological model in their pursuit to accomplish social and behavioural change in health (Department of Health, 2014). This model, similarly to

Bronfenbrenner's ecological framework, recognises health as influenced by various dimensions within an individual's life including factors such as income, gender and social equality together with peer networks (Department of Health, 2014). These factors can all either enhance or hinder health outcomes (WHO, 2014, Department of Health, 2014). Figure 2 below represents a visual illustration of the socio ecological model.

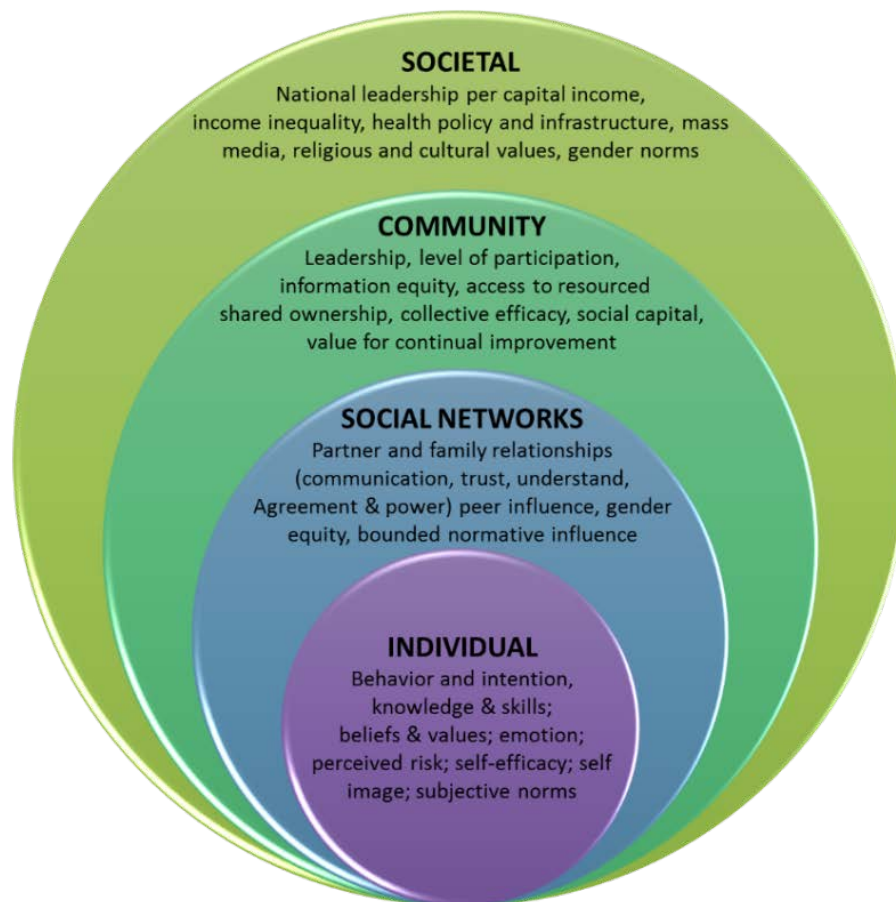


Figure 2: WHO Ecological framework adapted from WHO (2014) and DoH (2014)

Recognising the socio-ecological model within South Africa's health promotion initiative seems inevitable as communicable diseases aren't spread only due to lack of knowledge, attitudes or social and cultural norms, but are also influenced by unequal living conditions and gender inequalities (Department of Health, 2014).

As early as 1989, Kickbusch stipulated that "self-care actions do not take place in a political or societal vacuum" (Kickbusch, 1989). In the contextualising paragraph

(Chapter 1 paragraph 1.1.1) it was mentioned that risk-taking behaviour is influenced by social, economic and environmental circumstances and therefore health behaviour does not only take place on individual level but also on a societal level. Kickbusch similarly elaborated that the health and well-being of an individual is created by their social relationships (Kickbusch, 1981). The development of health promotion in South Africa can therefore be viewed as a positive movement towards health as health promotion programmes focus on social, economic and environmental levels.

2.4 THEORETICAL PERSPECTIVE UNDERPINNING HEALTH PROMOTION

The previous paragraphs aimed to give an overview of the concept health as it appears in literature. Since health is such a complex concept with numerous definitions in diverse research fields, it is important to address the theoretical underpinnings of health research in the health promotion setting. Moore, Haines, Hawe and Shiell (2006) suggest that health research could be more advantageous when seen through a social network perspective as it gives an all-inclusive understanding of community practises. Social relationships within a community provide unique networks and thinking strategies to not only access health resources but also activate preventative strategies through community involvement (Eckermann, Dawber, Yeatman, Quinsey & Morris, 2014; Moore *et al.*, 2006).

The WHO strongly supports an all-inclusive holistic approach towards health promotion as community engagement and partnerships between all stakeholders are seen as integral parts of health promotion when combined with health education curriculum and ethos of the school (St Leger, 2006). This holistic approach towards health promotion is reinforced by Bronfenbrenner's ecological systems theory as the achievement of health promotion proves to be more effective in communities like school settings where interrelated networks were taken into account. Health is thus a consequence of different interactions or lack of interactions between a person and their environment (Kok, 2004).

The different ecological systems (Bronfenbrenner, 1979) in which an individual function is set out below and illustrated in Figure 3:

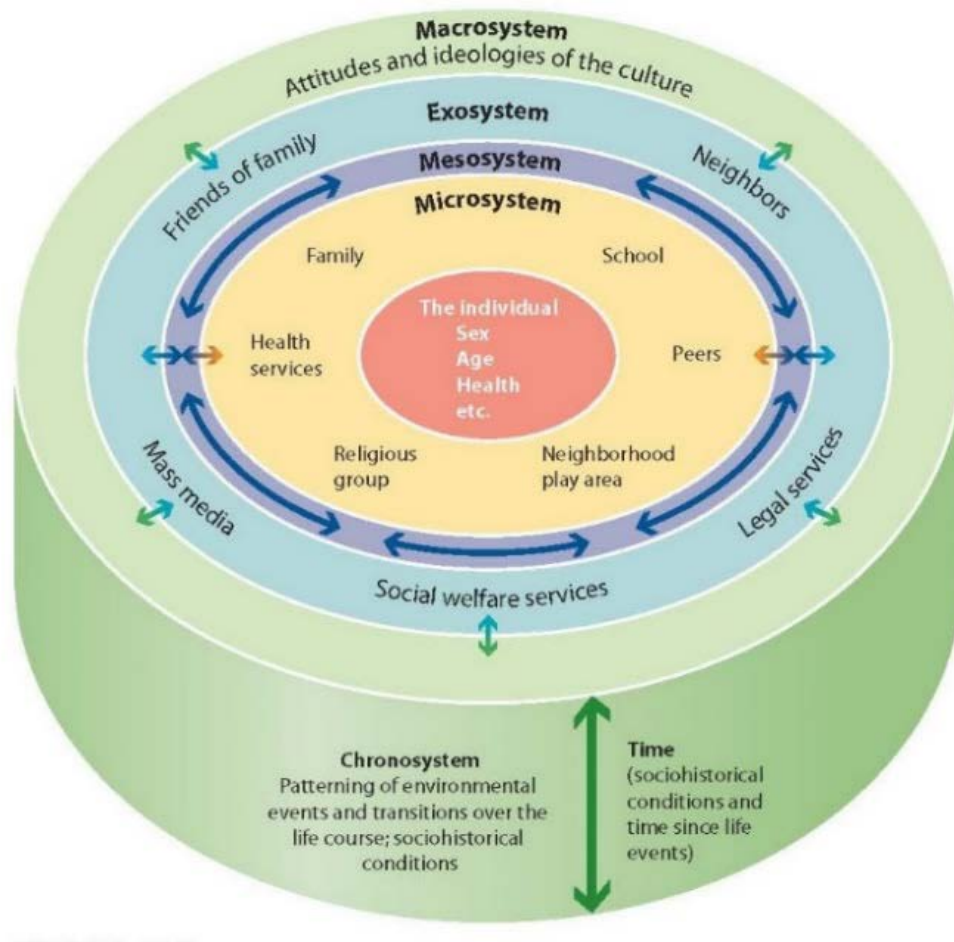


Figure 3: Bronfenbrenner's Ecological Theory extracted from Santrock (2011)

- Microsystem:** This system represents the individual's immediate surroundings and relationships where he spends most of his time (Bronfenbrenner, 1979; Santrock, 2011). This will include all direct exchanges with people, and their thinking (Boon, Cottrell, King, Stevenson & Millar, 2011). Therefore, these connections are considered the intimate relations which orientate the individual (Bronfenbrenner, 1979). Although these relations orientates an individual, they is not viewed as a passive entity in his micro-system, but interacts with others and adds experiences to their own microsystem (Santrock, 2011).

- **Mesosystem:** This represents the interrelationships or links between different microsystems of the individual (Boon *et al.*, 2011). Connections or the lack of networks between parents and teachers or health promoters and teachers will be an example of this level.
- **Exosystem:** This level represents interactions where an individual doesn't directly deal with, but still has an impact on their life (Boon *et al.*, 2011). Practical examples will include the school governing board and their duties which will have a strong impact on the quality of a school and therefore indirectly support or hinder a child's development (Santrock, 2011).
- **Macrosystem:** The macrosystem includes the cultural make-up of the society in which an individual lives (Boon *et al.*, 2011). Cultural viewpoints on politics, customs, cultural values, economy, government and media will all be situated in this sub-system (Bronfenbrenner, 1977).
- **Chronosystem:** This represents the socio-historical condition in which a child develops and changes with generations. Currently children are exposed to more technology than their parents or grandparents were and therefore lead a very different life (Santrock, 2011).

Support for the ecological systems theory applied to health promotion can be found in the literature on health and health promotion in schools (Langford *et al.*, 2014). Paat (2013) correspondingly argues the importance of a holistic theoretical perspective as individuals do not exist as separate entities but are in constant relations with other people and organisations which in return are in contact with additional relations. It is apparent that all sub-systems within a school should be taken into account when changing to become effective Health Promoting Schools. The interconnectedness and interdependence of Bronfenbrenner's theory can also be seen in Kwatubana and Kheswa's (2014) research as the negligence of health promotion can have a negative effect on academic achievement and in turn have a ripple effect on other areas of wellbeing of a school. Interconnections can also clearly be seen in the effectiveness of

the National School Nutrition Programme of South Africa. Since the implementation of the NSNP not only did it improve physical health and alleviate short term hunger of learners, but it also had a direct influence on academic achievement as punctuality, school attendance and concentration heightened (Kwatubana & Kheswa, 2014).

Extending the ecological perspective to this study can be beneficial as health promoters interact in complex systems which co-exist in associations with other systems. This indicates that health promoters are placed at the centre of their own micro, meso, macro and exosystems which interconnects with all stakeholders in the health promotion domain's sub- systems. The relevance of the ecological models is thus apparent as it incorporates a holistic view of health promotion within a complex structure and connectedness with different environmental factors whilst also focusing on personal factors (Whitelaw *et al.*, 2001).

Lohrmann (2010) likewise, created an ecological model for School Health Programmes shown in Figure 4. This model integrates the systems in Bronfenbrenner's model, the Health Promoting School's goals and the aspects influencing school environment to present a clear picture of how a health promoting school can have an effect on a child's environment (Lohrmann, 2010).

Additionally, Lohrmann (2010) suggests that stakeholders can have an impact on the extent to which schools address wellbeing of learners as seen in the outer shapes of Figure 4. The six smaller circles within the model represents the services and curricula (health education, physical education, food and nutrition services, counselling and social services, employee wellness, health services) provided to learners and staff. The concentric rings around these smaller circles represents (1- inner ring) the healthy school environment, (2- second ring) governance structures of health promotion, (3- third ring) school infrastructure and (4- fourth ring) family and community participation.

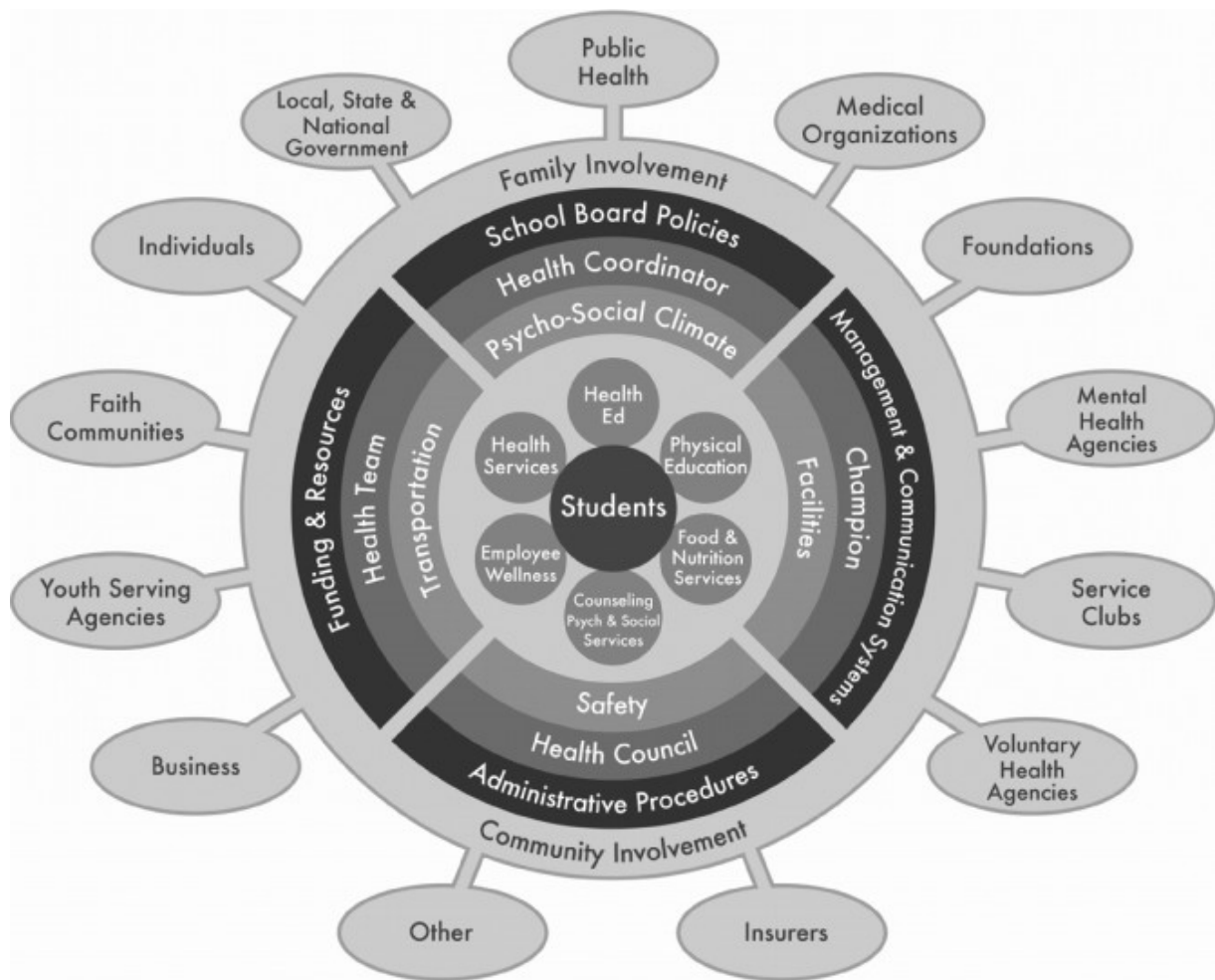


Figure 4: Coordinated School Health Programme ecological model extracted from Lohrmann (2010)

The model is particularly relevant for this study as it shows to what extent different stakeholders (for instance health promoters) and the interrelatedness to other settings can have an impact on effective health promotion (Lohrmann, 2010). The model is particularly relevant for this study as it demonstrates the extent of the impact different stakeholders (for instance, health promoters), and the interrelatedness to other settings can have on effective health promotion.

2.5 DEVELOPMENT OF HEALTH PROMOTION

From the literature, it is evident that the promotion of health is continuously developing as countries; policy makers and researchers are focusing on concepts such as resilience, mindfulness and building the capacity for health promotion (Lee &

Stewart, 2013; Compton, 2005). As mentioned above the health promotion model aims to empower individuals and their communities to take control of and improve their own health and well-being (WHO, 1986). Health promotion movements led policy makers to focus on building people's skills in managing all aspects of life and emphasising settings rather than individuals (Oliver & Peersman, 2001).

To better understand and elaborate on the meaning and purpose of health promotion, it is necessary to consider the origin and development of health promotion. The World Health Organisation (WHO) played a significant role in the promotion of health by creating awareness and designing policies to assist numerous countries towards health. The initial development of health promotion initiative was launched in Canada and driven by the *Lalonde Report* (1974), which focused on preventative measures and promoting health in general (Edmondson & Kelleher, 2000), thus confirming the movement away from viewing health through the medical model. Later, other studies supported this report by similarly suggesting that health is not simply biological but also encompasses environmental, biological and lifestyle factors as well as health care services (Edmondson & Kelleher, 2000; O'Donnell, 2009; Viner & Macfarlane, 2005).

In the early 1980's health promotion was even further articulated because of the growing dissatisfaction of health policies and strategies which was focused on the delivery of medical care (WHO, 1986). A further contribution towards the development of health promotion was the escalating costs of medical care (WHO, 1986). In 1986 the World Health Organisation held its first international conference during which they identified specific actions for health promotion in the *Alma Ata Declaration* (WHO, 1986). A number of countries accepted these actions and at the next international conference, it was evident that health promotion could be effective (WHO, 1997). Various policies and documentation followed to direct the WHO's Global Health Initiative on improving and supporting health and wellbeing. These documents serving as guidelines are summarised below:

- **Alma Ata Declaration (WHO, 1978)**

Health promotion was advanced due to this declaration's acknowledgment of primary health care as a crucial step in attaining a healthy population (WHO, 1986). One of the key aims of the conference was promoting health of individuals and groups through community settings (WHO, 1986). Most significant for South Africa was the conference's emphasis on creating equity together with economic and social development (Tones & Tilford, 2001). Also, relevant for South Africa was the Alma Ata Declaration's statements that these inequalities are politically, socially and economically unacceptable (Tones & Tilford, 2001). Even more relevant for the South African context is the Alma Ata Declaration's statement that all people have the right to participate as individuals or as groups to make plans regarding their health (Tones & Tilford, 2001).

- **Ottawa Charter for Health Promotion (WHO: 1986)**

The Ottawa Charter was concluded at the First International Conference on Health Promotion. The Ottawa Charter was significant for the creation of health promotion as it included more practical steps in achieving health progress and on achieving 'Health for All by the year 2000 and beyond' (WHO, 1986). Jones and Furner (1998) highlights the Ottawa Charter's call on creating health as well as preventing health problems by empowering individuals to make controlled decisions about their health. These actions were oriented towards *building healthy public policy; creating supportive environments; strengthening community action, developing personal skills; and a reorientation of health services* (WHO, 1986). The Ottawa Health Charter defines health promotion as *the process of enabling people to increase control over, and improve their health* (WHO, 1986).

- **Adelaide conference on Healthy Public Policy (1988)**

During the Second International Conference on Health Promotion the relevance of the Ottawa Charter was reaffirmed. The main focus of the conference was to move

governments into creating economic, social and health policies to promote health (Tones & Tilford, 2001). During the conference, it was also affirmed that health is a fundamental human right and a social investment (Edmondson & Kelleher, 2000). The obligation of equity in health was stressed together with public policy to improve women's health (Tones & Tilford, 2001). Particularly relevant for this study was the acknowledgement of creating supportive environments during this conference (Edmondson & Kelleher, 2000) as schools can be seen as such a setting.

- **Sundsvall Statement on Supportive Environments for Health (1991)**

This statement highlights the importance of a supportive environment and the interdependency between environment and health. The emphasis was placed on sustainability and the influences human development has on the environment and consequently the influences on health quality. The conference further emphasised the active engagement of people to make environments more supportive for health (WHO, 1999). Although the document doesn't directly refer to schools, it does state that solutions should come from sectors such as education as it can complement the creation of supportive environments (WHO, 1991). The Conference further focused on education, food and nutrition, home and neighbourhood, work, transport and social support and care (Tones & Tilford, 2001).

- **Jakarta Declaration for Promoting Health (WHO,1997)**

This conference was significant as it was the first conference held in a developing country and involving the private sector (WHO, 1999). The focus of the Jakarta Declaration was to create health promotion programmes which could be implemented and maintained (Jones & Fruner, 1998:1). The Jakarta Declaration encouraged this initiative by calling for actions from different international and national sectors to *promote social responsibility, increase investments in education, consolidate and expand partnerships, build community capacity, empower individuals and secure an infrastructure for health promotion through settings like schools* (WHO, 1997) and thus placed health promotion at the centre of health (Edmondson & Kelleher, 2000). The

conference thus called for governments to support networks for health promotion by reflecting on health promotion and re-evaluating strategies to promote health (WHO, 2009). These actions empowered the individual and secured an infrastructure for health promotion (Tones & Tilford, 2001).

- **Fifth Global Ministerial Conference, Mexico (2000)**

During this conference (Health Promotion, Bridging the Equity Gap), various cases displayed the potential of health promotion. The main themes in these presentations were the empowerment and strengthening of previous disadvantaged communities with a strong focus on environmental health (WHO, 2000). South Africa, together with other countries, signed this statement by declaring action to implement strategies to bridge the gap in health (WHO, 2000; Department of Health, 2014).

The key issues that were discussed during this conference included the reaffirmation of health promotion as a relevant action in addressing health challenges “by enabling people to take action” (WHO, 2000). The holistic understanding of health was also highlighted in that health involves different determinants and that the equity gap in health should be overcome by considering strategies to do so (WHO, 2000). It was also concluded that health promotion was based on scientific method and strategies and that health promotion is socially relevant (WHO, 2000).

Lastly, the case studies presented at the conference were an eye-opener for the mobilisation of financial, material and human resources to ensure effective health promotion (WHO, 2000).

- **Sixth Global Conference for Health Promotion in a Globalized World, Policy and Partnership for action (WHO, 2005)**

At the sixth global conference held in Bangkok it was established that health promotion had proved to be an effective strategy and that it should be fully exploited by health sectors to accomplish health for all (WHO, 2005). It was also established that since the execution of the Ottawa Charter that many entities signed pledges in support

of health promotion but that not all of them acted on these pledges (WHO, 2005). Therefore, a call for a global pledge to take action was specified by re-instating the Ottawa Charter for health promotion by including the private sector, government, politicians, civil society and international organisations to implement this health promoting actions (WHO, 2005).

- **The Nairobi Call on Action on Health and Development (2009)**

During the conference in Nairobi the following actions were identified for health promotion: Firstly, there was a call for renewed focus on capacity building for health promotion. This included the strengthening of leadership, securing reasonable financial resources, developing health promotion practitioners' skills (including health promoters), and improving tools and methods for interventions as well as the improvement of the management and monitoring of performance.

Secondly, the strengthening of health promotion interventions through the integration with health systems was proposed. This would be done through the strengthening of leaderships, enhancing policy (for example prioritising programmes such as HIV AIDS) and by ensuring access for all.

Thirdly, collaboration through partnerships and intersectoral action was emphasised by strengthening leadership, enhancing policy and implementation and by building and applying evidence. Next, it was established that communities should be empowered through community ownership and by developing sustainable resources.

Lastly, it was concluded that health literacy is an important part of health promotion and that actions to enhance health literacy should include the provision of supporting empowerment and embracing information and communication technologies (WHO, 2009).

- **The Helsinki Statement on Health in All Policies (WHO, 2013)**

The conference held in Helsinki mandated re-focuses on actions stipulated in the Alma Ata Declaration and the Ottawa Charter. The conference subsequently focused on governments to take responsibility to prioritise health and equity (WHO, 2013).

- **9th Global Conference on Health Promotion: Shanghai Declaration on promoting health in the 2030 Agenda for Sustainable Development (WHO, 2016)**

This conference held in Shanghai recognised the Ottawa Charter for Health Promotion as a compass for future health promotion programmes and actions. This declaration made it clear that bold political choices should be made for health and that health inequities require political action across sectors. It further stated that a global joint action is needed where no one should be left behind. To accomplish this, governments have an accountability to address economic policies particularly those regarding unemployment and unsafe working conditions. A call was also made on business leaders to not put profit above peoples' health. Lastly, it was recognised that communities are significant settings for health promotion and that health literacy should empower and drive equity.

An additional document constructed by the World Health Organisation about health promotion is the *Expert Committee on Comprehensive School Health Education and Promotion* (WHO, 1997). This document sanctions recommendations to advance health as well as education through schools. (WHO, 1997). The main aim of this committee was to establish more schools that can be labelled as Health Promoting Schools (WHO, 1997).

As demonstrated above health promotion is a very broad concept which encompasses various dimensions, ideas and actions. Currently there is no agreed upon definition for health promotion, but cited definitions in literature all have corresponding elements. For the purpose of this study these elements were combined to create the following

definition: Health promotion is the action of empowering people with control, resources, support, equity and healthy environments in order for them to be mindful in making choices for optimal physical, mental and social well-being (WHO, 1986; WHO, 1997; Viner & Macfarlane, 2005; Naidoo & Wills, 2009).

Ewles and Simnett (1999) developed a framework which outlines health promotion activities. These activities include: preventive health services (primary, secondary and tertiary), community-based work, organizational development, healthy public policies, environmental health measures, economic and regulatory activities as well as health education programmes. Ewles and Simnett (1999) further stipulates that health promotion activities do not always fall into specific categories as mentioned above and that health promotion does not always occur during deliberate activities but sometimes occurs informally.

The development of health promotion as seen in above mentioned conferences and policies is a well thought out and documented concept with its main aim optimal health for all. The necessity of health promotion is practically self-explanatory given health inequities as well as the occurrence of diseases and other factors influencing optimal health. The WHO's view of health promotion as an activity that takes place in supportive environments through community participation (Dennill & Rendall-Mkosi, 2012) places the emphasis on a setting like schools where children of all ages can be reached through community participation.

2.6 HEALTH PROMOTION IN SOUTH AFRICA

South Africa first joined the health promotion movement led by the WHO in 1990 (Onya, 2007). The first indication of health promotion in a policy appeared in the African National Congress (ANC) health policy document (Coulson, 1999). The newest policy regarding health promotion in South Africa was conscripted and released by The Department of Health in 2014. Currently, Health Promotion is located within the Social Sector Cluster (SSC), Primary Health Care (PHC) and the Nation Department of Health (DoH) (Onya, 2007). Service delivery is the responsibility of the national,

provincial and local governments with funding for health promotion coming from the Department of Health (Onya, 2007).

The National Health Promotion Policy and Strategy underwrites South Africa's re-commitment towards long and healthy lives for all South Africans (Department of Education, 2014). This document summarises the strategy for the term 2015-2019 by clarifying the role of health promotion at national, provincial and district levels and clarifying service delivery by other stakeholders (Department of Health, 2014). The Integrated Health Policy together with the National Health Promotion Policy and Strategy equally emphasises the need for collaboration between different departments and other stakeholders to prioritise service delivery (Departments of Health & Education, 2012, 2014)

The structure for health promotion delivery consists of a directorate in the National Department of Health specifically allocated for health promotion with the nine provincial governments employing further health promotion coordinators (Wills & Rudolph, 2010). Extended programmes for health promotion services are provided by non-governmental organizations (NGO's) such as Soul City and LoveLife (Wills & Rudolph, 2010).

Although there are various initiatives to promote health in South Africa, there are still some challenges in different sectors that create a barrier to promoting health. The Department of Health (2014) accordingly argues that key social, behavioural and structural determinants of health need to be addressed in order to relieve the health burden people face daily. Before these social, behavioural and structural influences can be addressed, an agreed upon definition of health promotion is thus needed to focus stakeholders' attention on their responsibilities.

The National Health Promotion Policy and Strategy defines health promotion as a *"diverse range of concepts related to health education; communication for social and behavioural change; information, Education and Communication (IEC); Social marketing; advocacy; and social and community mobilisation"*. To reach these goals

set out in the Department of Health's definition, the focus for health promotion interventions should include the following audiences (Department of Health, 2014):

- **children under five years**, with a focus on promoting better health for children;
- **women of child bearing age**, with a focus on creating awareness on services available to women of child bearing ages;
- **men**, with the focus on promoting a change in gender norms and values by encouraging broader involvement in health issues;
- **youth**, with a focus on addressing risky behaviour and promoting healthy lifestyle practices;
- **older people**, with a focus on community-based programmes and support groups to promote regular health and self-management of chronic health conditions; and
- **marginalised populations**, with a focus on the specific health needs of this target audience, and

A few barriers in the health promotion movement in South Africa have been established. These barriers include inadequate research and evaluation of health promotion existing in the South African context; scarce trained health promotion professionals to notify policy makers concerning relationships between health determinants; evidence regarding health promotion in relation to economic and political effect are absent; and standards and norms regarding health promotion education and training are lacking (Onya, 2007).

As stipulated in Chapter 2 paragraph 2.4, health promotion forms part of wider ecological networks of relationships with different individuals, groups and organisations. The NHPPS recognises health promotion as an action which impacts the individual as well as social and community networks, norms and attitudes (Department of Health, 2014). This view of the Department of Health is pleasing as it indicates a shift in direction where services to individuals and communities receive priority. The

progress and improvements set out by the NHPPS would be significant as Onya (2009) indicated that health promotion services were still not a priority of the Department of Health back in 2009.

2.7 SCHOOLS AS SETTINGS FOR HEALTH PROMOTION

A settings approach for health promotion is popular as it promotes health within a social context. A settings approach redirects its goal away from treating illnesses to rather discovering the possibilities of the places individuals use to live, learn, work and play in (Mukoma & Flisher, 2004). Various settings have been identified to promote health. These settings include hospitals (Huang, Chien & Chiou, 2016), workplaces (Kliche, Riemann, Bockermann, Niederbuhl, Wanek & Koch, 2011), universities (Torp, Kokko, Ringsberg, Dooris, Wills & Newton, 2014) communities (Galiatsatos, Sundar, Qureshi, Ooi, Teague & Hale, 2016) church (Beric & Dzeletovic, 2003), correctional institutions (Beric & Dzeletovic, 2003) schools (Bennett, Cunningham & Johnston, 2016) and the media (Beric & Dzeletovic, 2003).

In South Africa, the settings approach is also considered as an effective tactic to drive the growth of health promotion (Onya, 2007) and therefore schools were considered as one of these settings.

School health promotion is actively implemented by numerous partners in the health sector as they fully accept the potential of schools as a setting for health promotion (University of the Western Cape (UWC), 2006). Childhood experiences during the formative years are directly correlated to later beliefs, attitudes and behaviour regarding health (Kessler *et al.*, 2010). Acknowledgement of this fact led to the HPS approach as children spent a great deal of their time in school settings and schools have a significant influence on student's outlooks on life. The adolescent years are especially regarded as a fundamental developmental phase where learned health skills and behaviours could be transferred to later life and evidently be carried over to own families and the wider community (Kirby, Laris & Roller, 2006).

Various researchers highlighted the importance of early interventions during childhood and adolescence in order for individuals to develop into healthy and well adapted adults (See Chapter 1 paragraph 1.1.1) (Easton, 2012; Goosby, 2013; Heusser & Elkonin, 2013; Langford *et al.*, 2014; Noh, Kim, Oh, & Kwon, 2014; Pikhartova, Blane & Netuveli, 2014; Poonawalla, Kendzor, Owen & Caughy, 2014; Smith *et al.*, 2015). Since early experiences have an impact on later life, it is important that schools play a vital and significant role in future public health.

Bronfenbrenner's ecological model views children's health holistically by integrating the family, school and wider community (Bronfenbrenner, 1979). Stewart, Sun, Patterson, Lemerle and Hardie (2004) highlighted these settings as essential to children's health and well-being. Schools can however be a more practical setting for reaching children as Sormunen, Saaranen, Tossavainen and Turunen (2012) mentioned that schools offer unique situations to address health needs because of their wide-ranging influence. Langford, Bonell, Jones and Campbell (2015) similarly identified schools as settings which offer an all-inclusive, sustainable and effective environment to reach children. Within the school environment, children are equipped with the knowledge, attitudes, values, skills and services to make better decisions about their health (St Leger & Nutbeam, 2000).

Using the ecological framework to view schools acknowledges the connections among various individuals in a school community (Bronfenbrenner, 1998). Strong social bonds results in connectedness and social capital and has been proven to reduce occurrence of bullying and enhance tolerance and conflict management (Rowe & Stewart, 2009).

The unique position of schools to equip learners with life-long knowledge, attitudes, values and skills poses as a valuable asset. Thus, if Health Promoting Schools are implemented effectively, it can address numerous issues that children face considering the resources available at a school.

2.8 HEALTH PROMOTING SCHOOLS

2.8.1 What is a Health Promoting School?

In an effort to strengthen global health, the World Health Organisation conceptualised Health Promoting Schools through policies in the 1950's (Johnson & Lazarus, 2003). The Declaration of Alma Ata was first used as a framework where national governments were motivated to steer health through action plans and multidisciplinary partnerships (WHO, 1978). The Ottawa Health Charter for Health Promotion followed in 1986 and forms the basis for Health Promoting Schools by suggesting core objectives to both improve the health status of children and to improve the quality of education (WHO, 1986 Swart & Reddy, 1999). The Health Promoting School's framework is still relevant and functional today with the main goal of the global school health initiative to increase the number of Health Promoting Schools by improving the overall health of all members of the school community (DOH and DOE, 2012).

Various definitions for Health Promoting Schools exist, but the most used definition by the World Health Organisation defines a health promoting school as a "school constantly strengthening its capacity as a healthy setting for living, learning and working" (WHO, 1999). A more comprehensive definition used by the World Health Organisation still applicable for current health promoting initiatives, is as follows:

"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" (WHO, 1997)

Johnson and Lazarus (2003) elaborate on the involvement of families and the wider community by adding all stakeholders in a school community (health and education officials, educators, pupils, parents, and community leaders) to be responsible in health promoting actions. The health promoting school can accordingly be seen as an

environment where all levels of human existence flourish through a continuous deliberate effort made by the broad school community. In order to reach these goals, set out for health promotion in schools, the WHO (1997) outlined a policy with a range of strategies to firstly address health priorities:

- ***perform research to improve school health:*** consult various research and the opinion of experts in the field of health promotion to define the value of health promotion;
- ***construct capacity to advocate for improved school health programmes:*** Practical documents and policies are created that consult various research and expert opinion on the nature, possibility and value of school health programmes. Each practical document is intended to address a specific health issue and provides guidance in applying integrating solutions into the school health program;
- ***strengthening national capacities:*** Health and education departments and sectors are encouraged to work in partnership on strategies and programmes to strengthen public health through schools, and
- ***forming Health Promoting Schools through alliances and networks:*** Global networks have been formed to improve health through schools. Various alliances include UNESCO, UNAIDS, Disease Control and Prevention, Educational Development Centre and Education International. The aim is to form alliances between all governmental, non-governmental, business and private sectors and organisations to become involved in creating Health Promoting Schools.

The WHO's policy on creating Health Promoting Schools is set out to be used by individual countries in order to develop and strengthen the capabilities of Health Promoting Schools. These strategies can be reinforced by means of encouraging all members of a school community to work cooperatively to *"provide students with*

integrated and positive experiences and structures which promote and protect their health" (WHO, 1999). The WHO correspondingly specified the Health Promoting Schools (HPS) framework which schools must adhere to in order to be regarded as a HPS (Langford *et al.*, 2014). These three key characteristics within the framework are: *input to the curriculum; changes to the school's ethos/environment or both; and engagement with families or communities, or both.*

When considering all the data set out by the WHO and the numerous countries implementing this program, it is evident that the health promoting school's framework is a popular and current method for strengthening wellbeing and health. The WHO framework's effectiveness has been verified by two different systematic reviews. The first review was conducted in 1999 and proposed "limited but promising" data that this approach could benefit student health (Lister-Sharp, Chapman, Stewart-Brown & Sowden, 1999). A later systematic review in 2015 determined that the WHO framework is effective at improving some aspects of student health and shows evidence of promise in improving others (Langford *et al.*, 2014).

Although many researchers recognises the importance of school connectedness, social capital and in effect health promotion, the practical implementation thereof can be problematic (Rowe & Stewart, 2009). A growing body of evidence recognises the incorporation of HPS with a whole-school approach as an effective method to promote health in school settings (Fung *et al.*, 2012; Rowe & Stewart, 2009; Stewart & Wang, 2012; Rowe, Stewart & Somerset, 2010:197). A whole-school approach is nested within Bronfenbrenner's ecological theory as it views a school as a multidimensional and interactive system that can change over time (Bronfenbrenner, 1979; Ttofi & Farrington, 2010). The HPS model in itself is considered a holistic approach due to its emphasis on the school as a whole by integrating different dimensions of a school system to achieve optimum health. These systems include health education within the curriculum, implementing school health policies; and relations with health services, families and the community (Stewart & Wang, 2012).

Health Promoting School's forms the basis as key settings and strategies to address the health of the entire school community in a sustainable manner instead of targeting individuals. Health Promoting School's should also be viewed as a continuing and dynamic process where stakeholders are constantly evaluating, planning and implementing strategies as outlined by the HPS model (Australian Centre for Health Promotion, 2012).

2.8.2 Health Promoting Schools in the United States of America

Health in schools in the USA and Canada are addressed through the Comprehensive School Health Program (CSHP) (Walcott *et al.*, 2008). This model set the following strategies in promoting children's health through schools: supporting and involving families and the school community, partnerships with communities and external disciplines through a democratic process (Allensworth, 1995).

The newest model released for school health promotion was implemented in 2014 in the United States of America. The Whole School, Whole Community, Whole Child Model (WSCC) emphasise the collaboration between health and education sectors to achieve better coordination and a shared focus in the planning of strategy and the execution thereof (Johnsson Chiang, Meagher & Slade, 2015). Additional emphasis is put on the collaboration between the school, community, health and education sectors to provide backing for every child to reach their full potential (Johnsson Chiang *et al.*, 2015). The model concentrates on Health Education, Physical Education and Physical Activity, Nutrition, Environment, Health Services, Counselling, Psychological, and Social Services; Social and Emotional Climate; Physical Environment; Employee Wellness; Family Engagement and Community Involvement as integrating components (Hunt, Barrios, Telljohann & Mazyck, 2015). This concept aims to move from theory to practical implementation by challenging problems previously encountered in addressing health promotion (Johnsson Chiang *et al.*, 2015).

The collaboration between different sectors is also viewed as a more efficient strategy to reach health promoting goals and have the potential to utilise resources

economically (Johnsson Chiang *et al.*, 2015). Figure 5 below illustrates the Whole School, Whole Child, Whole Community approach to health promotion. In the image, it can be seen that the original three components of the health promoting school framework set out in the Ottawa Charter namely, *input to the curriculum*, *changes to the school's ethos/environment or both*, and *engagement with families or communities, or both* are still incorporated.



Figure 5: The Whole School, Whole Community, Whole Child Model (WSCC) extracted from (Johnson Chiang *et al.*, 2015)

2.8.3 Health Promoting Schools in Australia

The Australian Health Promoting Schools Association (AHPSA) was created in 1994 to lead and implement health promotion (AHPSA, 2014). The AHPSA uses the criteria from the International Union for Health Promotion and Education (IUHPE) to guide their health promoting school movement. These guidelines are as follows: Using the resources available in school communities to advance health and learning; building relationships with different stakeholders within the school and wider school communities to address health needs; aiming to provide an *inclusive physical and social school environment*; accepting and applying policies about health promotion; providing health education and life skills relevant for specific ages; and improving access to health services (AHSPSA, 2014).

Australia also uses the whole school framework set out in the Ottawa Charter namely, *input to the curriculum, changes to the school's ethos/environment or both, and engagement with families or communities, or both* to promote health in schools (WA Health Promoting Schools Association (WAHSPSA), 2000). Although health promotion in Australia presents some advances, they also face some challenges in executing health promotion programmes. Marshall, Sheehan, Northfield, Maher, Carisle and St. Ledger (2000) reviewed health promoting school practices in Australia and concluded that relations between the wider school community and health services only took shape in emergency situations. Collaboration with the wider school community thus proved to be problematic. Research also indicates that although schools tried to involve parents through committees etc., that parent participation were still challenging (Mutch & Collins, 2012).

2.8.4 Developments in Europe: The Schools for Health Europe Network (SHEN)

The SHEN was first established in 1991 and developed a framework which directed the implementation of Health Promoting Schools in Europe. Six areas were included in the guiding of their framework: *School physical environment; social environment; community involvement; policies; health skills; and access to services* (WHO, 1996). More

than 43 countries form part of the SHEN to encourage safe school environments which in turn encourages health (Lohrmann, 2010). Similarly, to South Africa, health promotion traditionally formed part of the formal curriculum which focused on diseases or the absence of illness. The SHEN since has led to the development of health as an action which should be integrated into all aspect of school and not just formal curricula (Lohrmann, 2010).

In 1997, the ENHPS (European Network for Health Promoting Schools - now known as the SHEN) held its first conference and established 10 principles for the creation of Health Promoting Schools in Europe (ENHPS, 1997; Gray, Young & Barnekow 2006). The first two principles focused on the need for Health Promoting Schools and inclusion of all by highlighting democracy and equity. The third principle was aimed at accrediting children in the health promotion movement by highlighting empowerment and competence. The fourth, fifth and ninth principle consists of the framework set out by the Ottawa Charter: school environment, curriculum and the schools' relationships with parents and the wider community. Next, the successes of Health Promoting Schools where included by adding the measuring of effectiveness of health promoting actions. Collaboration and shared responsibility between different stakeholders such as governments especially health and education departments were introduced. The training of teachers to promote health was addressed by including health promotion in their initial and in-service training. Last, but not least the importance of sustainability was added by motivating governments to pledge commitment to provide resources (Gray, Young & Barnekow 2006).

One of the key principles of Health Promoting Schools across Europe is the inclusion of children's participation. Children's participation is viewed as critical for them to take ownership which in turn will encourage more effective health promotion (Gray, Young & Barnekow 2006). Significant to notice is the SHEN's less structured model which allows more freedom for personal interpretation than the Australian and US/Canadian approach to health promotion in schools (Arthur *et al.*, 2011).

2.8.5 Effectiveness of Health Promoting Schools

In 2014, the World Health Organisation directed the Cochrane collaboration to give an elaborate review on health promotion interventions in schools. This is the most extensive and inclusive evaluation of Health Promoting Schools up to date and included the following health topics: physical activity, nutrition, substance use (tobacco, alcohol, and drug), bullying, violence, mental health, sexual health, hand-washing, cycle-helmet use, sun protection, eating disorders, and oral health (Langford *et al.*, 2014).

According to this report it was established that the HPS approach had a positive outcome in diminishing bullying tendencies, improving healthy nutritional choices, decreasing body mass index (BMI), and improved physical activity and fitness capability (Langford *et al.*, 2014). In the same review it was concluded that there was not enough evidence to evaluate the effectiveness of HPS approach for sexual health, hand-washing, cycle-helmet use, eating disorders, sun protection, oral health or academic achievement.

A previous systematic review indicates that schools using the health promoting school framework can be effective in guiding members of a school community in engaging in healthy nutritional choices (Stewart & Wang, 2012). The same review also revealed that schools using the health promoting school framework offered a more supportive environment, accommodating character and a more engaging community (Stewart & Wang, 2012).

Evidence therefore suggests that the HPS approach can develop certain areas of health concerns. An added advantageous point of the HPS approach is that one health promoting program implemented in a school could serve as a means to build confidence in addressing other health topics (McNab, 2013). It would seem that the HPS model would be an effective way of addressing the myriad health risks we face in

South Africa, especially where the amount of problems faced by schools could make stakeholders feel dispirited.

2.8.6 Development of Health Promoting Schools in South Africa

The development of health and wellness has long been an important part of formal school curricula in South Africa. The school subjects, Health Education and later Life Orientation, together with integrated learning areas, addressed health issues and aimed to equip learners with the knowledge to make informed health choices (CAPS, 2011). The National Department of Education however recognised the shortcomings of only including health topics as a formal curriculum outcome and also seized the more holistic whole school approach advocated by the WHO (Department of Education & Department of Health, 2012). The evolution from Health Education to a more comprehensive programme includes education, training, research, legislation, policy coordination and community development (Department of Health, 2014).

A renewed focus on health took place since the beginning of South Africa's democratic government in 1994, by creating policies set out in the Reconstruction and Development Programme (RDP) of the African National Congress (Swart & Reddy, 1999). This policy led to change in which different government departments, non-government organisations and other associates understood their role and purpose in health promotion (Swart & Reddy, 1999). The change in policies was motivated by the limited health related support schools received prior to 1994. The traditional model of school health was focused on medical evaluations such as growth monitoring, visual and auditory screening, adequate nutrition and health education. This restricted school health model further contributed to health inequalities as services were provided based on race (Pick, Shisana, & Lee, 1996).

The South African Government together with the various departments of education embraced the approach to holistic wellness by including legislation and policies by making school compulsory for all children between the ages of 7-13 (South African Schools Act, 1996); introducing the '*no school fee*' system to support the access to

education (Schellack, Meyer, Gous & Winters, 2011) and by also adopting the HPS model advocated by the WHO (Johnson & Lazarus, 2003).

The HPS model was first presented during 1994 at a workshop in Swaziland and in 1996 South Africa held its first Health Promoting Schools Conference at the University of the Western Cape (Coulson, 2000). In 1995, individuals from the education, health and welfare sectors, as well as non-governmental organizations created a voluntary network intended to offer backing for the development of Health Promoting Schools in the Western Cape. It was during the first National Conference (1996 and 1997) that real progress was made in the planning of HPS's as it was agreed that plans and strategies should be made around existing government structures and contexts (Johnson & Lazarus, 2003).

During 2000 the National Committee of Education Support Services (NCESS) endorsed the WHO's strategy for HPS to ensure the progress of *healthy school policies, supportive learning environments, strong community links, personal skills development and the provision of appropriate education support services* (Johnson & Lazarus, 2003). The Department of Health supported above mentioned initiatives by including HPS in their 5-year health plan outlined in the Healthy Schools Programme (Department of Health, 2014). The Department of Health in partnership with the Department of Education and Welfare also created the National Guidelines for the Development of Health Promoting Schools (Department of Health, 2000). This policy stipulated five main dimensions for Health Promoting Schools in South Africa presented in Figure 6 below.

Various other policies, programmes and legislation are also relevant for the development and support of Health Promoting Schools in South Africa. These are discussed below.



Figure 6: Five components of Health Promoting Schools/sites in South Africa adapted from the Department of Health (2000)

2.8.6.1 The Education White Paper 6

Special Needs Education- Building an Inclusive Education and Training System played a pivotal role in the implementation of health promotion as it supports the holistic HPS initiative and Bronfenbrenner's ecological theory by including different dimensions of health. This awareness was created by the 2001 White Paper's inclusion of the physical, emotional, social and learning needs of all learners (Department of Education, 2001). The inclusive movement was further supported by the National Strategy on Screening, Identification and Support (SIAS) document which allowed schools to offer interventions for learners at risk for developing health or learning gaps (South Africa, 2008). These interventions are implemented by the District Based Support Teams (DBST) and School Based Support Teams (SBST) (Kwatubana & Kheswa, 2014).

The Education White Paper on Inclusive Education is regarded as one of the significant documents in South Africa as it changed the way individuals and organisations think about Education. As mentioned above, children were not only excluded on grounds of race to receive adequate education and health services but were also excluded on grounds of disability (Department of Education, 2001). The need for effective training in health promotion and inclusive education are however still a great concern given the ineffective implementation of mentioned policy due to lack of skills and knowledge (Dalton, Mckenzie & Kahonde, 2012).

2.8.6.2 National Health Promotion Policy and Strategy

In accordance with the Education White Paper 6, the Department of Health and the Department of Education started to co-direct and support the Health Promotion Initiative with over-arching policies. In 2003 the first National School Health Policy was launched followed by the 2006 Health and Wellness in Education Framework (Kwatubana & Kheswa, 2014) and thereafter the National Health Promotion Policy and Strategy in 2012.

The National Health Promotion Policy and Strategy based all their goals and strategies on the WHO's view of health as a basic human right and accordingly re-committed to enhance the health of all South Africans. The key aim of the National Health Promotion Policy and Strategy is to provide guidance to health promotion stakeholders by equipping people, families, communities and the society to direct and own the different determinants of their own health (DoH, 2014). This will be done by providing different strategies for stakeholders on how to execute health promoting programmes (DoH, 2014).

Relevant for school health promotion is the NHPPS's goals to ensure the creation of enabling environments which promotes healthy behaviour, the promoting for additional human resources to implement health promotion services and the strengthening of evaluation methods for health promotion interventions. The policy also sets certain responsibilities for health promoters working within schools and

envisaged the improved coordination of health promotion services to all South Africans.

2.8.6.3 Integrated School Health Policy

In 2012 the Integrated School Health Policy was launched and is viewed as a progressive change of the HPS model as the health and education sectors recognised the importance of a collaborative and cohesive strategy that aims at using joint approaches and integrated interventions to address barriers and provide health services at schools (Kwatubana & Kheswa, 2014). It further set out a supportive culture to promote and progress learner's wellbeing and optimal health (Departments of Health and Education, 2012).

The Integrated School Health Policy, similarly to the National Health Promotion Policy and Strategy, based all their goals and strategies on health as a basic human right in recognition of the Bill of Rights of the South African Constitution (Department of Health and Education, 2012). This policy pledges to "put children first" by committing to health-related school policies, the creation of healthy physical and learning environments, ensuring skills-based health education and health and nutrition services which are school-based (Department of Health and Education, 2012). Although the school health programme aims to reach the total population of learners, services will be custom-made for different developmental stages of children and to specific health needs in various communities and schools (Department of Health and Education, 2012). The specific services provided to developmental stages are demonstrated in Table 1 (paragraph 2.8.6.4).

Although the departments of health and education recognise the importance of health services and policies set by these sectors are in place, the execution of these policies are problematic with little to no coverage in some areas (Department of Health and Education, 2012). It is believed that the Western Cape has gone furthest with creating health promotion opportunities by including early childhood development, the rights of children and addressing malnutrition through vegetable gardens (UWC, 2006).

KwaZulu-Natal and Gauteng also pursued the initiative and had successes with their separate strategies (Kwatubana & Kheswa, 2014). No evidence on the successes or shortcomings of health promotion in schools in the North West province could be found.

2.8.6.4 The current nature of Health Promoting Schools in South Africa

Health Promoting Schools are viewed as inclusive, holistic and integrated systems which aim to assist individuals in a school community to reach optimum health and wellbeing. Rosas (2015) indicates that Health Promoting Schools with systems thinking in mind aims to reach *individual, professional, procedural and policy* levels concurrently through interventions that include physical, biological, ecological, social, political and organizational relations and patterns. The complexity of the systems theory highlights the difficulties in creating practical qualities and guidelines which a school must adhere to in order to be regarded a health promoting school.

To understand the current scenario in schools regarding health promotion, it is necessary to first take a look at what it is a Health Promoting School should do when they promote health. The DoE and DoH worked in partnership to outline the following qualities for what a Health Promoting Schools should be (Department of Health and Education, 2012). These qualities include the encouragement and nurturing of health and learning on all possible levels by including all stakeholders teachers, education officials, unions, learners, parents and all other persons involved in the school community) to deliberately make the school a healthy setting; combining different actions and programmes to create and provide a healthy environment, health education and health services for school staff and learners. These services will include outreaches to the community, nutrition and food safety programmes, physical education and recreation, counselling, social support, mental health promotion and health promotion; practice and use policies with qualities that respects all members of the school community's wellbeing and dignity, offer prospects for successes, recognise positive efforts and accomplishments; collaborate with community leaders in

understanding the value of community involvement towards health and education and to improve the health of all members of a school community (teachers and other school personnel, learners, families and the wider community).

A further aim of the ISHP is to assess every learner once during each of the four school phases or additional assessments when a learner repeats a grade, or if a teacher, parent or learner him/her-self request additional assessments (Department of Health and Education, 2012).

The Integrated School Health Policy, as set out by the collaboration between the Department of Health and Department of Education, provides a complete school health package of services for primary and secondary schools regarding health screening, on-site services and health education (Department of Health and Education, 2012). These services are summarised in Table 1 below:

Table 1: The school health package as set out by the Integrated School Health Policy (DoH & DoE, 2012)

Health Screening	On-site services	Health education
Foundation phase (Gr. R–3)		
• Oral health • Vision • Hearing • Speech • Nutritional assessment • Physical assessment (gross & fine motor) • Mental Health • Tuberculosis • Chronic illnesses • Psychosocial Support	• Parasite control • De-worming and bilharzias control (where appropriate) • Immunisation • Oral health (where appropriate) • Minor ailments	• Hand washing • Personal & environmental hygiene • Nutrition • Tuberculosis • Road safety • Poisoning • Know your body • Abuse (sexual, physical and emotional abuse)
Health Screening	On-site services	Health education
Intermediate phase (Gr 4-6)		
• Oral health • Vision	• De-worming • Minor ailments	• Personal & environmental hygiene

• Hearing • Speech • Nutritional assessment • Physical assessment • Mental Health • Tuberculosis • Chronic illnesses • Psychosocial Support	• Counselling regarding SRH (if indicated), and provision of and referral to services as needed	• Nutrition • Tuberculosis • Medical and Traditional Male circumcision • Abuse (sexual, physical and emotional abuse including bullying, violence) • Puberty (e.g. physical and emotional changes, menstruation & teenage pregnancy) • Drug & substance abuse
Senior phase (Gr 7-9)		
• Vision • Hearing • Speech • Nutritional assessment • Physical assessment incl. - Anaemia - Mental Health - Tuberculosis - Chronic illnesses - Psychosocial support • Minor ailments • Individual counselling regarding SRH, and provision of or referral to services as needed	• Minor ailments • Individual counselling regarding SRH, and provision of or referral to services as needed	• Personal & environmental hygiene • Nutrition • Tuberculosis • Abuse (sexual, physical and emotional abuse including bullying, violence) • Sexual & reproductive health • Menstruation • Contraception • STIs incl. HIV • MMC & Traditional • Teenage pregnancy, CTOP, PMTCT • HCT & stigma mitigation • Drug and substance abuse

		• Suicide
Health Screening	On-site services	Health education
FET (Grade 10-12)		
• Nutritional assessment • Vision • Oral health • Ear examination • (Hearing) • (Speech) • Chronic Illness • TB screen • Anaemia screen • Psychological support • Mental Health • Physical assessment	• Minor ailments • Individual counselling regarding SRH and provision of or referral to services as needed	• Personal & environmental hygiene • Nutrition • Tuberculosis • Abuse (sexual, physical and emotional abuse including bullying, violence) • Sexual & reproductive health • Menstruation • Contraception • STIs incl. HIV • MMC and traditional • Teenage pregnancy, CTOP, PMTCT • HCT & stigma mitigation • Drug and substance abuse • Suicide
All Schools		
• First aid kit • Water and sanitation • Cooking area • Physical safety • Ventilation (airborne infections) • Waste disposal • Food gardens • Recycling		

A broad outline of what it is a health promoting school does when promoting health was given above together with the services provided. This will provide a background to better comprehend the current scenario regarding Health Promoting Schools.

Although some health promotion programmes has been implemented with success stories, it is documented that there is still not enough evidence to draw conclusions about *all* aspects of health concerns when using the HPS approach (Langford *et al.*, 2014). Despite the importance of student health and wellbeing, various studies found major barriers and challenges in the development of Health Promoting Schools. Stewart and Wang (2012) identified that the need for further professional training in the HPS approach; additional studies to understand the implementation of HPS; longer intervention periods; improved follow-up evaluations and adequate funding were all factors contributing to failed interventions.

Although the UWC reported on an increasing number of Health Promoting Schools in most provinces (UWC, 2006), no research on the functioning of Health Promoting Schools in the North West Province could be found. Major challenges faced in South Africa could be ascribed to the following reasons set out by the Department of Health and Department of Education (Department of Health and Education, 2012):

- Unsatisfactory partnership between different stakeholders (especially the DOH and DBE);
- Unbalanced circulation of resources and therefore competition for limited resources;
- Health promotion services to provide higher quality of life are overshadowed by the high demand for immediate and medicinal services, and
- Not all stakeholders responsible for the HPS service model ascribe importance to providing school health services.

As was discussed earlier, schools have health teams to provide assessment, screening and health education as set out in Table 1. The ISHP (South Africa, 2012) states that these services should be made possible to all learners but should focus on children from poor communities with limited access to health services. Rhoda, Waggie, Filies, and Frantz, (2016) found that these services were inadequate due to the shortage of visits by health teams. The limited visits thus place learners at risk of developing future health or learning problems if not addressed as health screening offers early identification to barriers (Kwatubana & Kheswa, 2014).

Kwatubana and Kheswa(2014) reported on additional results contributing to challenges in the provision of health promoting services: These included the poor administration of health services as there were no clear procedures in place; practical spaces for screening and assessments were limited or problematic; school personnel did not always understand their role in health promotion as some were unaware of the ISHP; the delivery of services related to health are still not integrated into schools as teachers did not contribute; a lack of communication and coordination exists between the SBST and DBST; parents did not adhere to referrals from nurses as they did not regard it as part of a school activity.

Although limited data is available for success stories regarding health promotion in South Africa and especially the North West Province, there are a few programmes with success. The National School Nutrition Programme is believed to successfully provide learners in previously disadvantaged communities with nutritious meals (Kwatubana & Kheswa, 2014). Kwatubana and Kheswa (2014) further reports that the National Policy on HIV/AIDS (1996) aims at the provision of information and education regarding issues of sexuality and that the successful implementation of the NSNP contributes to the health of learners of school going ages. Health education also seems to be one of the goals of the ISHP which receives the most success (Kwatubana & Kheswa, 2014).

2.8.6.5 Motivation for Health Promoting Schools in South Africa

Since 1997 approximately 32 countries in Africa adapted the HPS model and by 2007 it was reported that 300 schools (in Africa and South Africa) are functioning Health Promoting Schools (WHO, 2013). In South Africa, particularly, health promotion and the Health Promoting Schools' initiative forms a significant part of changing and developing limited recourses and inequalities of the past such as poverty and racial discrimination.

Additionally, children face various health risks in South Africa. First, is the HIV/AIDS epidemic which contribute to the numerous obstacles children face to attain optimum health (DoBE, 2010). An estimated 300 000 children are infected with HIV and the infection number increases by 50 000 each year (DoH, 2010). The HIV and AIDS epidemic not only has a direct effect on children's physical health but also contributes to psycho-social factors (school drop-out, financial problems due to parental illness, child headed households) and mental problems (grief due to death of family members, discrimination and stigma, abuse, social exclusion (DoH & DoE, 2012). Other health risks that numerous children in South Africa face, includes malnutrition; obesity; bilharzia and soil-transmitted helminth infections (Berry & Hall, 2010; Dickson, Awasthi, Williamson, Demellwee & Garner 2000; Reddy *et al.*, 2010). Risk of respiratory infections and burns due to unsafe energy sources; and having to use unhygienic lavatory facilities (Hall, 2011).

Secondly, the many challenges children in South Africa face don't stop with physical illnesses or challenges. According to the Departments of Health and Education (DoE & DoH, 2012) it is estimated that 17% of children (ages 6-16) have mental health problems. In the Western Cape it was established that a great number of children face anxiety disorders, post-traumatic stress disorders, depression and conduct disorders. (Kleintjies & Flisher, 2006).

Health, well-being and academic achievement as well as the reducing of inequalities can all be enhanced through constructive and healthy school settings (Reily & Kelly,

2011). Improved education allows students to take better control over practices and decisions regarding health behaviours; promotes autonomy; and reduces risk taking behaviours (EQUINET, 2012). Various policies set out by the departments of education support the health promoting initiative as it is geared to create healthier, empowering school environments. HPS's furthermore serves as a valuable tool as education in health can provide learners with skills to recognise health barriers which they can possibly avoid and thereby influence whole communities (Department of Health and Education, 2012).

It is also vital to note that together with ever existing problems and issues, that the 21st century brings new challenges for health and health promotion. Fast growing technology and changes in society asks mindset changes to see health as a social investment (Kickbusch, 2012). Kickbusch (2012) identified the following as three determinants of 21st century health:

- *Unsustainable lifestyles*: Health challenges are connected to unsustainable lifestyles and unsustainable manufacturing and consumption patterns.
- *The flow of people*: Increasing migrations causes dislocation of people and results in conflicts. It also influences correct assessment of public health and other health issues.
- *The hurry virus*: Modern lifestyles together with the media, urbanisation, new professions and the entry of women in the workplace contribute to the high demands of time schedules and consequently high levels of stress, anxiety and depression.

Above mentioned challenges together with the challenges discussed in Chapter 1 paragraph 1.1.1 provides a comprehensive outline on the necessity of the successful implementation of Health Promoting Schools. When health promotion is neglected, children are placed at risk for developing health problems as well as educational

problems which can have an effect on various other dimensions of their lives as well as other people in these children's lives.

2.9 Conclusion

The main goal of this chapter was to provide an outline regarding health, health promotion and Health Promoting Schools. The concept health was discussed to clarify a definition which proved to be adequate for this study, but also in line with literature. The definition of health was also discussed according to South African literature and policies which were followed by the theoretical underpinning of health in research. This was done to better comprehend the social context of health and the importance thereof in South African research.

Secondly, health promotion and its origin were summarised in order to form a picture of the evolution from health promotion to health promotion in various settings. Schools were then identified as one of the key settings in health promotion. The school setting was further investigated by examining Health Promoting Schools in its global context and thereafter in the South African context. The South African context was viewed in more detail by investigating the motivation for Health Promoting Schools and the successes as well as barriers faced in Health Promoting Schools. Lastly, the current scenarios in Health Promoting Schools in South Africa were examined.

Above mentioned literature review forms the basis for literature regarding the health promoter which will be discussed in Chapter 3. Key conclusions that could be made from above mentioned literature review, is the global and national need for Health Promoting Schools and the need for more effective implementation set out by different policies and legislation.

THE HEALTH PROMOTER

3.1 INTRODUCTION

From Chapters 1 and 2 it is clear that Health Promoting Schools, if applied well, is the most effective method to comprehensively address the health needs of children. The literature review on Health Promoting Schools revealed that these programmes are executed successfully to varying degrees but that there is still room for improvement. The implementation of health promotion is still changing for the better as national policies are constantly updated and altered to better equip stakeholders with strategies to implement health promoting programmes.

Effective collaboration between various stakeholders was identified as one of the key factors in the success of health promotion programmes. Health promoters are regarded as one of the crucial stakeholders in creating and implementing health promotion programmes on a practical level. These health promoters are therefore in direct contact with the communities in which health promotion is necessary. To effectively execute their responsibilities, policy makers and researchers need to investigate the barriers which health promoters face in their daily routines. Effective

solutions for the barriers can only be found if there is an agreed consensus on who the health promoter is and what it is they do when they promote health in settings like schools. This chapter will give an overview of what the literature indicates about the definition of health promoters, types of health promoters, responsibilities of health promoters and also the barriers health promoters encounter.

3.2 HEALTH PROMOTERS

3.2.1 Defining health promoters

As mentioned above in the introduction section, it is crucial that an agreed consensus is formed of who the health promoter is before, effective solutions for barriers in health promotion can be made. Finding a detailed definition and clarification of health promoters in the literature proved to be difficult as various studies used the term health promoter when referring to any health or education professional contributing towards health promotion (Hung, Chiang, Dawson & Lee, 2014). These professionals included teachers, nurses, cosmetologists, principals, school nurses and any other staff involved in school health promotion as well as university students (Ahlers-Schmidt, Redmond, Struempf, Hunninghake & Nimeskern 2014; Barros *et al.*, 2014, Hung *et al.*, 2014, Mendoza- Núñez *et al.*, 2013).

An additional problem contributing towards a vague definition of health promoters was that literature made no clear distinction between health workers, community health workers and health promoters (McDermott-Levy & Weatherbie, 2012). Various other titles such as public health officers, environmental health officers, health educators, health planners, and health communicators were also used and caused an even greater confusion in finding a suitable definition (Tengland, 2010).

Definitions that could be found to best describe health promoters are outlined below. Reischmidt, Hunter, Fernandez, Guernsey de Sapien and Meister (2006) defines a health promoter as a *"health worker or community health worker who educates, motivates, and supports the members of the community in their pursuit of health"*. Tengland (2010) expands on this definition by referring to health promoters as health

workers dealing with positive health aspects through empowering community projects. Further extensions of definitions for health promoters includes skills such as counselling, support as well as the formation of communication links between health sectors and the community (Brownstein, Hirsch, Rosenthal & Rush, 2011). Although the above-mentioned definitions describe health promoters, it is still vague and unclear as to the distinction between health promoters and other terms, such as health workers and community health workers. The ambiguity of the term health promoter could be ascribed to Tengland's (2010) statement that the profession of a health promoter is seen as a fairly new profession.

The participants for this study are known as health promoters working in schools in the Dr. Kenneth Kaunda District of the North West Province and are employed permanently by the Department of Health. In accordance with the above-mentioned definitions and guidelines for Health Promoting Schools in South Africa, a health promoter in this study will be described as a person trained to educate, motivate and support members of a school community to take action in making educated and controlled decisions regarding their health while supporting other co-members of the school health team. It is essential that these health promoters are also mindful and respectful towards different cultural viewpoints and expressions within the community they are based at (Department of Health, 2014).

3.2.2 Types of health promoters

To establish effective health promoting programmes, *social, political, economic and physical* situations need to be altered to foster supportive environments (Department of Health, 2014). These supportive environments can be created within *households, schools, institutions of higher learning, PHC facilities, hospitals, communities, workplaces, taxi ranks, shopping centres and places of worship* (Department of Health, 2014). A number of professionals are responsible for promoting health in some of the aforementioned settings. Nurses, teachers, community health workers and other professionals like doctors all contribute to health promotion in some of these settings.

Since literature often refer to these professions as health promoters, a short description of each will be given to make a clear distinction between individuals solely working as health promoters and those individuals with added health promotion duties.

3.2.2.1 Community health workers (CHW)

As seen in the definition paragraph above, the title “health promoter” could sometimes refer to the same occupation as that of a community health worker/promoter. Although, community health workers and health promoters have some responsibilities which overlap, they have different job descriptions and therefore their occupations are regarded as separate.

As was the case with health promoters, a number of titles were given to community health workers in literature. These terms included lay health workers, health navigators, community educators, health promoters and health advisors (Hohl *et al.*, 2016; Kim *et al.*, 2016; Nguyen, Stewart, Nguyen, Bui-Tong & McPhee, 2015; Rosenthal, Wiggins, Ingram, Mayfield-Johnson & De Zapien, 2011). Literature regarding community health workers is however in abundance and it was easier to conclude a definition.

Community health workers are defined as lay members of communities who work either for pay or as volunteers in association with the local health care system in both urban and rural environments and usually share ethnicity, language, socioeconomic status, and life experiences with the community members they serve (Hohl *et al.*, 2016). Lehmann and Sanders (2007) defines community health workers similarly by referring to them as individuals with a lesser amount of training than professional workers who originates from the particular community they work in and should be selected by residents of the same community in order to provide answers to community members for their activities. It was also concluded that traditional, faith and complementary healers should also be included as community health workers (Lehmann & Sanders, 2007). Community health workers are regarded as crucial members in health

promotion also in South Africa since lack of human resources has been identified as a barrier in the provision of health services (Lewin *et al.*, 2010).

Community health workers are also regarded as key role players in the provision of HIV services which includes education about preventative measures for HIV as well as counselling patients regarding antiretroviral therapy (Lewin *et al.*, 2010). Although CHW have minimal training to execute these responsibilities, it was established that they compensate with the unique development of their own techniques which are in line with the understanding of the communities they work in (Zulliger, Moshabela & Schneider, 2014). Although Zulliger, Moshabela and Schneider (2014) identified a need for training, they also commented that the training should not influence these unique adaptation processes which allows for cultural capabilities.

According to the NHPPS (DoH, 2014) main responsibilities and activities for community health workers in South Africa includes planning and administration. This comprises the planning of health promotion actions as well as report writing. The next main responsibility includes the implementation of plans and strategies by implementing healthy environments for children and integrated health promotion services. Additional duties of the community health workers include effective communication to build relationships with different stakeholders and the negotiating the need for resources to team leaders. Other everyday duties include the promotion of healthy lifestyles through the Healthy Lifestyles (HLS) Programme, encouraging physical activity, prevention of alcohol abuse and tobacco use, promote safer sexual practices and encourage healthy diet. This would be done by arranging campaigns and events to promote awareness and by spreading health promoting resources (IEC material, transport etc.). The National Health Promotion Strategy further identifies the provision of support and technical assistance to the Ward Based PHC Outreach teams as part of community health workers' responsibilities (Department of Health, 2014).

3.2.2.2 Teachers as health promoters

Teachers and other school staff are also considered as health promoters (Flaschberger, Nitsch & Waldherr, 2012) especially since they are placed as members within the School Based Support Team (Department of Health, 2014). Not only are they responsible for specific duties as members of the SBST, but as teachers they are placed within the centre of a school setting which is regarded as a safe setting for health promotion initiatives (WHO, 2009). Within schools, teachers play an essential role as partners in the preventing and identifying of behavioural, learning and mental health difficulties among all children (Whitley *et al.*, 2013: 56-70). The importance of teachers as health promoters are further highlighted due to the fact that mental health promotion is similarly viewed as part of school classroom priorities (Durlak, Weissberg, Dymnicki, Taylor & Schellinger, 2011). The WHO correspondingly places teachers at the centre of health promotion by identifying specific activities in schools such as social and emotional education and developing whole-school approaches to holistic health (WHO, 2013). However, teachers do not necessarily have the knowledge and skills to prevent these difficulties and to promote health (Whitley *et al.*, 2013: 56-70).

A recent study in England investigated newly trained teachers' attitudes towards their skills and confidence regarding health promotion. The results of this study indicated that most of the teachers felt confident in addressing ten health related topics (Pickett, Byrne, Reidijk, Shepherd, Roderick & Grace, 2015). A different study conducted in Australia revealed that teachers felt positive regarding the recognition of students who are at risk of social, emotional and behavioural issues, but that they did not have the knowledge and confidence to assist learners with mental health promotion (Askell-Williams & Lawson, 2013).

Studies regarding health promotion actions of teachers on specific topics have been done in South Africa as well. One such study revealed that teachers' training regarding HIV/AIDS education helped with their belief in self-efficacy and that their interventions could have positive outcomes (Mathews, Boon, Flisher & Schaalma, 2006). In contrast

with the above findings, the role of teachers in addressing issues regarding sexuality and sex education have been proved to be judgemental and critical (Smith & Harrison, 2013). The same study also revealed that teachers did not ascribe school drop-out rates to the high prevalence of HIV infections (Smith & Harrison, 2013). In addition to above statements, teacher responsibilities could be negatively affected by the teachers' own mental health as teachers' needs have changed considerably over the past years (Kutame, Maluleke, Netshandama & Ramakuela, 2014).

Effective training in all health-related areas, health promotion as well as mental health are thus of paramount importance in the successful implementation of the whole school approach to health promotion. Thus health promotion and mental health promotion need to be integrated into the educators curricula (Askell-Williams & Lawson, 2013: 126-143).

3.2.2.3 Nurses as health promoters

Nurses also act as health promoters by means of promoting public health through disease prevention initiatives (Kemppainen *et al.*, 2013; Anastasios Tzenalis & Chrisanthi Sotiriadou, 2010). Kemppainen *et al.*, (2013) in accordance with the WHO (2013) however, states that health promotion is more complex and moves beyond disease prevention. Although nurses generally agree that health promotion is part of their job description, Tossavainen *et al.*, (2004) found that health promotion has no relevance in relation to their experience. Nurses are therefore only considered as general health promoters, who give health information and provide care for patients (Kemppainen *et al.*, 2013).

Although most literature specified nurses as health promoters within health care facilities, literature also places nurses within school settings. Traditionally, the role of the school nurse, as a health promoting team member, is to provide early identification of problems and interventions to promote health (American Academy of Pediatrics, 2008). In South Africa, nurses form a crucial part of school health teams and provides services to all learners in specific school areas (Kwatubana & Kheswa,

2014). These services form part of the complete school health package of services which includes health screening, on-site services as well as health education which were illustrated in Table 1 (Departments of Health and Education, 2012). These health teams have the responsibility to visit learners once during each of the four school phases, except if additional problems occur (Department of Health and Education, 2010). Rhoda *et al.*, (2016) however, concluded that these visits by health teams were insufficient.

At present, it is also the responsibility of school health nurses to take a leading role in the implementation of HPS as part of the SBST (Department of Health & Education, 2012). Part of their leading role is to guide health promoters in their pursuit of health promotion initiatives (Department of Health and Education, 2012). This proves to be problematic as insufficient visits to schools by nurses will correspondingly result in a lack of guidance and leadership for health promoters. An additional challenge in the role of nurses as health promoters in schools are the lack of clear indication of what exactly are expected of them (Kemppainen *et al.*, 2013, Laforêt-Fliesse, 2010; McNab, 2014). Apart from the leading role that they have in guiding health promoters, the medical services they provide and education regarding health topics no policy could be found outlining the exact role and functions of these nurses when they promote health in schools.

3.2.2.4 Professionals as health promoters

A wide range of professionals are included when referring to the term health promoter due to their responsibilities, which comprises health promotion actions. These professionals include nurses, doctors, midwives, community workers, fitness workers, dentists, physical and mental health workers (Whitehead, 2003).

The ambiguity of the term health promoter is further illustrated by an interesting study conveyed by Beric and Dseletovic, already in 2003. The study aimed to determine the correlations with theory and practise within the health promotion and health education professions. Participants originated from Australia, Canada, Cuba, Finland, France,

Haiti, India, Puerto Rico, the United Arab Emirates, the United States of America, and Yugoslavia. These participants conveyed health promotion duties within different settings such as hospitals, universities, communities, correctional services and government organizations. This study concluded that countries like the United States of America, France, Australia and the United Arab Emirates train individuals like health promoters with a specific curriculum which include specific knowledge to prepare them for their field. Other countries for instance, India, Yugoslavia, Haiti, Cuba, Puerto Rico and Finland do not have specific specialized training for health promoters. In most of these countries health promoters were identified as physicians, nurses, teachers, health educators and dentists. Other professionals included community health workers, government employees, community leaders, sociologists, psychologists and social workers (Beric & Dseletovic, 2003).

The inclusion of all these professionals as health promoters highlights health promotion as a field which comprises of many elements. The view of Health as consisting of many determinants is therefore in correlation with the view of different professionals as health promoters.

3.2.3 The implementation of Health Promoting Schools in South Africa and health promoters' contributions

Wills and Rudolph (2010) concluded that most health promoters working in South Africa are based within primary health care clinics with the responsibility to provide talks based on specific themes highlighted on a health calendar. These educational topics include parenting, breastfeeding and the risk of transmitting HIV, immunisation, contraception as well as the option to terminate pregnancy (Department of Health, 2014). These educational conversations are provided to individuals or groups with the help of audio aids, visual aids and IEC materials and sometimes include practical demonstrations (Department of Health, 2014).

According to Wills and Rudolph (2010) it is also expected that these health promoters work with individuals with special needs such as physical disabilities, create

support groups on specific topics and make referrals where necessary. They are also involved with specific campaigns which address issues like immunisation, influenza, malaria control and oral health (Department of Health, 2014). While they deliver above mentioned activities to promote health, it is also expected from them to keep records regarding health promotion activities such as health education registers and attendance registers (Department of Health, 2014).

Duties which Wills and Rudolph (2010) included as part of the health promoters' responsibilities which were not described in the ISHP or NHPPS were as follows: the assistance to communities to identify and address health needs (accident prevention and hygiene practices) and supervising medication programmes.

As the duties stipulated above indicate, the occupation as health promoter is thought to be a radical break from narrow minded practices that focus solely on the prevention of disease (Tengland, 2010). Although the NHPPS and the ISHP both agrees on health education as one of the main responsibilities of health promoters, the following duties are included which demonstrates the break from merely viewing health promotion as preventing disease. A significant responsibility for health promoters is the NHPPS's encouragement towards health promoters to address issues of inequalities or risk behaviour among South Africans (Department of Education, 2014). To achieve this it is expected of health promoters to address risky sexual behaviours in youth; design interventions for marginalised populations; establish and facilitate community programmes and support groups for older people in order to manage chronic illness and mental health; support expectant mothers by helping them to recognise key signs of ill-health, supervising chronic conditions and to educate them on mental health issues; creating awareness regarding the social responsibility against gender-based violence and introducing child resistant containers to prevent paraffin ingestion (Department of Health, 2014).

As unclear responsibilities for health promoters was previously identified as a barrier in promoting health, the NHPPS also set out specific responsibilities for health

promoters working at National, Provincial and District levels (Department of Health, 2014). Participants for this study work at district level and therefore these responsibilities will be presented. The first responsibility set out by the NHPPS is the implementation of policies and regulations. This will include all legislature applicable for South Africans as well as policies such as the NHPPS and the Health Promoting School Policy. The second theme regarding health promoters' responsibilities is advocacy and communication. This will comprise health promotion interventions, the execution of health campaigns and screening, provision of IEC material as well as support and advocacy in different communities. The third theme identified in the NHPPS is a leadership role where health promoters are expected to establish relationships with different stakeholders in order to address health issues. The implementation of certain responsibilities is regarded as the fourth theme. This includes the implementation of community services in settings such as health facilities, communities and schools; the planning, coordination and implementation of health campaigns, distribution of IEC material, supporting Primary Health care teams; support CHW's with interventions; deliver health promotion services in health facilities; contribute in school health teams; implement the health promotion plan; create, facilitate and continue integrated support groups and facilitate the Health Promoting Schools programme. Additionally, health promoters also have a responsibility to support research, monitor and evaluate health promotion by reporting and keeping records of activities, evaluate implementation of programmes and to participate in community surveys. The last theme includes skills development and capacity building. Health promoters are responsible for the facilitation and support training for district and sub-district staff. (Department of Health, 2014). It is unclear who the district and sub district staff includes.

The responsibilities of health promoters working in different settings as indicated above shows some differences with a great number of duties overlapping. Although some of these health concerns could be addressed from various angles, the clear distinction of responsibilities could pose as a problem. Some health promoters have

mentioned the overlapping of responsibilities with health promoters working in different settings as problematic (Mthobeni & Peu, 2013). It is also unclear if the same health promoters are responsible for aforementioned actions in all health promotion settings, or if health promoters move to different settings. What is definitely clear is that health promoters have a myriad of responsibilities which are crucial in establishing health and wellness for all.

3.2.4 Responsibilities of health promoters in implementing Health Promoting Schools

In the Western Cape Province, the Health Promoting Schools initiative is implemented by members of the Department of Health, Welfare and Education, community organisations, volunteers and members of the private sector" (Kirby *et al.*, 2006). Although this is the aim for other provinces including the North West Province, it is not clear who implements and drives the Health Promoting Schools' initiatives (DoE & DoH, 2012). The participants for this study are employed by the Department of Health, but the extent of collaboration with other sectors such as the DoE and Department of Welfare is unclear.

At present, it is the responsibility of school health nurses to provide school health services which includes all the duties set out in table 1 (Department of Health & Education, 2012). The Integrated School Health Policy further states that the implementation of HPS is the responsibility of different members of the School based Support Team (SBST). Since South Africa has an inclusive education system, the School-Based Support Team took a prominent role in supporting and coordinating support services to learners with learning barriers, teachers, parents and other members of the school community (Du Toit, Eloff & Moen, 2014). The School-Based Support Team (SBST) consists of the Life Orientation teacher, members of the school health team, representatives from the school governing body, representatives of relevant NGOs, peer educators and learners (Department of Health & Education, 2012).

The SBST has an important role in effectively preventing and managing any problems that may hinder learning and development of learners (Du Toit *et al.*, 2014).

Additionally, the Integrated School Health Policy distinctively places health promoters as a supplementary category of personnel within the SBST to support a professional nurse within a specific district (DoE & DoH, 2012). The professional nurse will fulfil a leading role in the SBST as well as supporting and guiding health promoters until they acquire the necessary skills to deliver quality service without mentoring (Department of Health & Education, 2012). The placement of health promoters as part of the SBST means that health promoters must be able to collaborate with principals, life-orientation teachers, and the school governing body, learners and all other members of the school health team.

Apart from the NHPPS, the ISHP is the only other document which could be found which indicates a health promoter's role within the health promotion initiative. According to this document, the main responsibility of these health promoters will be the provision of education about health topics (Department of Health and Education, 2014). The overlapping of skills can be seen here again as the ISHP also states health education and promotion within schools as the responsibility of community health workers.

Although the ISHP aimed to clarify the roles and responsibilities of health promoters, the interpretation of this document causes some confusion. The ISHP concluded that school health nurses should receive training in managing and conversing difficult topics such as adolescent sexual and reproductive health. Although nurses have a leading role in supporting health promoters, the ISHP positions health promoters as the primary staff for providing education and promotion regarding health within schools. The document should therefore indicate if and to what extent health promoters should receive training on these topics. The policy also doesn't clarify if health promoters are qualified nurses or what training they received. Although the ISHP is a policy which stipulates the Departments of Education and Health's

collaborative role in creating Health Promoting Schools, it gives no further description, profile or job description for health promoters working in schools.

Though the Integrated School Health Policy was unclear about key functions of health promoters within schools, a more detailed job description of health promoters working in schools were conscripted in 2014. The National Health Promoting Programme and Strategy outlines a clearer function for health promoters within the Health Promoting Schools programme (HPS) as well as their function within the School Based Support Team.

3.2.4.1 Key functions of health promoters within the Health Promoting Schools (HPS) programme

The first key functions of health promoters working in school settings includes to be an activist for HPS's by inviting various stakeholders and organisations to the initiative and to have sponsorship meetings (Department of Health, 2014). They also need to invite participation from other structures and programmes in order to incorporate them within the HPS's model. Additional key functions include supporting schools by responding to invitations, having follow-up visits where necessary and supervising the HPS programme. In cases where schools and school staff are unaware of the HPS programme, it is these health promoters' duty to introduce principals, teachers, and school governing bodies, parents and learners to and educate about the HPS programme and assist them to form a health promoting school committee. Thereafter, it is the function of health promoters to assess the needs of the specific school and to develop an action plan according to these needs. The health promoter is then responsible for the training of the committee on how to implement the program and thereafter assess and supervise the action plan. After the implementation, the health promoter's function will be to assess and award schools the status of a Health Promoting School. The health promoters' duties don't end here as they are thereafter responsible for the monitoring of these schools by providing them with support on

how to maintain the status of HPS by using checklist and guidelines (Department of Education, 2014).

3.2.4.2 Functions of the health promoter within the School Health Team

The key function for health promoters supporting the School Health Team is the provision of information and health education (Department of Health, 2014). To do this, the health promoter's duties will include the implementation of health education programmes which includes specific topics outlined in the ISHP. They also play a supporting role in helping the school health team to organise health awareness events as stipulated on the health calendar. These health promoters are also responsible to spread health promoting messages and material to all stakeholders (Department of Health, 2014).

3.2.5 Challenges in health promotion linked to health promoters and their responsibilities

The Health Promotion Initiative in South Africa has experienced many challenges and shortcomings. Vergnani, Filsher, Lazarus, Reddy & James already noted in 1998 that school health is influenced by fragmented health services and a lack of staff. In 2006, the inadequate workforce still posed to be a problem that influences the growth of Health Promoting Schools negatively (UWC, 2006). More recently, the WHO (2013) similarly recognised health promotion capacities and limited health promotion personnel as key problems in executing the health promotion strategy, which contributed to irregular and insufficient visits to schools as well as insufficient follow-ups where necessary. The Department of Health acknowledged this problem as they stated that human resources and their salary levels differ significantly across different provinces. The department also stated that clear norms and standards of employment need to be formed in order to move health promotion forward (Department of health, 2014). When school visits do take place, a lack of adequate referral systems further contributes to the absence of action against identified health needs (Shung-King, 2009). The fragmented and inadequate school visits by health personnel are further

impacted due to a lack of transport and poor road conditions that they have to encounter (Shung-King, 2009).

A lack of knowledge was also identified as one of the key problems for health promoters to carry out their responsibilities effectively. The lack of knowledge included poor counselling skills, superficial facts on health topics and inability to motivate people to make lifestyle modifications (Botes, Majikela-Dlangamandla, & Mash, 2013; Mash, Kroukamp, Gaziano & Levitt, 2015). The WHO concluded in an inter-sectorial case study that the training of health personnel is a serious gap in building health promotion capacity (WHO, 2013). Together with the lack of training the Department of Health correspondingly identified unclear and indistinct allocation of responsibilities for health promoters as contributing to underachievement of health promoting goals (Department of Health, 2014). The Department of Health acknowledged above mentioned findings as they made the development of *job descriptions, occupational classes and curriculum development* their priority by including it into the newest policy and strategy on health promotion (Department of Health, 2014).

Moreover, partnerships and collaboration are also one of the major problems since the start of implementing Health Promoting Schools in South Africa. In the late 1990's, Swart and Reddy (1999) already established that a lack of co-operation and co-ordination across departments of health and education contributed to the barriers faced by health personnel to support the HPS initiative. More recently collaboration and alliance with different stakeholders are still regarded as barriers to enforce health promoting strategies effectively (UWC 2006). Since then, inter-sectorial collaboration by the DoH and DoE and the amalgamation of health promoting personnel was identified as a way of affecting the shared policy concerns of both the education and health sectors (WHO, 2013). It was further recognised that the health promoters do not only need collaboration and support, but also need stakeholders to recognise their work and efforts and the importance of their responsibilities (Hung, 2014).

Partnerships with the wider community are also problematic as health workers encounter resistance or a lack of partnership with parents within school communities (Schellack *et al.*, 2011). Mash *et al.* (2015) similarly encountered resistance from community members. With regard to collaboration and respect of health promotes within the community.

Financial support, the withdrawal of financial support, withdrawal of school health personnel such as school nurses and deficiency in infrastructure also proves to be contributing factors in the difficulties in creating HPS (UWC, 2006). The Department of Health included the requirement for sustainable financial support and other recourses as part of their strategy to facilitate health promotion (DoH, 2014). In direct response to lack of financial support, school health nurses themselves identified insufficient infrastructure and a lack of privacy to adequately screen children physically and mentally as major issues that impact the quality of services they offer (Shung-King, 2009).

In 2013 research was conducted in a rural area called Hammanskraal, situated in the North West Province, which highlighted similar problems as stated above (Mthobeni & Peu, 2013). These health promoters work for a hospice and are employed by the government as well as a non-governmental organisation. The problems and needs as experienced by these health promoters working with adolescents orphaned as a result of AIDS are included in this study to create an integrated picture of the challenges health promoters' experience. A further merit for inclusion was the fact that these health promoters mentioned a concern that the duties and responsibilities they have sometimes overlapped with government employed health promoters (Mthobeni & Peu, 2013).

The following problems were identified by the health promoters themselves (Mthobeni & Peu, 2013):

- unwillingness of adolescents to participate in health promotion activities;

- health promoters work in difficult circumstances with inadequate incomes which hinder their commitment to perform responsibilities;
- lack of transport interfered with necessary follow-up visits;
- health promoters experienced problems with resources as there sometimes was an absence of funds, shortage of staff, inadequate buildings or facilities and shortage of equipment (computers; medical equipment);
- staff shortages were a great concern as the workload was growing;
- health promoters experienced problems with referrals to other professional staff. This included medical screening for health promoters themselves and follow up visits for people in the community;
- Lack of mental health support for health promoters as there are no debriefing sessions;
- Health promoters identified a need for in-service training and skills development, and
- Health promoters also identified a need for respect from management by involving them in decision making process.

From the literature, it is clear the health promoters face numerous challenges in the execution of their responsibilities. To overcome these abovementioned challenges, coordination and partnerships are essential. The successes of health promoters depends on collaboration, support and assistance from all stakeholders including the DoH and DOE, teachers, health workers (including health promoters), governing bodies, learners, the community and all other persons in the school community (Hung *et al.*, 2014; WHO, 1996).

The Integrated School Health Policy (ISHP) suggests regular meetings with the different stakeholders responsible for executing the school health programme to ensure the outlines and objectives set out in the policy are met (DoE & DoH, 2012).

Hung *et al.*, (2014) likewise, highlights the importance of coordination, administration and communication between the different members responsible for the ISHP through regular meetings to discuss information and experienced knowledge, allocate tasks and to preserve resources.

Collaboration with the wider community such as professional health personnel (doctors, occupational therapists, dentists, psychologists, etc.) are crucial where learners are in need of further assistance outside the skill or scope of practice of the school health team (DoE & DoH, 2012). Health promoters therefore need to build networks and relationships with professionals and all stakeholders including other health promoters. In order to do so effectively, they need training on resolving conflict and building and maintaining relationships (Hung *et al.*, 2014).

To further enable health promoters in effectively executing health promotion activities, the DOH and DOE identified that health workers needs to be assigned '*core responsibilities*' (DOH & DOE, 2012). Hung *et al.* (2014) suggested a clear outline or policy with guidelines which will assist health promoters to prioritise and organise tasks. The health workers need to be identified and categorized as school health staff without the endless other tasks they need to fulfil (South Africa, 2011). In order to fulfil these responsibilities, health promoters should receive ongoing training and education on topics related to school health promotion (Hung *et al.*, 2014). Health promoters also need training to enhance the implementation of strategies and roles set out for them in the national health promotion policy and strategy (Department of health, 2014). It is the Department of Health's' goal to work in collaboration with academic institutions in order to effectively train health promoters and building capacity of health promoters already employed by developing a curriculum (Department of health, 2014). A further goal will be to create a continuous professional development program, career path and job description for health promoters between 2015 and 2019 (Department of health, 2014).

3.3 CONCLUSION

While health promoters have a role to play in Health Promoting Schools and in health promotion in general, there is still some confusion regarding their definition and profession. The chapter gave an overview of the different terms referring to health promoters and made a clear distinction between them and community health workers, teachers working as health promoters, nurses working as health promoters and professionals with health promotion duties.

Additionally, the responsibilities of health promoters working in various settings in South Africa were described and thereafter their role in implementing Health Promoting Schools. Literature made it clear that the execution of health promotion programmes is certainly not without some setbacks. A literature review of these challenges was therefore given, which had specific links with health promoters. Thereafter, some suggestions from literature were outlined on how health promoters could receive better support to fulfil their duties.

Although literature regarding health promoters themselves and their direct influence within different settings are limited, enough evidence could be gathered to compose the Health Promoter Questionnaire used to collect data. The next chapter outlines the methods that will be used to obtain a profile of the health promoters employed in the North-West Province, Dr. Kenneth Kaunda District.

RESEARCH METHODOLOGY

4.1 INTRODUCTION

The aim of this chapter is to describe the research methodology used in this study. Therefore, in this chapter the research approach used, the research design applied, the data collection methods utilized and the data analysis methods used will be discussed.

4.2 LITERATURE REVIEW

In order to gain a better understanding of health promoters in schools a systemized literature search was conducted of relevant literature. This is important as a literature search enabled the researcher to adopt a theoretical stance towards health promoters in schools.

Some of the guidelines suggested for conducting a systematic literature review were used to identify the relevant search terms (Cooke *et al.*, 2012). The search terms therefore were: "health promote*" OR "health promotion" (abstract); "health promotion*" AND "schools*" (abstract). The data bases that were used are: EbscoHost (Academic Search Premier, Africa-Wide Information, CAB Abstracts, CINAHL with Full

Text, E-Journals, ERIC, Health Source: Nursing/Academic Edition, MasterFILE Premier, MEDLINE, Philosopher's Index, PsycARTICLES, PsycINFO, SocINDEX with Full Text.), GoogleScholar, and ScienceDirect.

The literature search was conducted to gain a better understanding of health, health promotion in schools and health promoters working in schools. The literature was also used as theoretical framework that enabled researchers to compile a questionnaire to better understand the profile of the health promoter in schools.

4.3 RESEARCH DESIGN

A research paradigm can be seen as a theoretical model that directs and organises the researcher's interpretation of reality (Birley & Moreland, 1998; Creswell, 2012: 70). De Vos & Strydom (2011:41) supports this view by referring to a research paradigm as the way a researcher views their research material. De Vos & Strydom (2011:41) also determined that the paradigm should be explained in a way that keeps communication to the reader clear and unambiguous.

Neuman (2006) states that "research in the social sciences involves the study of people's beliefs, behaviour, interaction and institutions in order to test hypotheses, acquire information and solve problems pertaining to human interrelationships". In this research project the plan was to objectively investigate the health promoter's role by using the biographical information, training, job description, communication methods, planning, school visits, transportation methods, support, barriers, coping and personal health as the variables. These variables were defined and measured by using a questionnaire. Because these variables were the subjective interpretation of health promoters the post positivistic paradigm which evolved from the positivistic paradigm was used. This conclusion was made as "post positivism recognises objectivity as an ideal that can never be achieve as reality is multiple, subjective and mentally constructed by individuals" (Nieuwenhuis, 2010:65).

4.4 ROLE OF THE RESEARCHER

In a research study, various stakeholders can play a role in the research process. In order to be reflective and allow for rigor in the research process the researcher will discuss her role in this study below. The role of the researcher is organised below according to the different elements of the research process.

The researcher was involved in various stages of the research process namely: Research proposal, Ethics application and the application of ethics applications throughout the research project, data collection, data analysis and the discussion of findings.

Research proposal: The researcher reviewed literature, identified the research problem and produced a research proposal for final review by a scientific committee of the North-West University.

Ethics: The researcher obtained permission from the Ethics committee of the North West University to conduct this research. A copy of the proposal was also submitted and approved by the Department of Health and the Department of Education to contact health promoters. Additionally, the researcher applied the key ethics principles throughout the study to ensure respect for participants in this study.

Data collection: Firstly, the researcher consulted with statistical services, and primary investigators to compile the Health Promoter Questionnaire. Secondly, the researcher circulated the questionnaires to the health promoters in the North-West Province specifically in the Dr. Kenneth Kaunda District. The researcher collected the questionnaires.

Data analysis: Additionally, the researcher assisted with the analysis of the quantitative data. The researcher conducted descriptive statistics such as frequencies to organize the quantitative data.

Interpretation and discussion of findings: Lastly, the researcher organized, interpreted and discussed the findings under the direct supervision of statistical consultation services to ensure the validity of the analysis and interpretation.

4.5 POPULATION AND SAMPLING

A population can be seen as the "total number of units from which data can be collected" (Parahoo, 2006). The population in this study were the health promoters currently employed by the Department of Health in the North West Province in the Dr. Kenneth Kaunda District of South Africa. This research population was restricted to a homogenous group of participants by excluding all health promoters that work in the medical field and only including health promoters that work in a school setting.

A non-probability purposive sampling technique that is primarily used in quantitative studies was chosen. Purposive sampling involves the selection of groups with a specific purpose in mind (Maree & Pietersen, 2010:178). Thus, purposive sampling was used to generate relevant data to answer the research questions and make plausible suggestions for policy making, further training or further research. Polit and Beck (2010) are of the opinion that quantitative researchers should include the largest sample possible that is representative of the target population. Therefore, for the purposes of this study the population was all available health promoters that are working in a school setting within the Dr. Kenneth Kaunda District of the North West Province (N=16).

The selection criteria for the purposes of this study were:

- (a) People employed by the Department of Health and deployed to work as health promoters in schools;
- (b) Working within the North-West Province and in the Dr. Kenneth Kaunda District, and
- (c) Were able read and understand English effectively.

Participants were excluded from this study if they were not able to read and understand English effectively, if they were employed in other Provinces and if they were employed as health promoters within the medical field.

4.6 RESEARCH CONTEXT

The research was conducted in South Africa, the North-West Province, Dr. Kenneth Kaunda District. The North-West Province is visually illustrated in the map below.

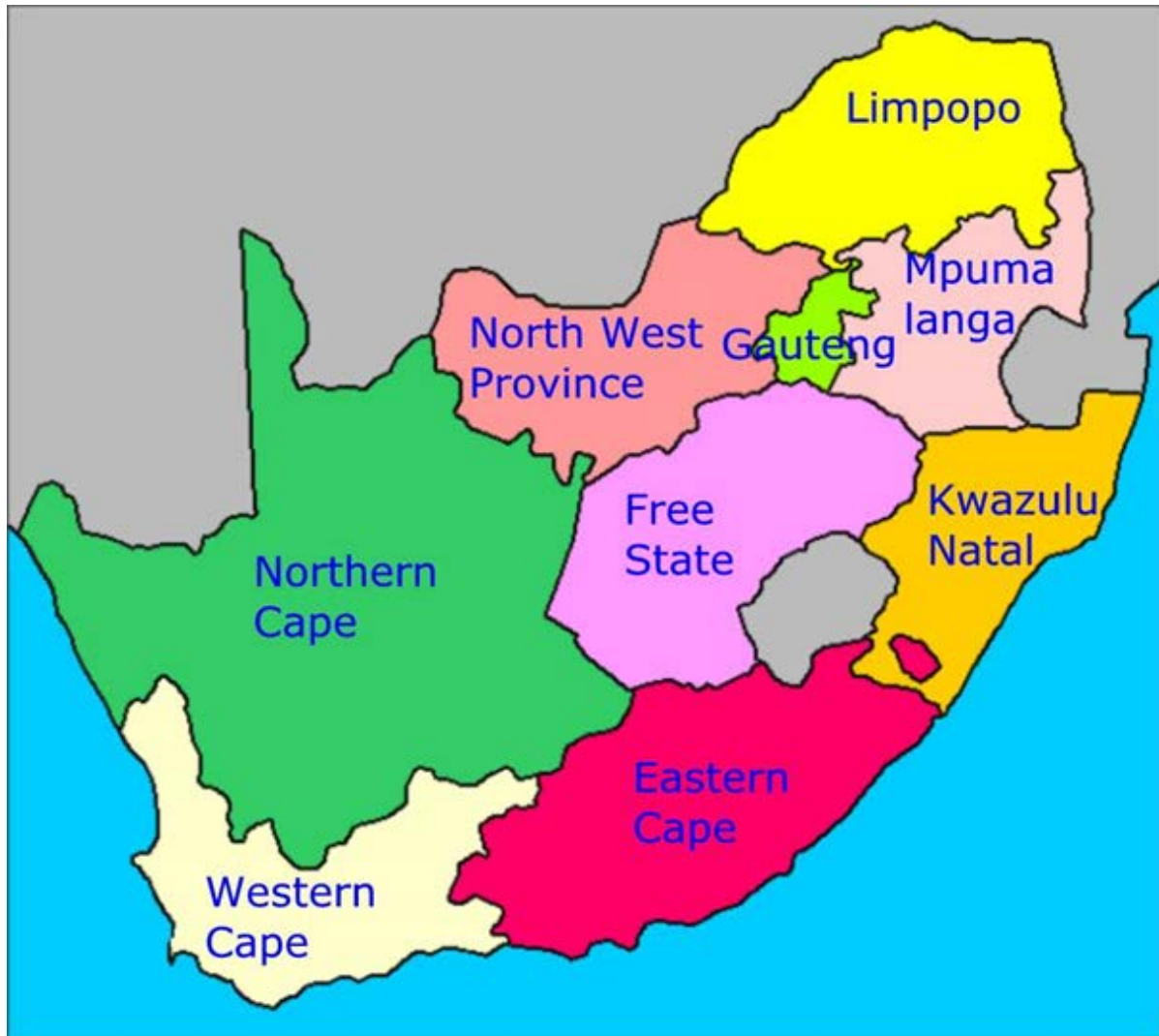


Figure 7: Regional map of South Africa

There are different school districts in the North-West Province namely: Ngaka Modiri Molema (Mahikeng/Zeerust/Lichtenburg Area); Dr. Ruth Segomotsi Mompati (Vryburg/Taung area); Dr. Kenneth Kuanda (Klerksdorp/Potchefstroom area); and Bojanala (Rustenburg/Brits area). The Dr. Kenneth Kuanda district is presented in the figure below.

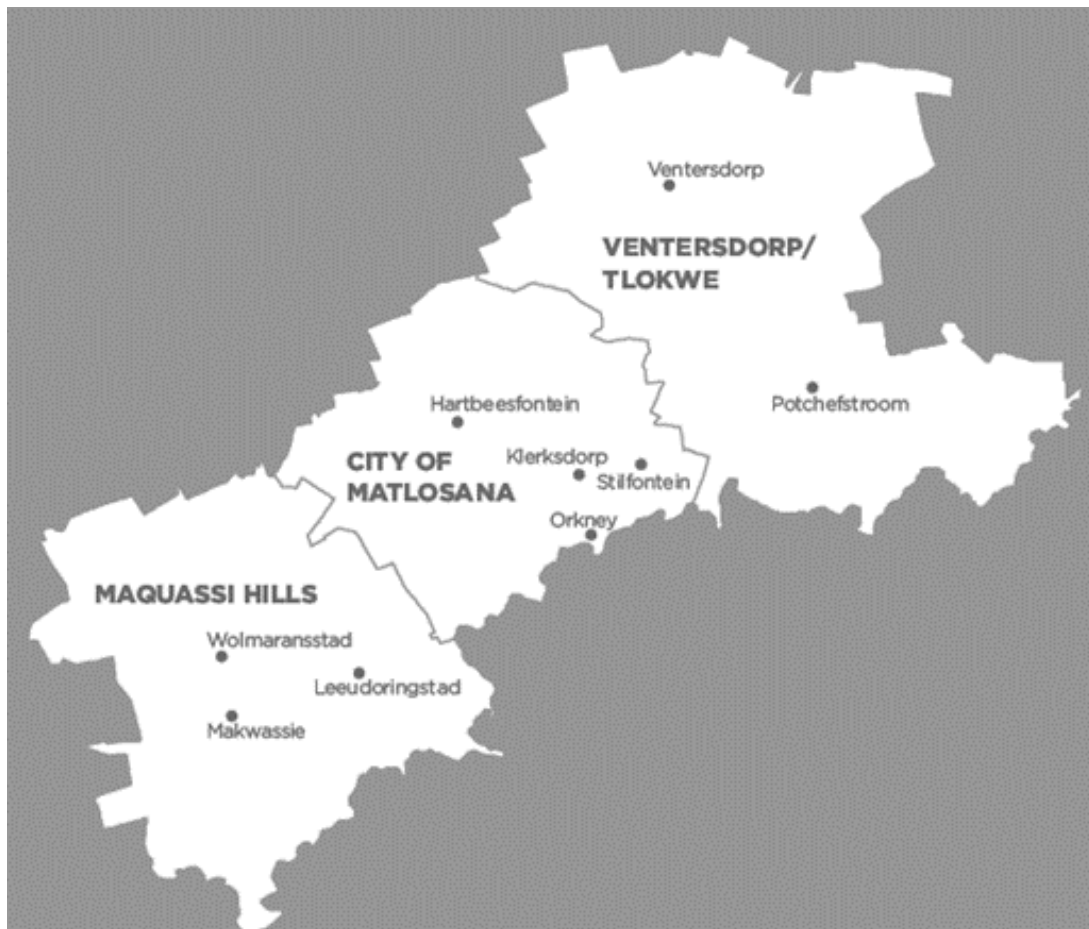


Figure 8: Map of the Dr. Kenneth Kaunda District

The Dr Kenneth Kaunda District Municipality (local government) is located within the North West Province. The district is located 65km south-west of Johannesburg and borders the Gauteng Province. It is the smallest school district in the province, making up 14% of its geographical area. The municipality consists of three local municipalities: Tlokwe/Ventersdorp, City of Matlosana and Maquassi Hills. This district serves 206 schools.

The North West Province, Dr. Kenneth Kuanda has been chosen to be included in this study as there had already been some initiatives in this community (school-based initiatives) with the objective to establish health promotion in schools. The findings of this study can therefore be used to support and/or adjust existing interventions and to promote the development of new interventions that can address the issues faced

by health promoters. Even though a selection of this specific community was initially made, findings will be available to all the communities in South Africa, and similar studies in other communities are encouraged.

Participants from different schools in the North-West Province, representing different gender groups, who are employed as health promoters in school settings by the Department of Health were selected to participate in this study. All health promoters that work within a school setting were included to allow for distributive justice. Literature and information regarding which specific schools these health promoters visit is unclear. The health promoters follow specific themes which are highlighted by national and provincial programmes set out by the Department of Health. Sometimes health promoters visit schools where a specific need arises, but it is unclear how health promoters are being made aware of specific needs.

4.7 DATA COLLECTION

In quantitative research, certain features of a phenomenon and not the phenomenon itself are being measured (Delport and Roestenburg, 2011). The quantitative data collection method that was used for this research was therefore to measure certain properties relevant to the profile of health promoters. The method chosen has to describe abstract concepts in terms of numbers or symbols in accordance with specific rules (Monette, Sullivan & De Jong, 2008:103-104). An extensive research questionnaire was compiled to achieve this aim.

Babbie (2007) defines a questionnaire as "a document containing questions and or other types of items designed to solicit information appropriate for analysis". The objective of the questionnaire was to obtain facts and opinions about the role of health promoters consisting of the following variables:

- biographical data;
- training;
- training needs;

- ways of communication;
- language;
- work demands;
- planning;
- transport;
- support;
- barriers, and
- personal health.

The questionnaires were administered in groups where each respondent completed their own document without discussing it with the other members of the group. As indicated by Delport & Roestenburg (2011:189), group-administered questionnaire can be an advantage because a significant amount of time and cost are being saved and the group are simultaneously exposed to the same stimulus. The quantitative data was collected by administering *The Health Promoter Questionnaire*.

4.7.1 The Health Promoter Questionnaire

The literature review provided different themes that guided the design of the questionnaire. Every theme identified in literature contributed to the formulation of questions in order to provide significant/relevant responses regarding the role of health promoters. These themes were used to formulate further investigations and develop training programmes for executing effective health promotion strategies in the North West Province.

The validity of conclusions was made and cross-referenced with existing literature. *The profile of the health promoter in schools in the North West Province* health promoter questionnaire was designed by statistical services of the North West University and the researchers of this study. Although the questionnaire was not piloted, experts were consulted regarding contents and language usage appropriate for the specific population. The aim of the questionnaire was to gather information about the role of the health promoter in schools within the North West Province specifically in the Dr.

Kenneth Kaunda District. Although questionnaire appears to be long, most questions are multiple choice questions and did not take participants longer than an hour to complete. The researcher was available during the completion of the questionnaire to ensure that participants could ask questions if there were any uncertainties.

The questionnaire was structured as follows (See Addendum A):

- **Biographical information of the health promoter:** the general biographical information such as the age, gender, race, nationality, and languages spoken.
- **Training and qualifications:** the highest qualification of health promoters as well as additional training received. This section also includes questions about what training is needed.
- **Work/ job description:** What is expected of health promoters in their daily work activities?
- **Communication:** Communication methods used to communicate with the Department of Health, other health promoters and schools.
- **Planning:** General information about the planning of activities within the school context.
- **School visits:** General information about the coordination of school visits and contact with teachers and learners at the schools.
- **Transportation:** Modes of transportation of health promoters.
- **Support:** Support given to health promoters from colleagues and the Department of Health.
- **Barriers:** Challenges and conflict in the execution of their daily activities.
- **Coping:** General questions about the coping strategies health promoters use in the execution of their daily activities.

- **Personal health:** General information about stress and other health issues faced by health promoters.

The questionnaire consists of 60 questions that were divided in eleven sections.

4.8 DATA ANALYSIS

A professional statistician was employed to provide professional guidance and advice in the proper conceptualisation, design and identification of themes before conducting the research in order to facilitate data analysis. The statistician also provided expert advice on selecting relevant instruments and analysis procedures.

Conclusions were made by quantifying standard deviations and derivation of mean in order to examine comparisons and deviances in patterns by using IBM SPSS Statistics version 23 (Grove, Burns & Grey, 2011). According to McDonnell and Timmins (2012:2492) the literature review and main objectives of a study should be taken into account when analysing data.

4.8.1 Reliability and validity

The instruments used in quantitative research are of central importance for ensuring reliability and validity (Nieuwenhuis, 2010:80). Reliability refers to the accuracy and the consistency with which a questionnaire measures (Polit & Beck, 2010). To ensure the reliability of the questionnaire it was administered by the researcher. There was no pilot study, therefore no statistical measures were employed to confirm validity and reliability, however, the reliability of the questionnaire was ensured by submitting it to peer reviewers, members of the statistical committee of the NWU and subject experts in order to ensure the face validity and construct validity to confirm that the questionnaire measures what it is supposed to measure (Polit & Beck, 2010). In the designing of the questionnaire, an expert statistician was also employed to ensure that all possible measures were taken to confirm reliability and validity.

4.9 ETHICAL CONSIDERATIONS AND PROCEDURE

Strydom (2011:127) states that researchers which do not execute research ethically are negligent towards society. Ethics should be taken into consideration throughout the research process (Creswell, 1998:89-92). An ethical code of conduct should apply to the research problem, purpose and questions, data collection, data analysis and interpretation and in the writing and distributing of the research (Creswell, 1998:89-92). The researcher was very mindful of these ethical considerations throughout the research process. Great care was exercised in assuring ethical conduct by considering the following topics highlighted by Strydom (2011:115-126):

By all means avoid possible harm to respondents and all other persons involved in the research.

- Ensure that all respondents participate voluntary and that they are aware.
- Acquire written informed consent from all respondents.
- Avoiding deception of subjects and/or respondents.
- Ensure the privacy and confidentiality of all involved.
- Ensure that researchers' behaviour is ethical and that they are competent.

Ethical approval: Ethical approval was obtained from the Educational Ethics Committee at the North-West University.

Gatekeepers in Communities: The Departments of Health and Education and the headmasters of Schools acted as gatekeepers to introduce the researchers to the prospective research participants. Gatekeepers were asked to invite participants to an information session that allowed participants to take part in a discussion regarding the aim of the research and what will be expected of participants. The participants were recruited through a manager of the Department of Health in the North West Province, Dr. Kenneth Kaunda District. Informed consent forms were available to the participants in order for them to study the consent form and ask any questions if needed.

Fieldworkers: The principal investigators of this study acted as fieldworkers. These fieldworkers were fluent in English. Fieldworkers received training to obtain informed consent, as well as in administering questionnaires. This training was presented by means of interactive practical workshops, presented by researchers from the North-West University with experience in conducting research, before the different data gathering days.

Capturing data: The numerical data gathered by means of a quantitative questionnaire was captured in an excel document by the principal investigators with the assistance of Statistical Services of the North-West University.

Sampling: Participants were selected by means of purposive sampling. All the health promoters working in a school context, in the North-West Province, Dr. Kenneth Kaunda District had equal opportunity to voluntarily take part in the research. A maximum of 16 participants were selected to take part.

Informed consent: Participants received informed-consent forms at least one week prior to the data gathering days in English. The informed-consent form provided participants with more information regarding the aims and objectives of the study, and what will be expected of the participants. The form also explained the research procedure and that participation in this research is voluntary. The informed-consent also indicated that the participants' identifiable information will not be made public, and that their information will be kept confidential within the research process. The informed-consent was submitted to the Ethics Committee for final review, before conducting the research. See Addendum B for the informed consent letter.

Anonymity and Confidentiality: Participants were assured that their identifiable information will be treated as confidential as possible and that their names will not be used in any report.

Incentive and reimbursement: Participants were not compensated for their participation in this research project. The data gathering took place in central locations

within the community. Travel to and from the research location were limited by conducting the research at a central location where participants can travel to the venue without any additional costs to them.

Data storage: The data gathered and participants' identifiable information will be stored in a safe place at the Faculty of Education Sciences, Potchefstroom Campus of the North-West University. Only the primary researchers will have direct access to all the hard copies (printed copies). The electronic data will be kept on password protected computers where only the principal investigators will have direct access to the information (external /flash drives which will be kept in locked rooms in at the North-West University). The printed and electronic data will be stored for five years and will be shredded, deleted and destroyed responsibly thereafter.

Monitoring of the Research: The principal investigators regularly monitored the research process during data collection.

Data collection procedure: The data collection took place over a period of one month during which the research team will collect data within the North-West Province, Dr. Kenneth Kaunda district of South Africa. Fieldworkers administered questionnaires individually.

Re-use of data: The data may be re-used in further studies with a clear focus on health promotion in a school context.

Additionally, the three principles that are stressed in the Belmont Report (1979) namely: Respect, beneficence and justice, were followed. All participants were informed that they could withdraw at any stage without any negative consequences. Furthermore, great care was exercised in assuring ethical conduct by all means avoiding possible harm to participants and avoiding any deception of the participants.

4.10 CONCLUSION

In this Chapter, the research design and methodology that were used to obtain a profile of the health promoters in the North-West Province, Dr. Kenneth Kaunda

district were presented. The application of the quantitative research method was discussed by presenting the different elements which directed the study. A detailed overview of the Health Promoter Questionnaire used to collect quantitative data was also presented. The chapter concluded with the ethical considerations and procedures which highlighted aspects which were considered throughout all the phases of the research process.

Chapter 5 will present the data that were obtained through the Health Promoter Questionnaire and will be followed by a discussion of the data. The data collected will then be corroborated with current literature about the relevant topics.

THE PROFILE OF THE HEALTH PROMOTER: A QUANTITATIVE INVESTIGATION

5.1 INTRODUCTION

Several categories of data were collected by circulating the Health Promoter Questionnaire to all health promoters currently employed in the Dr. Kenneth Kaunda District, North West Province. Although the aim was to involve more participants, it was beyond the control of the researcher to include additional participants as will be discussed in the limitation section of this chapter.

Currently there are only 16 employed health promoters in the Dr. Kenneth Kaunda District where three did not complete the questionnaire and 13 questionnaires were completed. Although this is a small number of participants, the legitimacy of the data was confirmed by employed statisticians of the North West University. The final systematic analysis was thus based on the responses of 13 participants which yielded a response rate of 81%.

The key aim of this chapter is to report and discuss data received in order to attend to the research question stated in Chapter 1 (*What is the profile of the health promoter in schools in the North West Province?*).

To answer the research question, systematic results will be presented in the form of frequency tables, graphs and pie charts. To ensure the logical sequence for the discussion, the data will be discussed under the following sections of the Health Promoter Questionnaire:

- *Biographical information of the health promoter*
- *Training and qualifications*
- *Work/Job description*
- *Communication*
- *Planning*
- *School visits*
- *Transportation*
- *Support*
- *Barriers*
- *Coping*
- *Personal health*

5.2 RESULTS

A professional statistician was employed to provide professional guidance in the proper analysis procedures by means of systematic measures. Conclusions were made by quantifying standard deviations and derivation of mean in order to examine comparisons and deviances in patterns (Grove, Burns & Grey, 2011). The results of the eleven sections of the Health Promotion Questionnaire will be provided below. A

comprehensive discussion of results will follow while taking into account the main objectives of the study and the literature review.

5.2.1 Biographical information

In this section, there are nine questions relating to the health promoters' biographical information. This information has been utilized to assist the researcher in concluding a profile of the health promoter based on their age, race, and marital status, number of children, nationality, home language, additional spoken languages, and previous occupation. None of the above-mentioned categories included in the biographical section were used in any way as a distinguishing category between different ages, races or genders, but were merely used in an attempt to obtain a better understanding of who the health promoter is. The findings of this section are given and illustrated below.

Figure 9 divide participants into their various age groups. It is clear that the majority of the participants are between the ages of 31-40 years old (61%), with 4 participants between the ages of 20-30 years (31%) and only 1 participant older than 50 years of age.

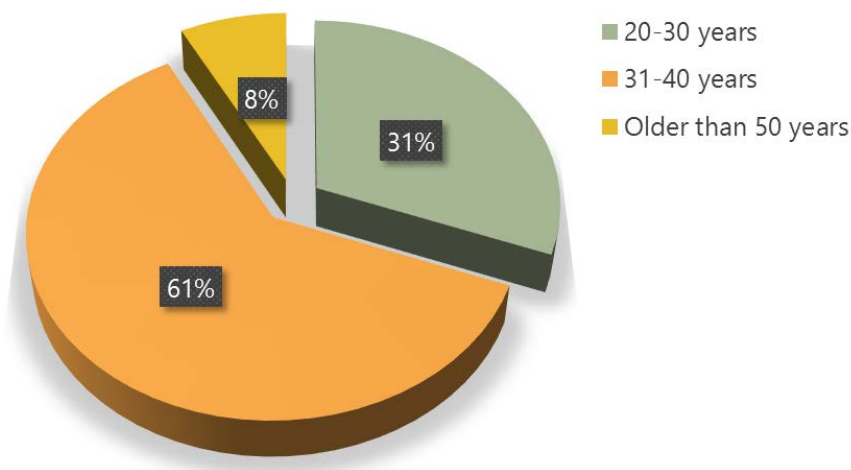


Figure 9: Age of the health promoter

An analysis of the gender presented in Figure 10 indicates that there is a clear male dominance in the participants represented by this study. The data indicates that there

are 11 (85%) male and 2 (15%) female health promoters. Question 3 of the health promoter questionnaire revealed that all participating health promoters are Black Africans.

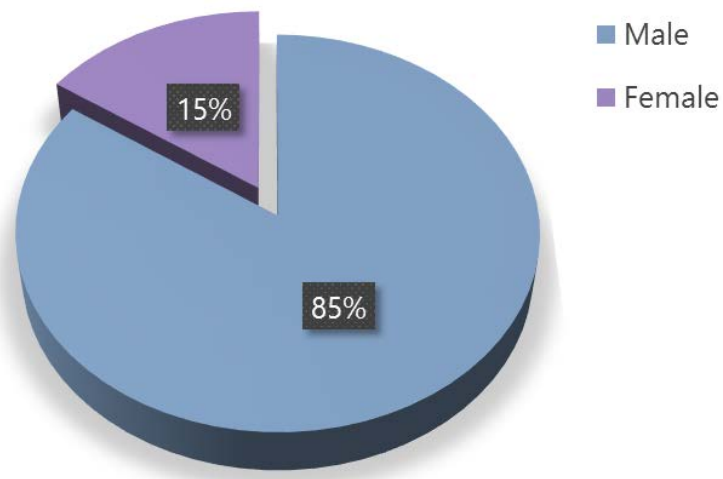


Figure 10: Gender of health promoter

In Figure 11 it can be seen that the family sizes of the participants varied: A total of 15.4% of the participants specified that they had no children, 76.9% had 1-2 children and 7.7% had more than 2 children in their household.

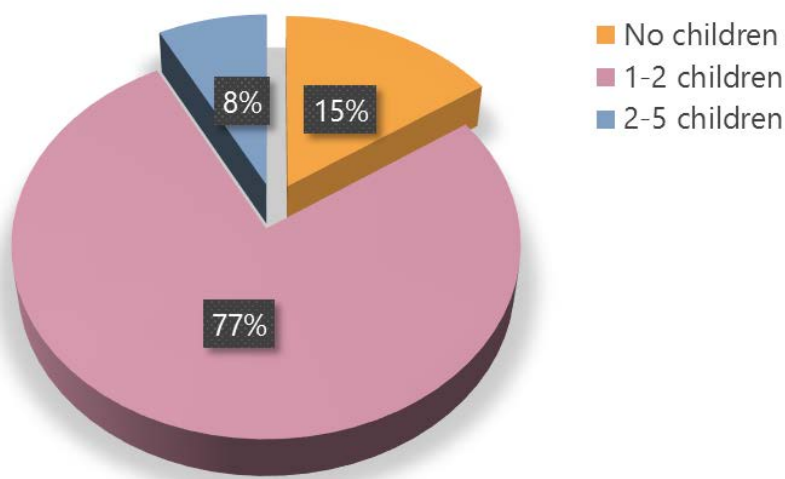


Figure 11: Number of children of the health promoter

Question 6 of the health promoter questionnaire analysed the nationality of the participants. As seen in Figure 12, all but one participant stated their nationality as South African. One participant did not complete the question.

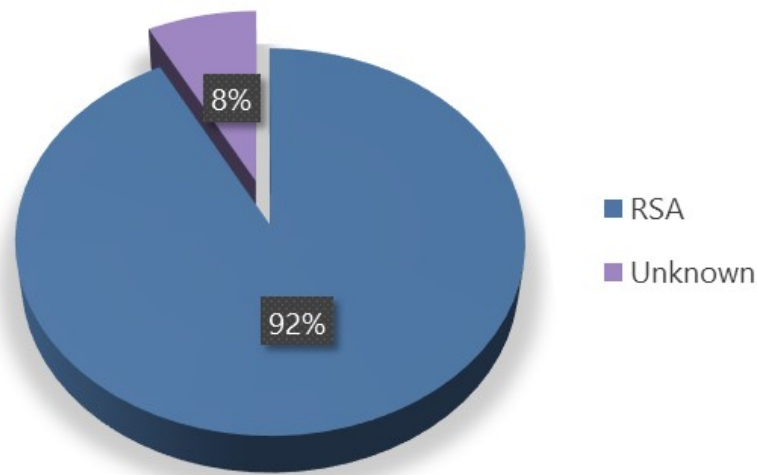


Figure 12: Nationality of the health promoter

Figure 13 is a representation of each participant's marital status. A total of 54% of the participants indicated that they are single, whereas 23% are married and 8% are separated. Two participants (15%) did not give an answer.

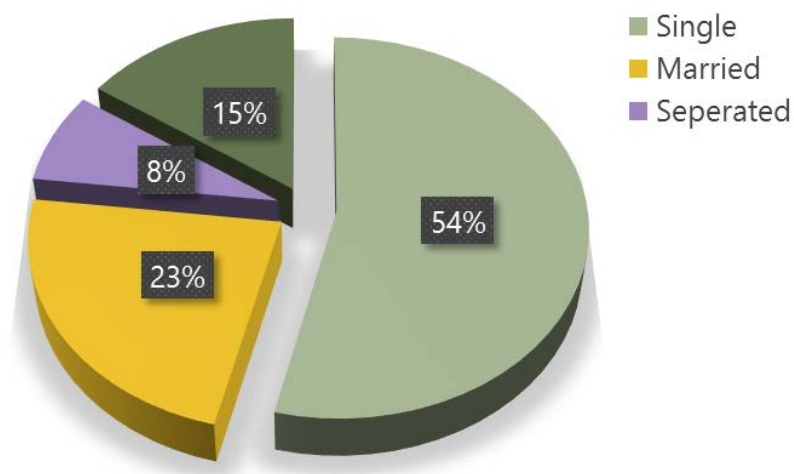


Figure 13: Marital status of the health promoter

Figure 14 divides participant's responses into their different home languages. More than 84% (11 out of 13) of the participants specified Setswana as their home language

and only two other participants stated isiXhosa and/or isiZulu as their home languages irrespectively.

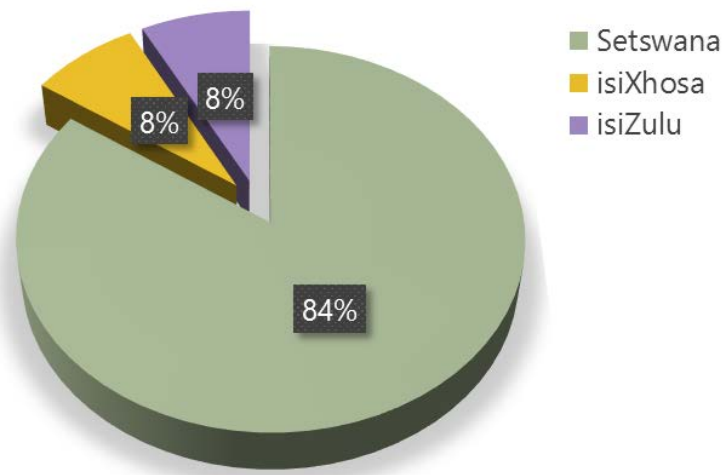


Figure 14: Health promoters' home language

The participants were then asked to complete a table with detailed columns about the extent to which they know the 11 official and 3 other language options. Table 2 illustrates that most participants speak English and Setswana to a large extent with only 8 of the participants indicating that they could speak Sesotho to a large extent. Although 1 participant indicated that he/she could speak English to a moderate extent, the researcher was available to answer questions when this participant completed the questionnaire. Furthermore, four participants can speak isiXhosa and 4 isiZulu to a large and moderate extent respectively. Most health promoters in this district can therefore speak two official languages to a large extent but are proficient in at least one other official language.

Table 2: The health promoter and spoken languages

Spoken language	Not at all	To a small extent	To a moderate extent	To a large extent
Afrikaans	1	4	6	2
English	0	0	1	12
Sepedi	6	2	3	1
Sesotho	2	1	2	8
Setswana	0	0	2	11
SiSwati	9	3	0	0
isiNdebele	12	0	0	0
isiXhosa	3	1	4	4
isiZulu	4	1	4	4
Tshivenda	12	0	0	0
Xitsonga	10	0	2	0
Fanagalo	9	2	1	0
Portuguese	12	0	0	0
International languages	12	0	0	0

Figure 15 is a representation of each participant's previous experience or occupation. The data exposed that most of the health promoters employed in the Dr. Kenneth Kaunda district were previously employed as either (a) Lay counsellors (31%); (b) Shop assistants (31%); or (c) HIV counsellors (15%). Although the health promoters previously employed as lay counsellors and HIV counsellors may have had previous experience in health promotion, 31% of the health promoters were shop assistants without any background in health promotion. The health promoters who indicated 'other' occupations on the questionnaire did not specify their occupation.

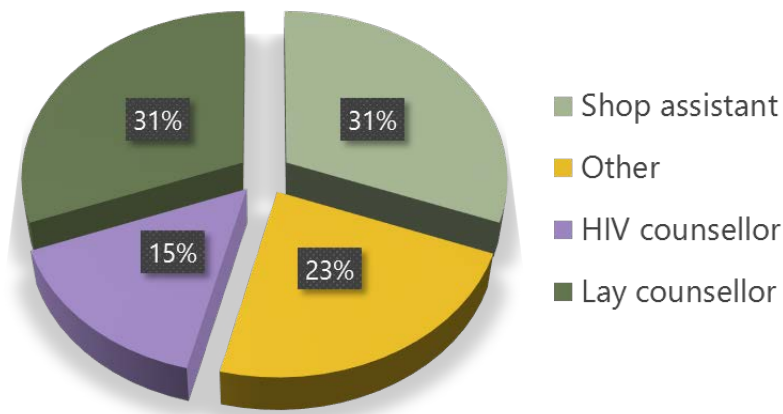


Figure 15: Previous occupation of the health promoter

Summary of biographical section: Health promoters are mostly black, male South Africans, between the ages of 31 and 50 years of age and single with 1-2 children of their own. They are able to speak Setswana and English and at least one other official language. Most of the health promoters have a background in some type of counselling but 31% do not have any background in health-related occupations.

5.2.2 Training and qualifications

Section B of the Health Promoter Questionnaire was compiled to investigate the level of training and qualifications of health promoters currently employed by the Department of Health in the Dr. Kenneth Kaunda District, North West Province. This section consisted of 4 main questions with an elaborate number of training themes related to the major problems within the health and education sectors of South Africa which could influence children's wellbeing and health. The findings of this section are set out below.

According to the information presented in Figure 16, most of the health promoters reported their highest qualification as completing Grade 12. Only 3 participants (23.1%) responded with a different answer which indicated some form of additional training beyond Grade 12. These participants stated that they were employed as an

auxiliary nurse and management assistant with one participant indicating that they has a diploma in marketing.

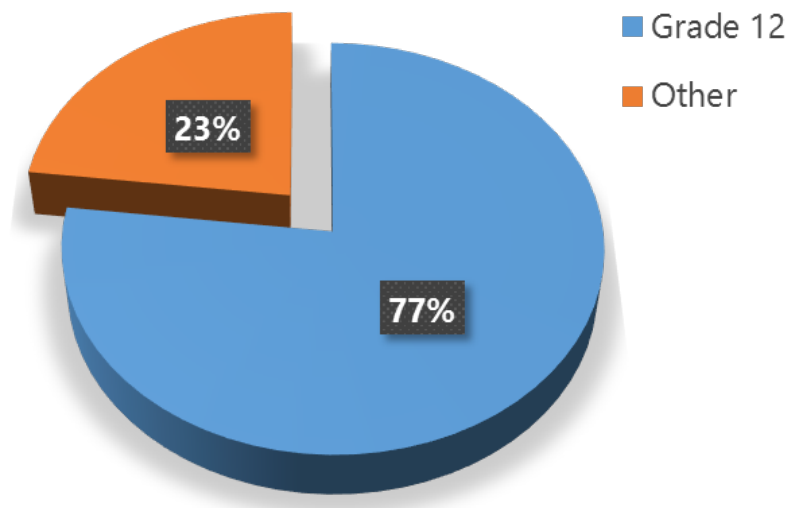


Figure 16: Highest qualification of the health promoter

Question 11 of the health promoter questionnaire was aimed at determining the type of training participants received concerning specific themes in the health promotion programme. Although most participants indicated that their highest qualification were Grade 12, most participants also specified that they had some form of training in health promotion themes whilst employed by the Department of Health.

Figure 17 below represents the answers given by participants regarding the training themes: alcohol/drug prevention, coping with death and mourning, HIV/AIDS, STD prevention, suicide prevention, violence prevention in schools (including bullying, fighting, homicide, rape etc.) and Tuberculosis.

According to the results, themes such as HIV/AIDS and STD prevention receive the highest priority, with more than 60% of these health promoters having received training to a large extent and with more than 15% who received training to a moderate extent. Only one participant indicated they did not receive any training in both HIV/AIDS and STD related themes.

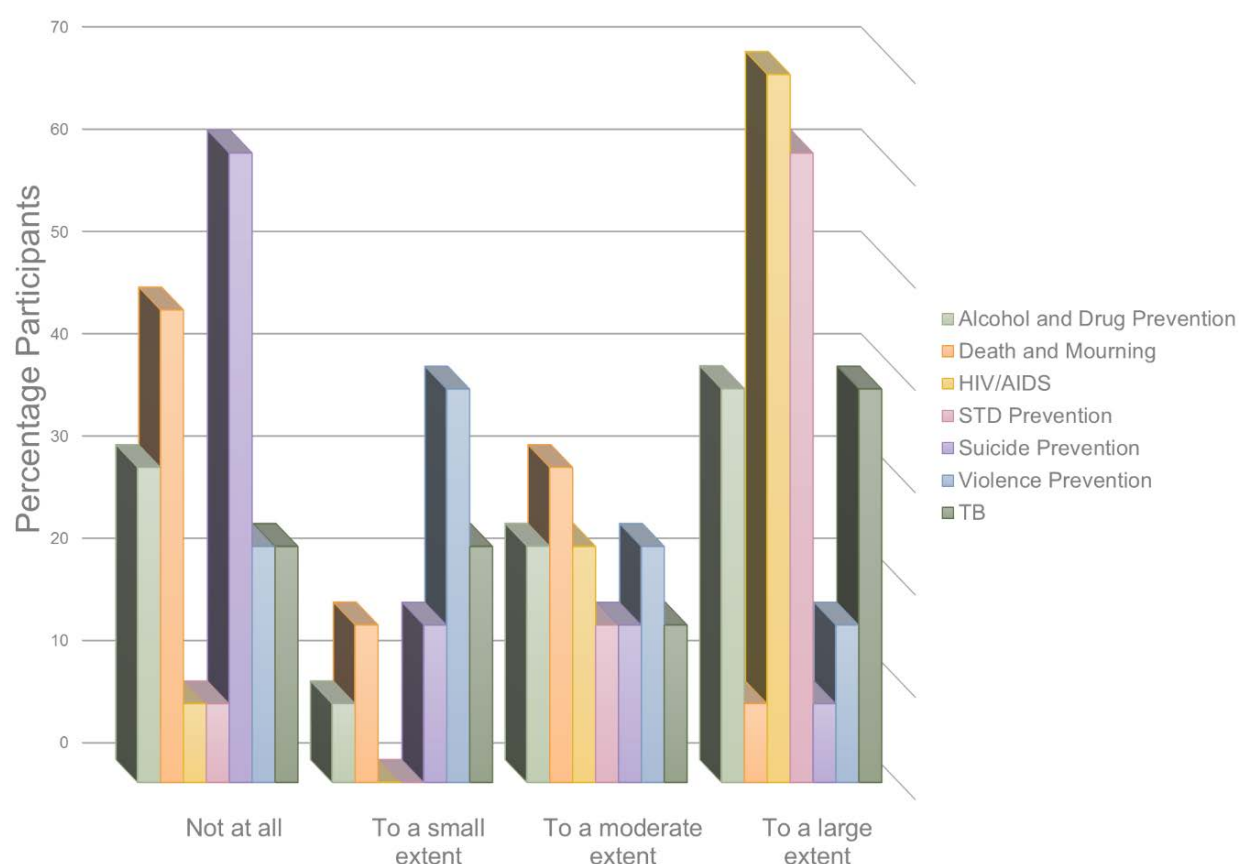


Figure 17: Training the health promoter received from the Department of Health

The themes Tuberculosis, violence prevention, alcohol or other drug use prevention as well as death and mourning received a variety of answers. As Figure 17 indicates, only 38% of participants received training in TB related topics with 15.4% and 23.1% who received training to a moderate and small extent respectively. A total of 23.1% participants did not receive any training whatsoever in TB related topics. Similar results for alcohol and drug prevention training were reported as 38.5% received training to a large extent, 23.1% received training to a moderate extent and 7.7% to a small extent. A total of 4 out of 13 participants (30%) reported that they did not receive any training regarding alcohol and drug prevention.

Violence prevention received less attention than above mentioned topics with only 15% and 23.1% of participants indicating that they received training to a large extent

and moderate extent respectively. A total of 38.5 % of participants received training to a small extent with 23.1% who did not receive training at all.

Death and mourning related training and suicide prevention are regarded as the topics with the least training. Participants specified that only 7.7% of them received training in death and mourning to a large extent, 30.8% to a moderate extent and 15.4% to a small extent. A total of 46.2%, which is almost half of the participants, stated that they did not receive training of any kind. Suicide prevention training had similar results as only 1 participant specified that they received training to a large extent with 15.4% of participants indicating they received training to a small extent and moderate extent respectively. A total of 61.5% of participants received no training in suicide prevention.

Results therefore indicates that participants did receive some form of training in health promotion themes, but there is still a gap in formal training and skills development in several major health promotion themes.

Figure 18 is a representation of the participant's comfort with their current health promotion knowledge.

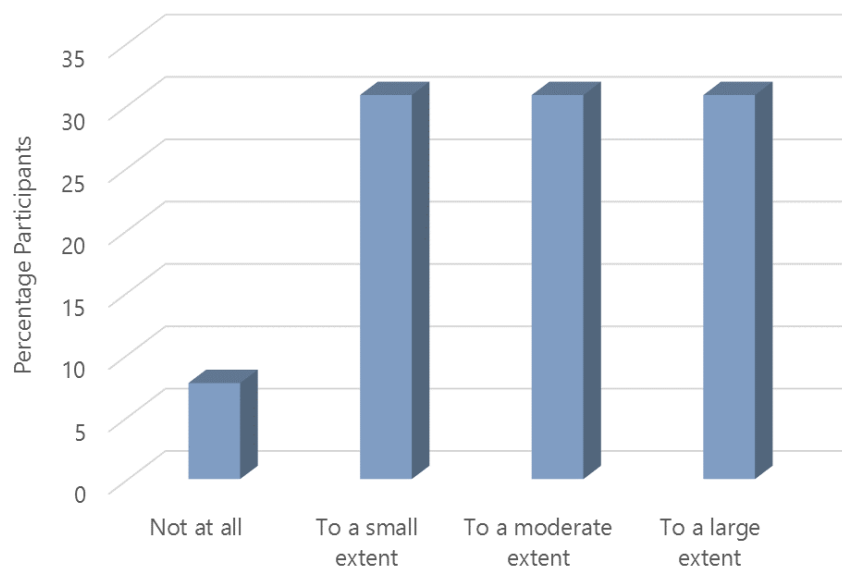


Figure 18: The health promoter's comfort with current knowledge

There was a relatively even spreading of the extent to which participants feel comfortable with the knowledge they have to execute their current responsibilities as health promoters. Of the 13 participants, 4 responded that they are comfortable with their knowledge to a large extent, 4 to a moderate extent and 4 to a small extent. One participant reported that they were not comfortable with their knowledge at all.

Question 13 of the health promoter questionnaire was compiled to determine the training which participants would like to undergo and are illustrated in Figure 19.

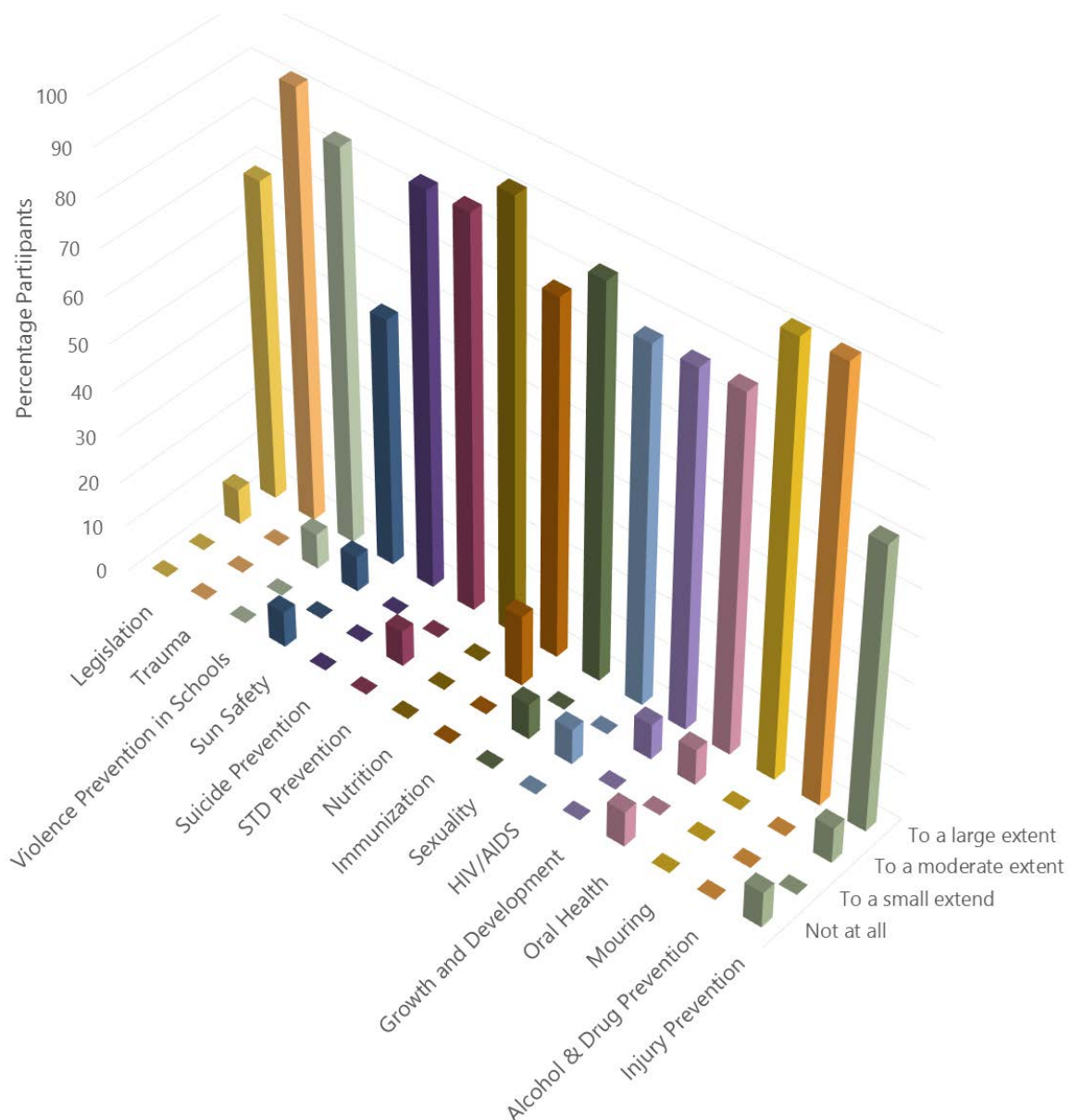


Figure 19: Training interests of health promoter

The themes of the training were selected by including topics already included in the Health Promoting School's programme and also added topics which literature proved to be possible health concerns for children in South Africa (McDermott-Levy & Weatherbie, 2012; WHO, 2013). Figure 19 illustrates that all of the training themes included in the questionnaire are topics which participants have an interest in receiving additional training in. Themes such as alcohol and drug prevention, mourning, HIV/AIDS, sexuality, nutrition, STD prevention, suicide prevention, violence prevention and trauma proved to be the most relevant

Summary of the training and qualification section: Most of the health promoters reported that they completed Gr.12 and have no additional formal training (such as certificates, diplomas or degrees) in health or other related subjects. They did however receive training in specific themes while employed as health promoters by the Department of Health. The training topics which received the most attention are HIV/AIDS and STD prevention. Participants received some form of training in TB as well as alcohol and drug prevention themes, yet still inadequate. Health promoters did not receive sufficient training in themes such as violence prevention, death and mourning and suicide prevention. Although the health promoters received some informal training in certain health promotion themes they do not feel comfortable with their current knowledge regarding health promotion. Even though they do not feel comfortable with their knowledge regarding the themes they are all eager and willing to undergo further training in topics such as: alcohol and drug prevention, mourning, HIV/AIDS, sexuality, nutrition, STD prevention, suicide prevention, violence prevention and trauma.

5.2.3 Work

This section of the health promoter's questionnaire aimed to determine the participants' current view and understanding regarding their work/job description, career satisfaction and salary.

Question 14 (a) of the Health Promoter Questionnaire enquired whether participants had a job description or not and question 15 further explored this question with specific job description topics. Figure 20 illustrates that a total of 61.5% participants had a job description to a large extent with 23.1% having a job description to a moderate extent. A total of 15.4% indicated that they did not have a job description at all.

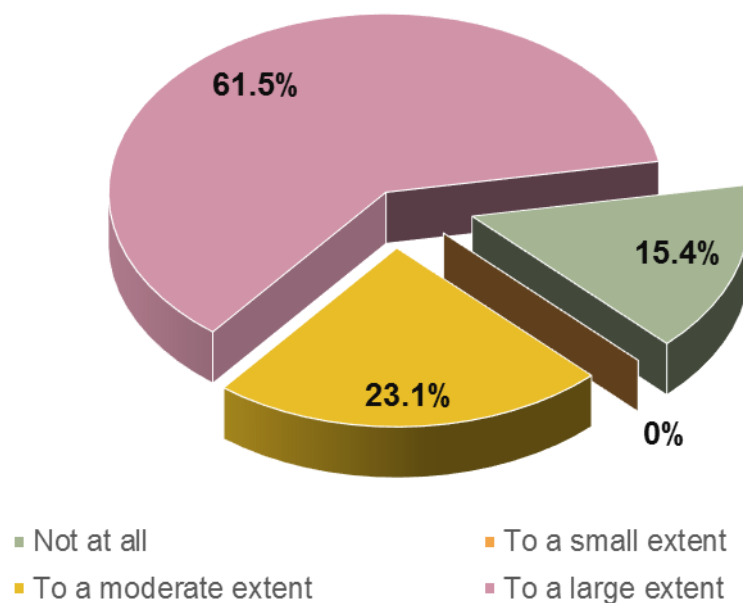


Figure 20: Job description of the health promoter

Next the extent to which such a job description exists and which themes and topics are included were investigated. The themes and topics included in the health promoters' job description are illustrated in Figure 21 below.

The topics included into the question were extracted from the job descriptions for health promoters in the Integrated School Health Policy (Department of Health and Education, 2012). When the questionnaire was finalised and administered the National Health Promotion Policy and Strategy (Department of Health, 2014a) which has a more detailed job description for health promoters were not available yet.

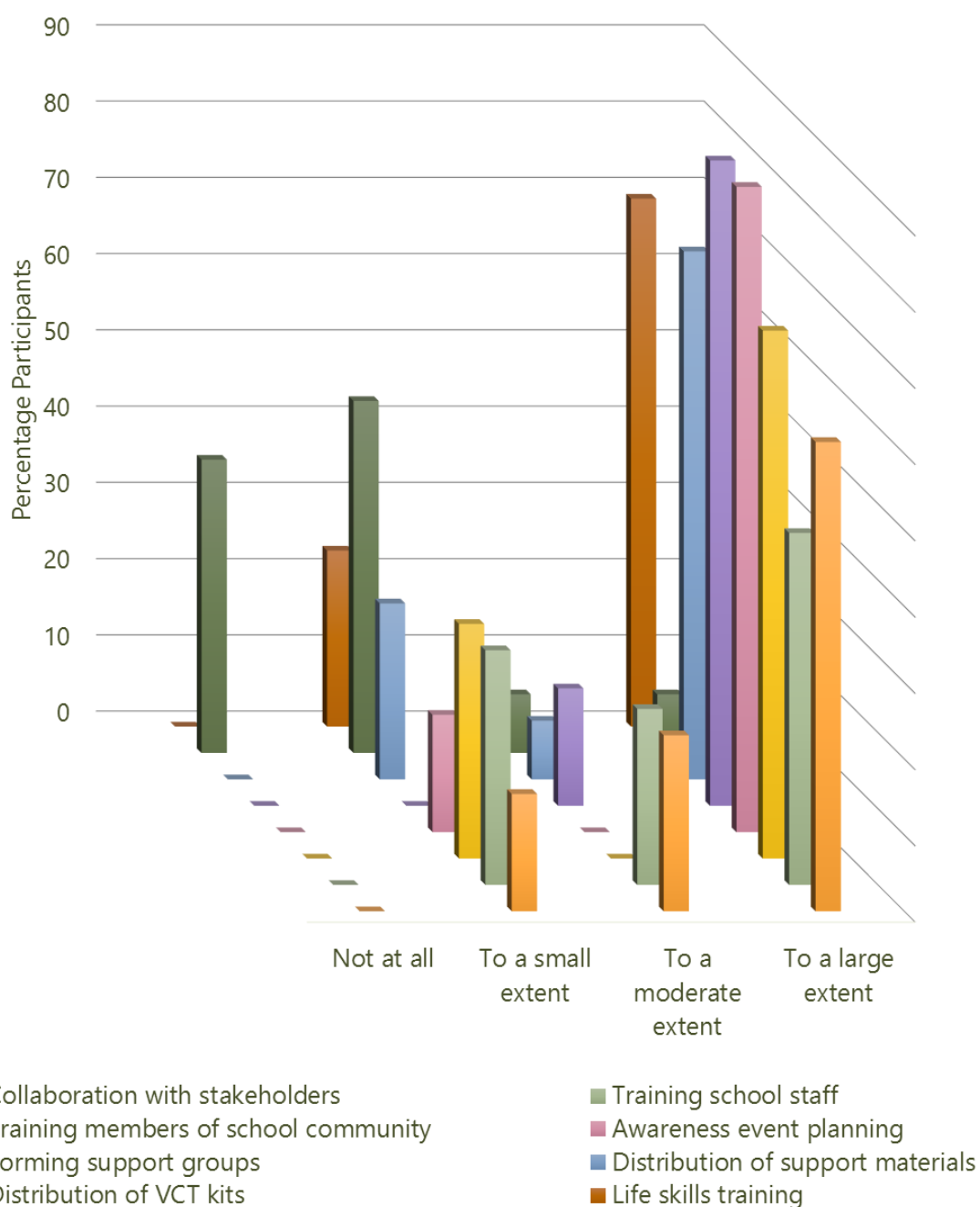


Figure 21: Detailed job description of the health promoter

The first question in this section intended to determine health promoters' collaboration with other stakeholders in the community. More than 60% (8 out of 13) of the participants indicated that their work entailed of working with other stakeholders, 23.1% indicated to a moderate extent while 30.8% answered to a small extent.

The second and third questions in this section investigated if health promoters had to train school staff or other members of the school community as part of their job description. In Figure 21 above, it can be seen that most participants' job description entailed training the school community regarding health topics with a small number of participants indicating that they had to train school staff. Life skills training were also added to this question with 69% of participants indicating that this was part of their job description to a large extent.

The next question focused on creating awareness and events for better health promotion. In this study, 84% of participants stated that this was also part of their job description. The responses of participants confirmed that 84.6% of them create support groups as part of their job description. Participants also specified that most of them had distribution of support materials as part of their job description but not the distribution of VCT (voluntary counselling and testing) kits.

As part of the Work section of the health promoter questionnaire, some questions focused on participants' salary and their view about their current career. Figure 22 below illustrates the results of these questions.

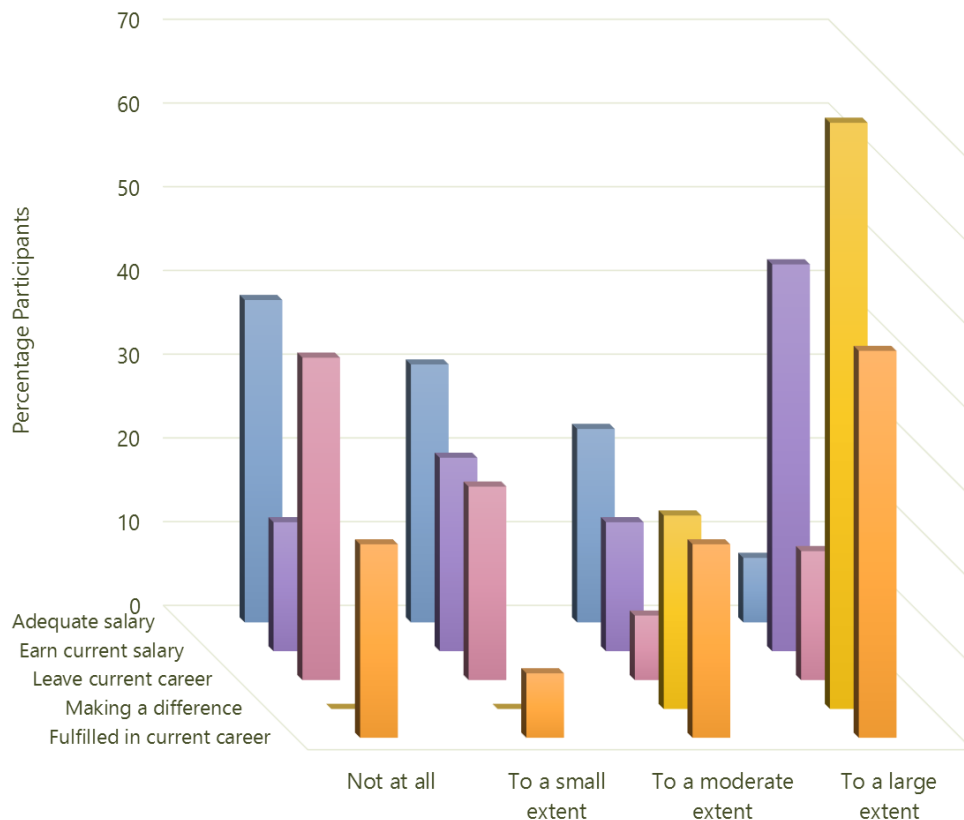


Figure 22: The health promoters' job satisfaction regarding different work aspects

First, the participants were asked whether they were fulfilled in their current career. Figure 23 indicates that 46.2% of participants were fulfilled to a large extent and 23.1% to a moderate extent. It is concerning that 23.1% of the participants did not feel fulfilled in their career at all with a further 7.7% who only felt fulfilled to a moderate extent.

Secondly, participants were asked if they would leave their current career if given the chance. This was asked to further investigate to what extent participants were fulfilled in their career. A total of 38.5% of participants would not leave their job at all with a further 23.1% of participants who would consider leaving their current career to a small extent. A total of 23% of participants specified that they would consider the possibility of a new career to a moderate extent (7.7%) and large extent (15.4%) respectively.

According to the responses of the participants 76.9% (10 of the 13) indicated that they felt they made a difference in promoting peoples' health. The rest of the participants (23.1%) specified that they made a difference to a moderate extent.

Participants were then asked about their salary. Almost half of the participants (46.2%) specified that they earn their current salary to a large extent. The rest of the participants had an even spread of responses with 15.4% (2 participants) who felt they earned their salary to a moderate extent, 23.1% (3 participants) to a small extent and 15.4% (2 participants) who felt they did not earn their salary at all. When participants were asked if they think that their salary was sufficient for the amount of work that they do, only one responded with the answer to a large extent. A total of 38.5 and 30.8% of participants indicated that their salary was not adequate at all or adequate to a small extent.

Summary of work section: Most of the participants indicated that they have some form of job description with 38% (5 of the 13) still lacking a clear job description. The participants who had a job description identified the following as part of their responsibilities:

- *Collaboration with stakeholders*
- *Training the school community regarding health topics*
- *Life skills training*
- *Creating awareness and events for better health promotion*
- *Creating support groups*
- *Distribution of support material e.g. IEC material*

The spreading and use of VCT kits are not regarded as part of their responsibilities.

Most participants indicated a fulfilment in their career with a small number of them not feeling fulfilled. The majority of participants likewise indicated that they wouldn't consider other careers with some of the participants considering such a prospect. The

participant's fulfilment in their career could be ascribed to their responses to the next question as a big majority of them indicated that they make a difference in promoting peoples' health. Although most participants indicated that they work hard enough to earn their current salary, an even bigger number of participants felt that their salary were inadequate.

5.2.4 Communication

In Section D of the Health Promoter Questionnaire it was the researcher's aim to determine the frequency or lack of communication as well as mode of communication between health promoters and schools, other health promoters, management, the Department of Health and the Department of Education.

Question 16 of the health promoter questionnaire explored the ways in which schools contacted participants if they encountered a problem. In Table 3 below it can be seen that in most cases the schools either called the health promoter's managers or the health promoters themselves. Some schools also use faxes, SMS or WhatsApp to contact health promoters.

Table 3: School's contact with the health promoter

	Not at all	To a small extent	moderate extent	To a large extent
Call manager	1	3	1	8
Sms/watsapp manager	7	4	0	1
E-mail manager	10	1	1	0
Fax manager	10	1	1	0
Call health promoter	2	0	3	7
Sms/Watsapp health promoter	6	3	0	3
E-mail health promoter	8	1	2	0
Fax health promoter	8	1	2	1

Question 17 explored the ways in which participants contacted the schools to notify them of upcoming visits. Correspondingly, to the answers in question 16 as illustrated in the Table 3 above, the participants used phone calls to a large extent with some of them using WhatsApp/SMS, e-mail or faxes illustrated in Table 4 below.

Table 4: The health promoters' means of contact with schools

	Not at all	To a small extent	moderate extent	To a large extent
Telephone	2	0	1	10
Sms/WhatsApp	9	1	0	2
E-mail	10	0	1	1
Fax	10	0	1	1

The stakeholders included in this questionnaire were other health promoters, sub-district office personnel and health promotion management. The results in Figure 23 below indicates that 53.8% of participants have meetings with other health promoters to a large extent with the rest of the participants specifying that they had meetings to

either a small or moderate extent. All participants therefore had meetings with other health promoters to some extent.

Meetings with health promotion management posed different results as only 23.1% of participants indicated that they had meetings with management to a large extent. A total of 38.5% participants specified that they met with management to a small and moderate extent respectively. Meetings at sub-district offices posed similar results as specified above as 38.5% indicated that they had meetings to a large extent with 30.8% indicating to a small and moderate extent respectively.

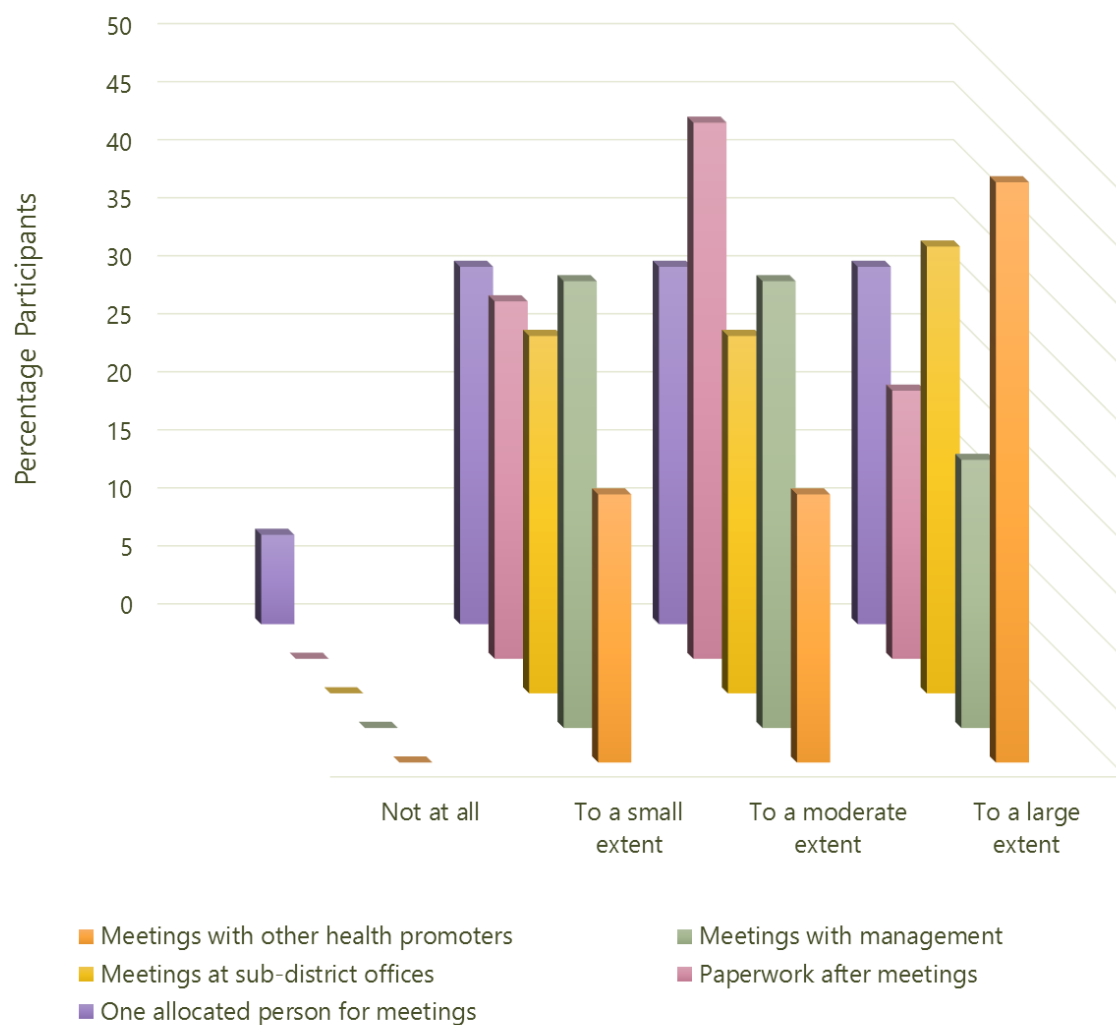


Figure 23: The health promoters' meetings with different stakeholders

Although all participants indicated some extent of meetings with other health promoters, sub-district offices and management, most participants only had meetings to a moderate or small extent.

Question 18 also revealed that participants received some form of paperwork after meetings as 4 participants (30.8%) indicated that they received paperwork to a small extent and 46.2% and 23.1% to a moderate and large extent respectively (Figure 23).

Question 18(e) explored to what extent one specific person attended all meetings during a year in order to assure continuance. The data revealed an even spread of data as 30.8% indicated that one person attends meetings to a small, moderate and large extent respectively.

From the pie chart in Figure 24 it is clear that the majority of meetings attended by participants vary between 0-2 per week.

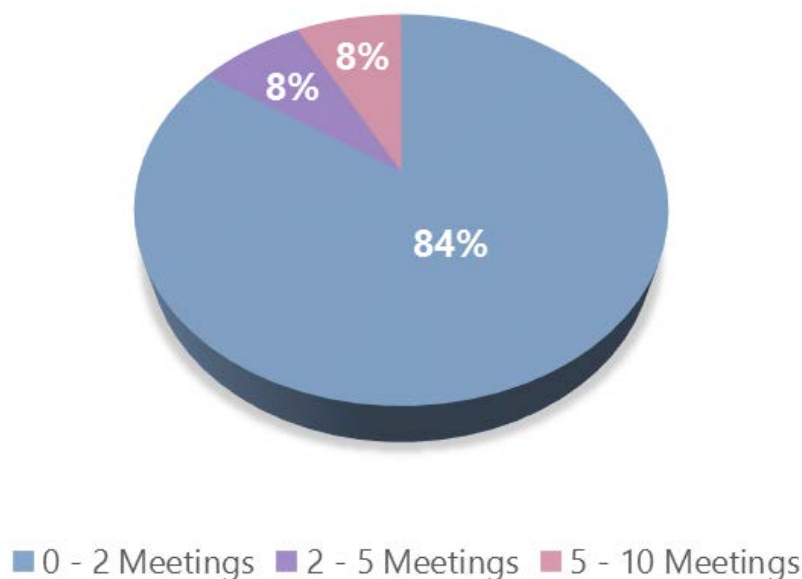


Figure 24: Number of meetings per week attended by the health promoter

Only 8% of participants reported regular meetings between health promoters, the DoH and the DoE. 46% of the participants indicated occasional meetings while a further 46% indicated that no meetings took place between these stakeholders (Figure 25).

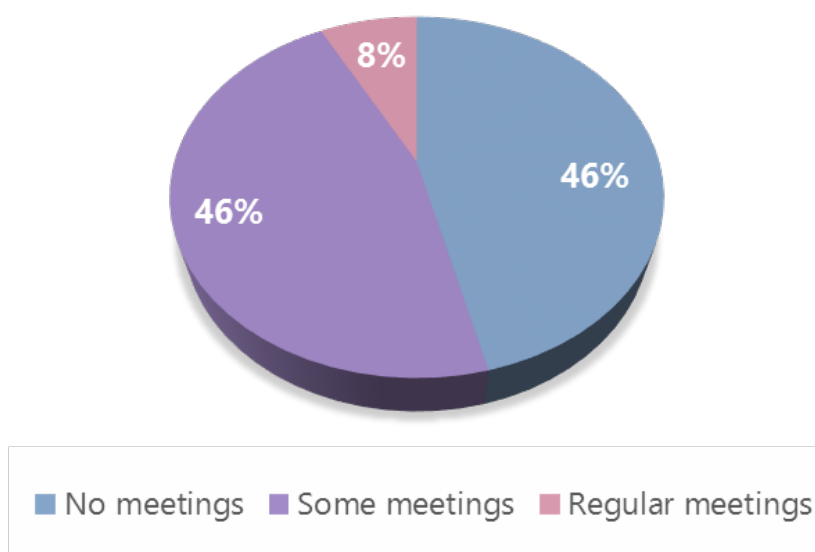


Figure 25: Meetings between the health promoter, DoH and DoE

It is further evident that the participants were unaware of any clear notations made during these meetings for future reference on progress (Figure 26).

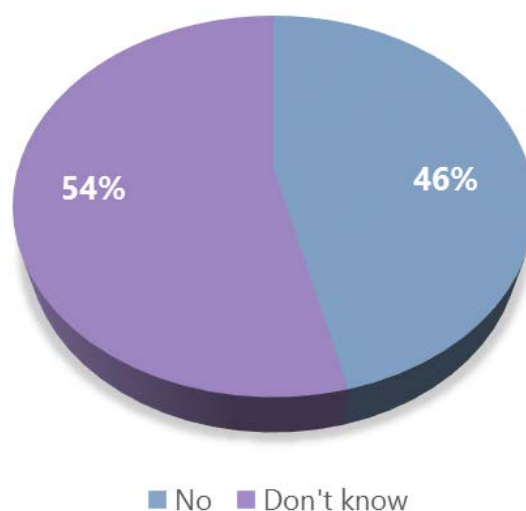


Figure 26: Notations made during meetings

Summary of communication section: Data revealed that communication between schools and participants or their managers mostly take place through telephone calls and sometimes SMS or WhatsApp messages. Although meetings with other health promoters, sub-district offices and management do take place to some extent, most participants only had meetings to a moderate or small extent. Almost half of the

participants specified that no meetings take place between health promoters, the Department of Health and Department of Education.

Participants had different viewpoints regarding paperwork after meetings with the majority stating the presence of paperwork to a moderate extent. The number of meetings attended varied between 0-2 per week with 46% of participants indicating occasional and no meetings respectively.

5.2.5 Planning

Questions 22-24 aimed to determine the kind of planning participants do and the support they receive regarding planning and the extent of rotation based plans to visit schools.

All but one participant stated that they received an events calendar from the Department of Health to compile further planning regarding health promotion activities. Thus, a total of 92.3% of participants received events calendars. Figure 27 further illustrates that 61.5% of participants compile their own events calendar to a large extent while 7.7% does not compile their own calendars. The majority of participants update their events calendars yearly.



Figure 27: Events calendar and the health promoter

Rotation-based plans are used as schedules in order not to skip any schools and to ensure that follow up visits are set in place when necessary. Figure 28 represents data with 2 (15.4%) participants indicating that they used a rotation-based plan to a large extent while the same number of participants stated that they used a plan to a moderate extent. A total of 9 (69.2%) participants indicated that they had such a plan only to a small extent.

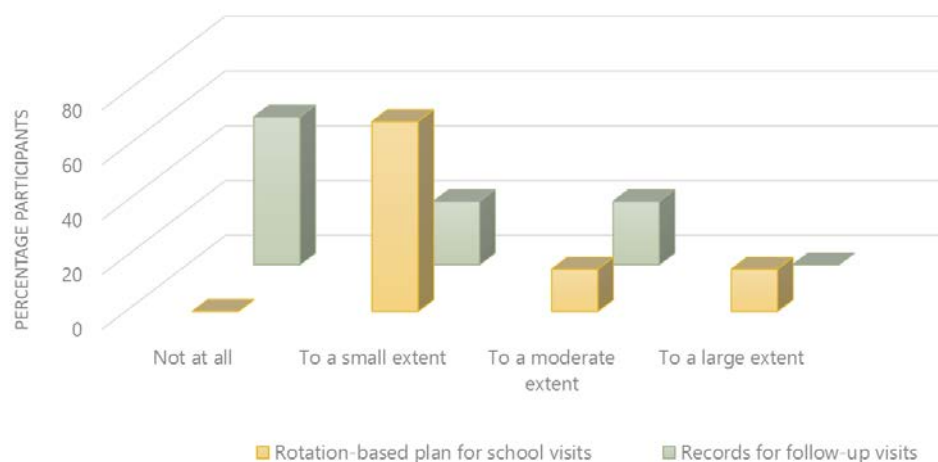


Figure 28: Rotation-based plans and records for school visits used by the health promoter

Further, more than half of the participants (53.8%) specified that they did not have any records where rotation-based plans are updated and problems highlighted, in order to revisit schools and to establish if problems were effectively addressed. Only a few participants indicated that they had such a plan to a moderate or small extent (23.1%).

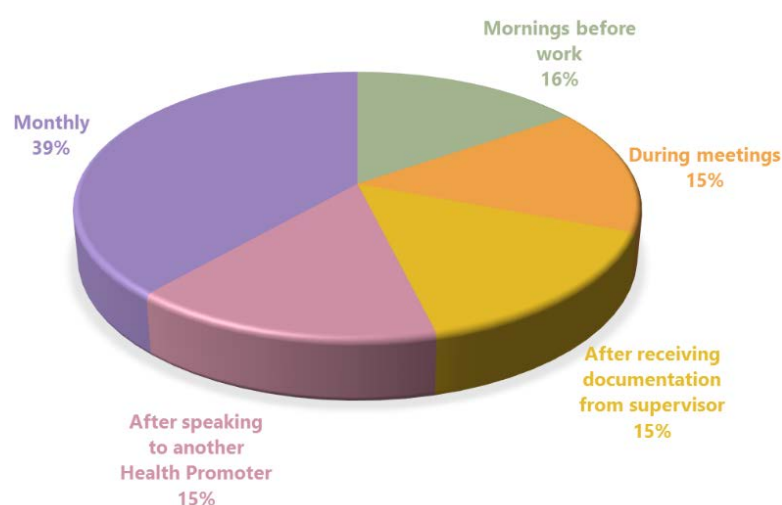


Figure 29: Time schedule for planning and the health promoter

Figure 29 illustrates when participants do their planning regarding health promotion duties. Most of the participants do their planning on a monthly basis with others doing it in the mornings before work, after speaking to other health promoters, during meetings or after receiving documentation from their supervisors.

Summary of Planning section: The majority of the health promoters in the Dr. Kenneth Kaunda District receive an events calendar from the DoH to do further planning regarding health promotion activities. The participants mostly compile their own calendar from this calendar received and update it yearly. Most participants do their individual planning on a monthly basis. A rotation-based plan to schedule visits in order to ensure that all schools are visited and re-visited if necessary is absent in most cases. Most participants also specified that they did not have records about follow-up visits to evaluate progress.

5.2.6 School visits

Section F of the health promoters' questionnaire was focused on school visits conducted by the health promoters with special interest in the way they notify the schools of visits, the time frame of school visits and the types of schools they visit. The questions were further aimed at determining the means of contact between health promoters/management and different schools as well as the type and extent of contact between health promoters, learners and other school staff and the reporting of misconduct.

Figure 30 is a visual representation of the way in which health promoters or their managers inform schools about future school visits. The results indicate that most of the participants (10 of the 13 health promoters – 76.9%) usually notify schools by calling them in advance and a further 15.4% (2 participants) notify schools by SMS/WhatsApp. One participant indicated that they visit schools without notifying them first.

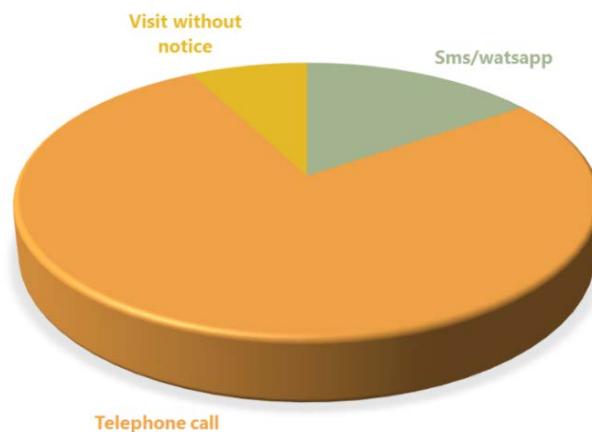


Figure 30: The health promoter and means of notification for school visits

In order to fulfil their duties as health promoters more than half of the participants (7 of 13– 53.8%) indicated that they spend between 30 minutes to 60 minutes per school when they visit (Figure 31). A further 23.1% (3 participants) indicated that they spend half an hour or less per school. One participant specified that a school visit takes 1-2 hours of their time and a further 2 participants (15.4%) stated that it takes 2 or more hours to execute their duties.

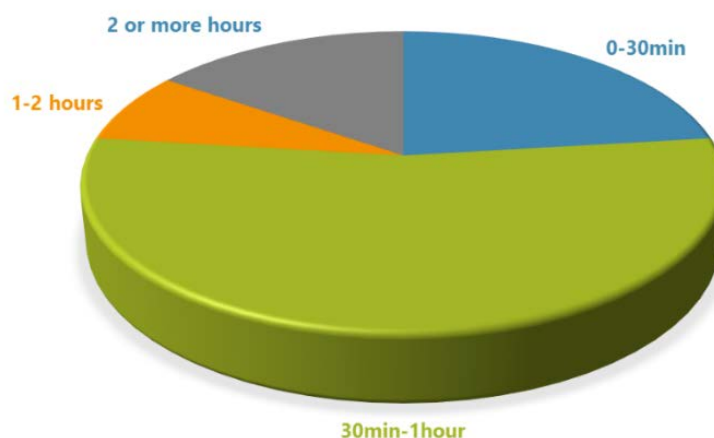


Figure 31: Time frame for school visits by the health promoter

In order to fulfil their duty in promoting health and educating learners on health-related topics, health promoters need to be in contact with learners. Question 28 illustrated in Figure 32 revealed the opposite as almost half of the participants (46.2%) specified that they did not have any contact with learners at all. Four participants

(30.8%) indicated that they have contact to a moderate extent with only 3 participants (23.1%) revealing that they have frequent contact with learners.

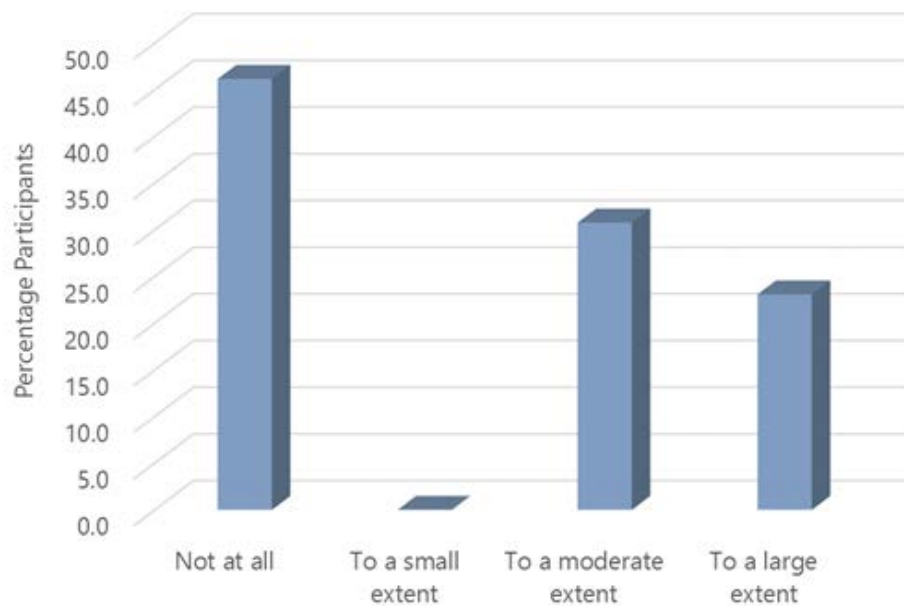


Figure 32: Contact with learners by the health promoter

The next question in the health promoter questionnaire investigated the type of contact that participants had with learners in order to fulfil their duty as health educators.

The data illustrated in Figure 33 revealed that most participants have contact with learners in group discussions or when teachers informed them of problems. It seems as if participants have limited contact with learners in individual private sessions but that learners (according to the participants) in most cases felt that they could approach health promoters to a large extent (38.5%), moderate extent (30.8%) or small extent (23.1%).

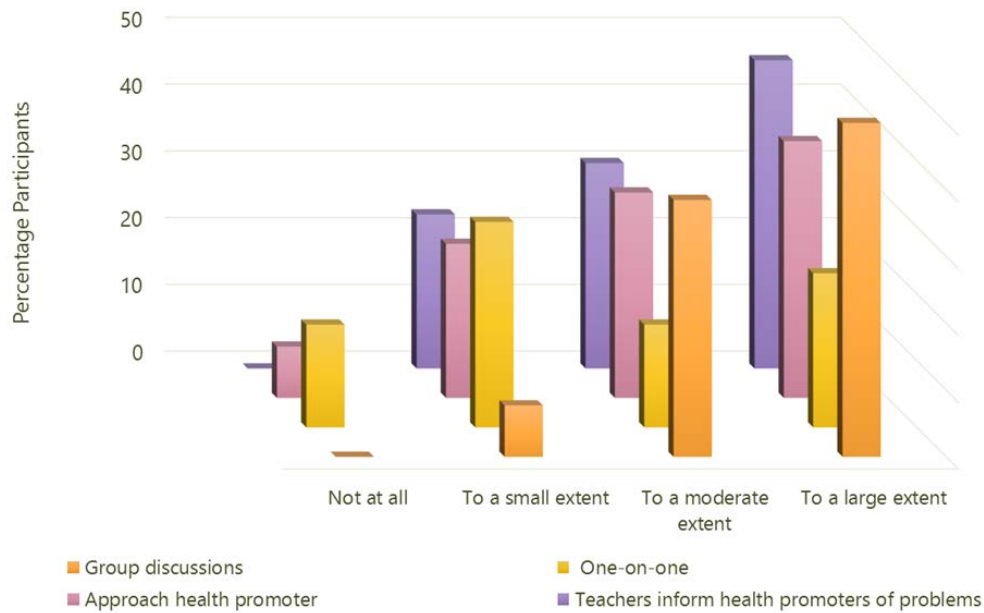


Figure 33: Type of contact with learners by the health promoter

Question 29 investigated if health promoters are familiar with staff and if participants ever felt intimidated by any school staff to not report misconduct. The answers as illustrated in Figure 34 revealed that almost half (46.2% -6) of the health promoters experienced some type of intimidation to not report misconduct. A total of 7 participants (53.8%) stated that they did not experience any intimidation to report misconduct at all.



Figure 34: The health promoter and possible intimidation by school staff in reporting misconduct

As can be seen in the pie chart below (figure 35), 53.6% of participants indicated that they report misconduct when they encounter it at schools with 30.8% who do not report misconduct at all. Two participants did not complete this question.

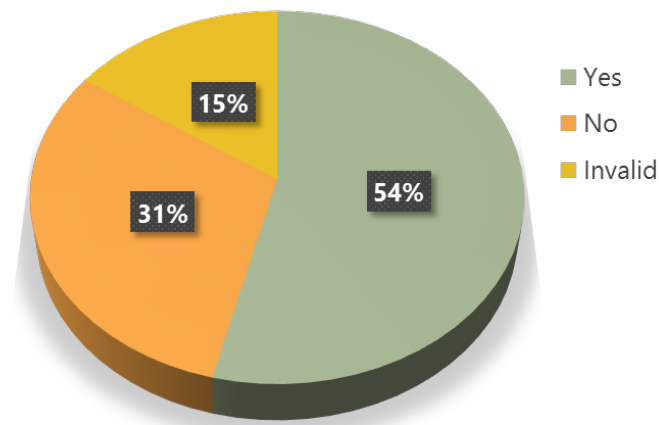


Figure 35: The health promoter and reporting of possible misconduct

Table 5 reveals the data received on the type of schools that the participants work at to promote health. Most participants work at Primary, Secondary and Public Schools on Private Property (PSPP), while some of the participants work at combined schools, day-care facilities and pre-schools. Most of the participants do not work at private schools.

Table 5: Type of schools the health promoter visits

Type of School	Yes	No
Day care facilities	7	6
Pre-School	6	7
Primary School	13	0
Secondary School	13	0
Combined School	7	5
PSPP	10	2
Private Schools	2	10

Summary of school visit section: Participants mostly visit primary, secondary and PSPP schools with some of the participants also visiting combined schools, day-care facilities and pre-schools. When participants or their managers notify the schools of upcoming visits, they usually make use of telephone calls. A school visit takes between 30 minutes to 60 minutes per school, with some participants visiting for longer periods.

Contact between participants and learners are minimal, but if contact take place it is usually in group discussions or when teachers inform participants of problems. Although individual contact is limited, the participants feel that learners can approach them if necessary. Participants are familiar with staff, but almost half of them stated that they are intimidated by staff to not report misconduct. Half or the participants do report misconduct with 31% not reporting at all. When participants report misconduct, they report to teachers/principal or their manager.

5.2.7 Transport

The answers from questions 32-39 of the health promoters' questionnaire sought to reveal valuable information about participants' mode of transport, travel distances, travel safety and travel costs.

Figure 36 reveals that the majority of participants live within 5-10km of their place of work with 31% living between 10-20km from work and no one lives further than 20km.

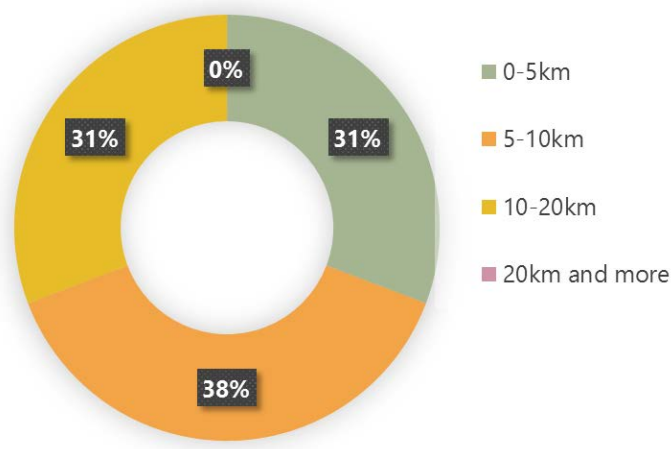


Figure 36: Travel distances between the health promoters' home and the work/office

The next circle chart (Figure 37) illustrates the travel distances between participant's place of work and the schools they have to visit. A wide spread of data was received as 31% of participants travel less than 5km to schools, 15% travels between 5-10km and 23% travels between 10-20km to schools. A total of 31% of participants indicated that they travel further than 20km to visit schools for health promotion duties.

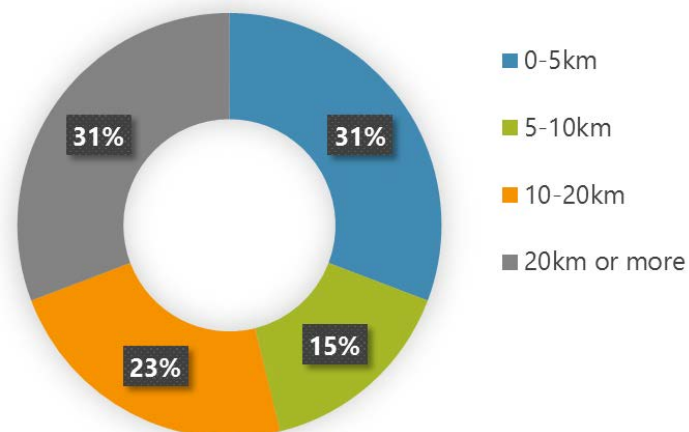


Figure 37: Travel distances between the health promoters' office and schools

Table 6 displays the mode of transport which participants use in order to travel the distances from their home to place of work.

Table 6: Mode of transport between the health promoters' home and office

Mode of Transport	Yes	No
Foot	3	10
Taxi	9	4
Bicycle	0	13
Bus	1	12
Train	0	13
Carpool	0	13
Own car	3	10
Company car	0	13
Spouses car	2	11

Table 7 displays the mode of transport which participants use in order to travel the distance from their place of work (offices) to the schools they have to visit. Various answers were given with only 5 participants indicating that they have access to a company car. Most participants had to make use of taxi's, foot or carpools. One participant stated that they did not have any transport available.

Table 7: Mode of transport between health promoters' office and schools

Mode of Transport	Yes	No
Foot	3	10
Taxi	4	9
Bicycle	0	13
Bus	1	12
Train	0	13
Carpool	2	11
Own car	1	12
Company car	5	8
Spouses car	1	12
No transport available	1	12

As shown in figure 38, 69% of participants indicated that they wake up at 5:00am to be on time for work.

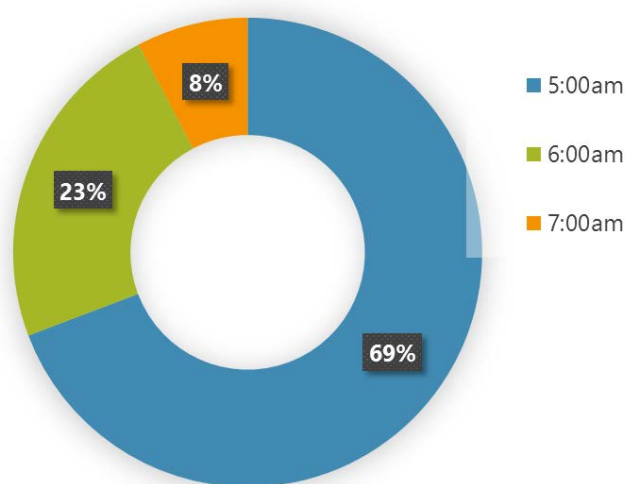


Figure 38: The health promoter and time of waking up in the morning

Responses for the health promoter's safety of transport to and from work varied. A total of 39% of participants indicated that their travels were safe with a further 15% specifying it as very safe. The rest of the participants consider their travels to work as dangerous with 15% regarding it as very dangerous and 31% as somewhat dangerous.

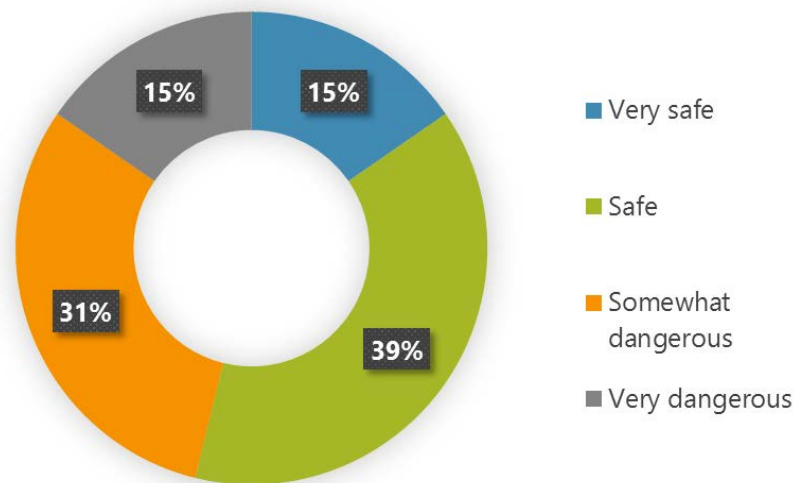


Figure 39: Safety of travels to work as experienced by the health promoter

The question regarding transport costs to and from work also posed various results. Almost half of the participants (46%) indicated that their travel costs varied between R800-R1200 per month, with 31% specifying their travel expenses as R400-R800 and a further 23% with travel cost lower than R400.

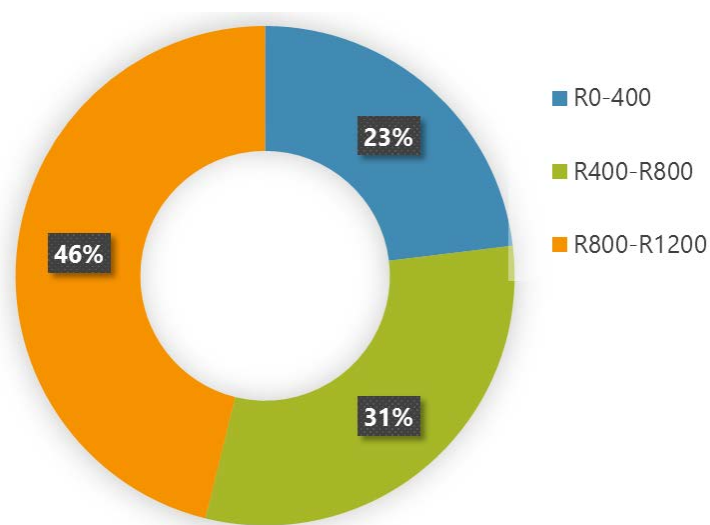


Figure 40: Cost of transport to work as experienced by the health promoter

Summary of Travel section: The majority of participants wake up at 5:00am to travel a distance of 5-10km by means of a taxi. 31% participants travel between 10-20km and 0-5km respectively. These routes are mostly considered safe with a further 31% of participants indicating that it is somewhat dangerous and 15% indicating that it is very dangerous. The cost of these distances travelled ranges between R800-R1200 per month with a further 31% stating a cost of R400-R800 per month.

Travels between place of work and schools take place by means of company cars, taxi's and foot. These distances differ between 0-5km (31%), 5-10km (15%), 10-20km (23%) and 20km or more (31%).

5.2.8 Support

Section H of the health promoter questionnaire investigated the kind of support the health promoters receive from various stakeholders in the health promotion programme.

Only one of the participants indicated that they have an assistant at their office to support them with administration tasks (Figure 41).



Figure 41: Assistance offered at the office to the health promoter

Question 41 explored the extent to which health promoters work in conjunction with principals, teachers, parents and school children. Figure 42 illustrates that most of the participants indicated collaboration with principals, children and teachers to a moderate to large extent.

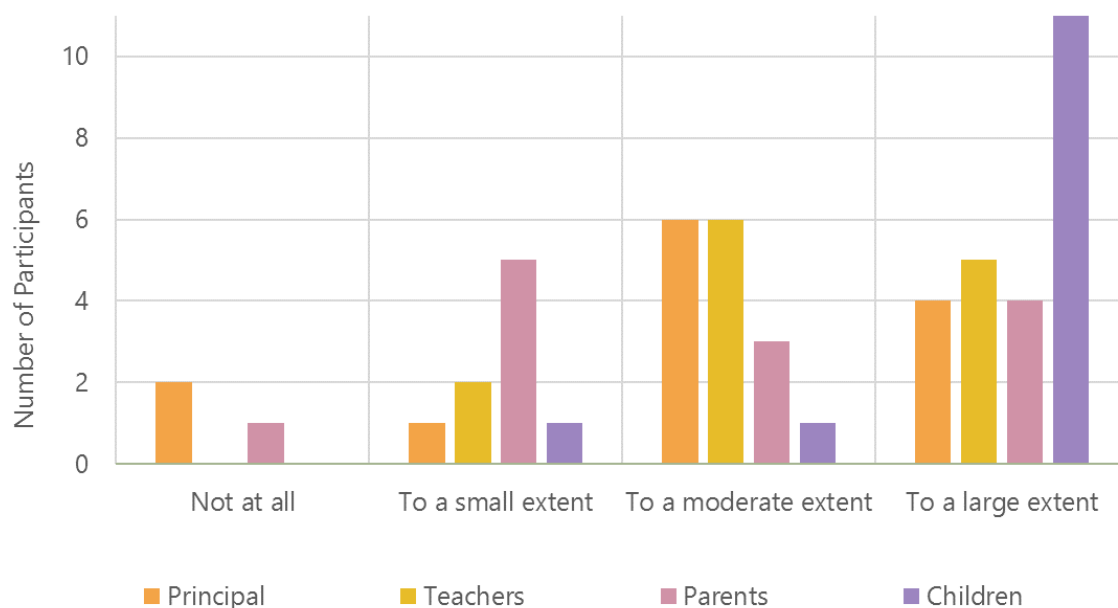


Figure 42: Collaboration with different stakeholders by the health promoter

Two participants stated that they did not work with the principal at all. Although some of the participants indicated collaboration with parents to a moderate to large extent, 6 of the 13 participants indicated that they worked with parents only to a small extent or not at all.

Question 42 of the health promoter questionnaire explored to what extent health promoters receive support from the DoE, DoH, principals, teachers and parents when performing health promotion activities. As can be seen in Figure 43 below, the participants mostly felt that they had support from the DoH, principals and teachers to a moderate extent. Assistance from the Department of Education are lacking as 4 participants indicated that they did not receive support at all and a further 5 participants indicated they only receive support to a small extent. Although results indicate that the Department of Health are more supporting, 5 participants still indicated that they received support to a small extent with a further 4 participants stating no support at all. Similar to the results of question 4, the participants specified support from parents to a small to moderate extent.

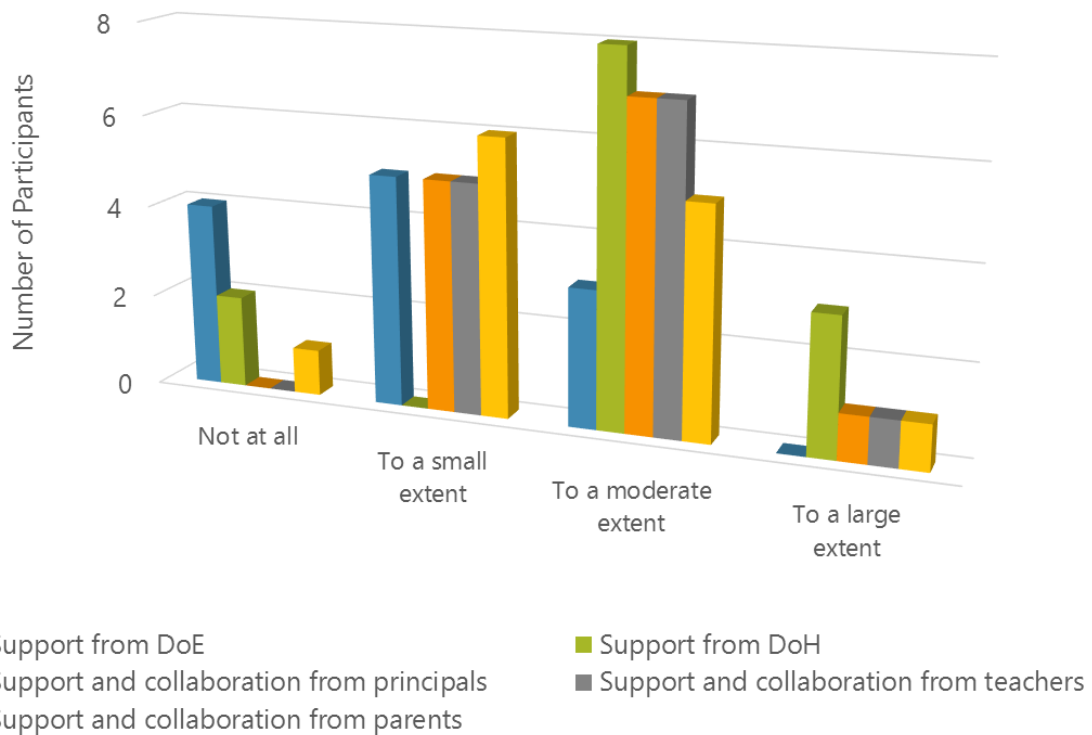


Figure 43: Health promoters' extent of collaboration with stakeholders

Question 42, illustrated in Figure 40 above explored if health promoters receive support from different stakeholders in relation to each other. Question 43 of the health promoter's questionnaire examined the kind of support health promoters receive from the Department of Health. It was already established in figure 43 that the DoH do provide some kind of support to health promoter. Figure 44 below represents the kind of support that health promoters receive from the DoH. Participants specified that the DoH are especially absent in emotional and physical support with minimal financial and medical support.

Although the DoH provides some workshops to better their knowledge, financial support, data for better planning and medical support, the participants indicated that it was still insufficient. Participants specified that they do receive support in the form of resources, but data represented in Figure 44 proofs that this is still insufficient.

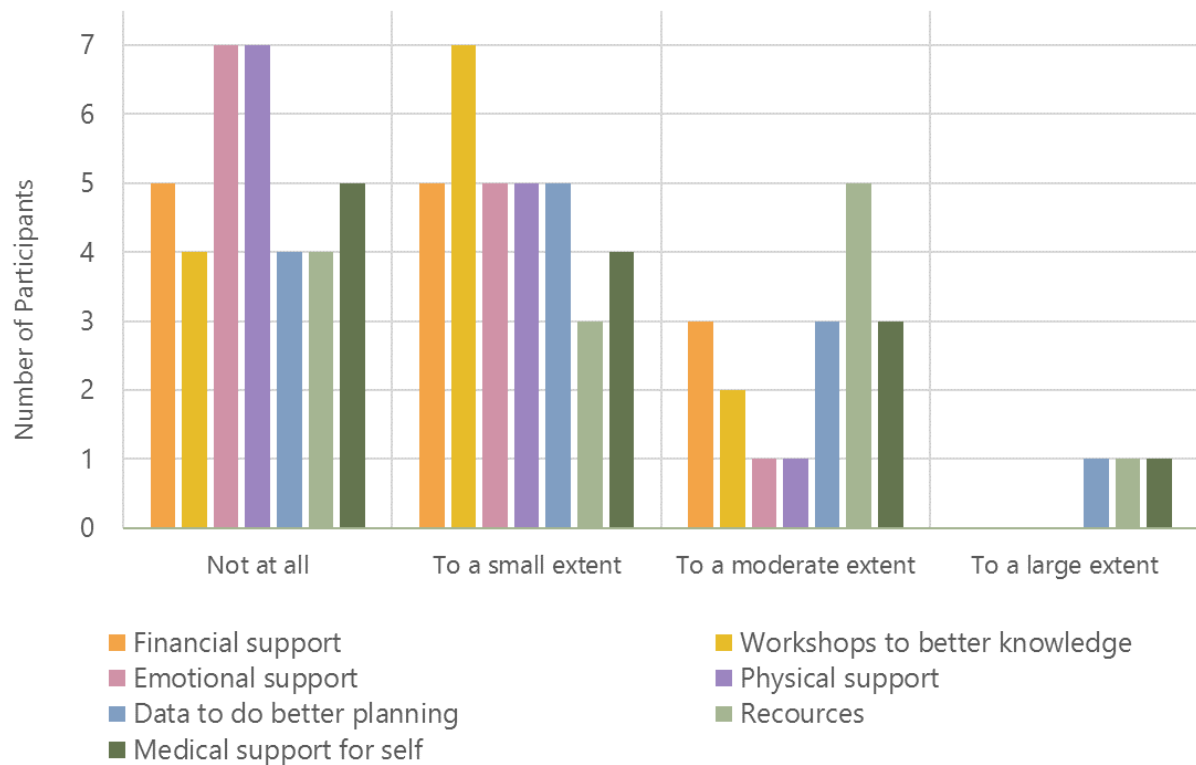


Figure 44: Support the health promoter receives from the Department of Health

The results illustrated in figure 41 above (Support health promoters receive from the Department of Health) are similar to results illustrated in Figure 45 below (Support health promoters receive from the Department of Education) although the DoH provides slightly more support in some areas. The results in Figure 45 display that support from the Department of Education in most cases are lacking. Only 5 participants stated that they receive resources to a small to moderate extent. Four participants indicated that they lack emotional support, data for better planning and physical support to a small extent irrespectively.

Almost 70% of the participants (9 of the 13) specified that they did not receive emotional support, physical support or data to help with better planning at all. More than 80% of participants (11 of the 13) stated that they did not receive financial support, workshops to enhance their knowledge or medical support at all.

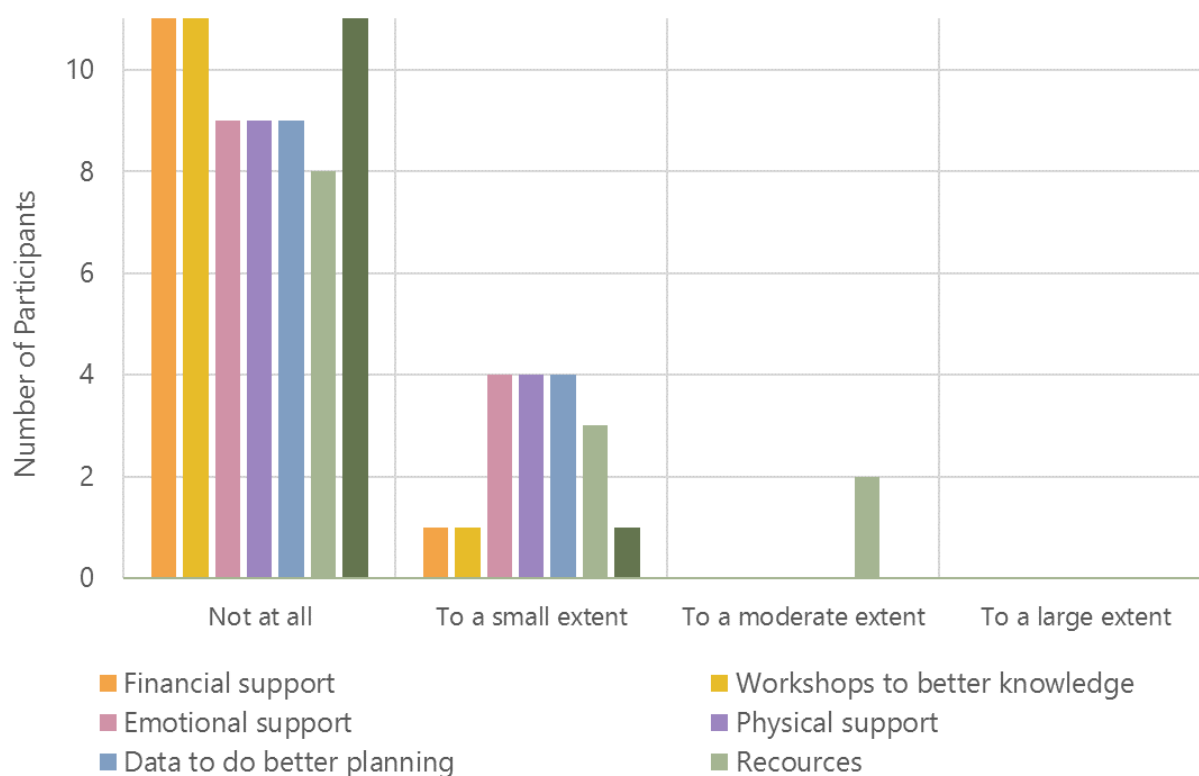


Figure 45: Support the health promoter receives from the Department of Education

The next question in the health promoters' questionnaire examined who the health promoters contacted when they needed support outside their scope of practise. This professional support could include any medical, health or social related problem at one of the schools they work at. In the data represented in Figure 46 below, it can be seen that in most cases the participants contacted either the Department of Health or the school nurse they work with. In some instances, they contacted the school teachers or social worker.

The data further reveals that support from professional occupations such as speech therapists, physiotherapists, psychologists, doctors and occupational therapists are either lacking or participants do not have connections or access to these professionals.

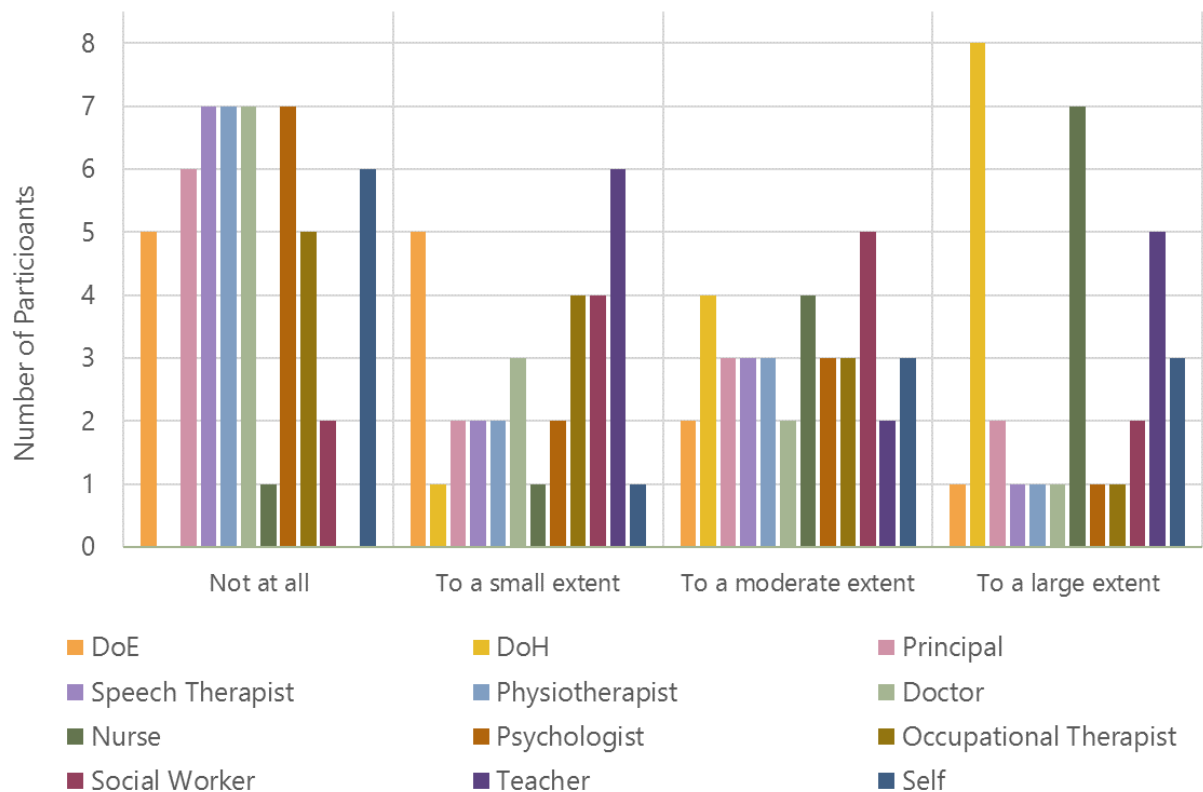


Figure 46: Who the health promoter contacts when in need of professional assistance

The previous question investigated who the health promoters contacted when they encounter problems at schools they work with. The next question of the health promoter's questionnaire investigated the degree of support or response received from the above-mentioned entities (Figure 47) or professionals when the health promoters approached them for help.

The data received are similar to the data for question 45. It is important to keep in mind that health promoters indicated (Figure 46) that they did not contact some of the entities and professionals such as the DoE, doctors, speech therapists, physiotherapists, psychologists and doctors. Data in Figure 47 reveals that the Department of Health as well as the school nurse and principals are the entities which give the most support when reacting to health promoters' requests for assistance. It does seem as if participants receive some support from social workers and teachers. Professionals such as speech therapists, physiotherapists, doctors, psychologists, occupational therapists provide the least support.

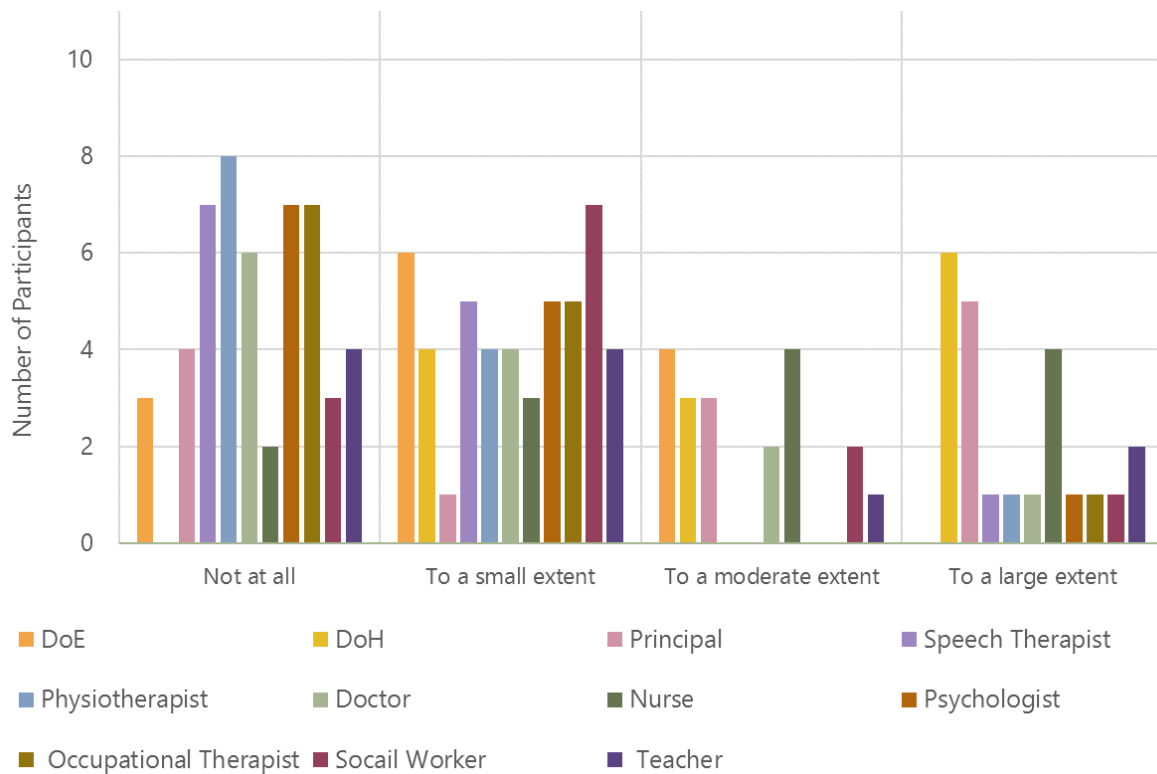


Figure 47: Degree of support from professionals to the health promoter

Summary of the support section: Participants mostly work in conjunction with principals, children and teachers. Collaboration with parents is insufficient as almost half of participants indicated working with parents to a small extent or not at all. Participants further indicated some support from the DoH, principals and teachers to a moderate extent while support from the DoE are lacking.

Although the DoH provides some support, the participants indicated that the DoH are especially absent in emotional and physical support with minimal financial and medical support. Although the DoH provides some resources, data for better planning as well as the provision of workshops to advance knowledge and skills, the results indicate that it is still insufficient. Support from the Department of Education is lacking in most cases with the provision of some resources, emotional and physical support as the only form of backing.

When participants need professional support, they contacted either the Department of Health or the school nurse they work with. In some instances, they contacted the

school teachers or social worker. Referral to professional occupations such as speech therapists, physiotherapists, psychologists, doctors and occupation therapists happens to a small extent.

5.2.9 Barriers

Section I of the health promoters' questionnaire investigated the barriers which health promoters in the Kenneth Kaunda district, North West province encounter when executing health promoting duties at schools.

The data set out in Figure 48 below represents to what extent participants experience conflict with different individuals. The entities included in the question were mostly individuals in direct contact with health promoters and which could pose problems for health promoters in executing their responsibilities effectively if there were conflict.

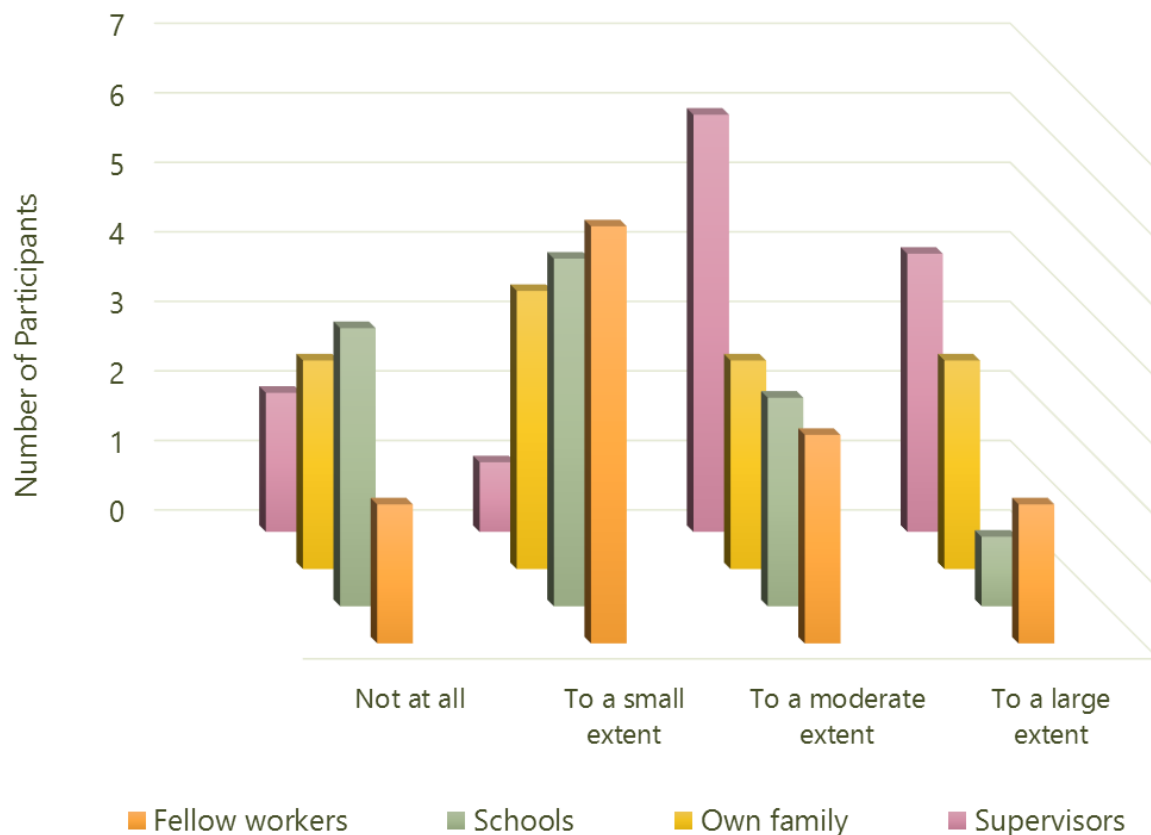


Figure 48: Extent of conflict the health promoter experiences with different individuals

Most participants experienced conflict with their supervisors as 4 indicated that they experience conflict to a large extent and 6 to a moderate extent. In most cases participants only encountered conflict with fellow workers, schools and their own family to a small extent.

Question 48 of the health promoter questionnaire was aimed at exploring the wide-ranging barriers that participants face daily in executing health promotion activities. The results shown in Figure 49 presented concerning data as the following were identified as the major barriers participants experience in the Kenneth Kaunda district to a moderate to large extent: divorced or single parent families, rape or sexual assault, inadequate health promoters to assist, abuse, alcohol and other addictions, poverty, parentified children, sick teachers, unhealthy children and inadequate learning material. Inadequate bathrooms and classrooms seem to be a moderate barrier with the training of teachers as the least of their barriers.

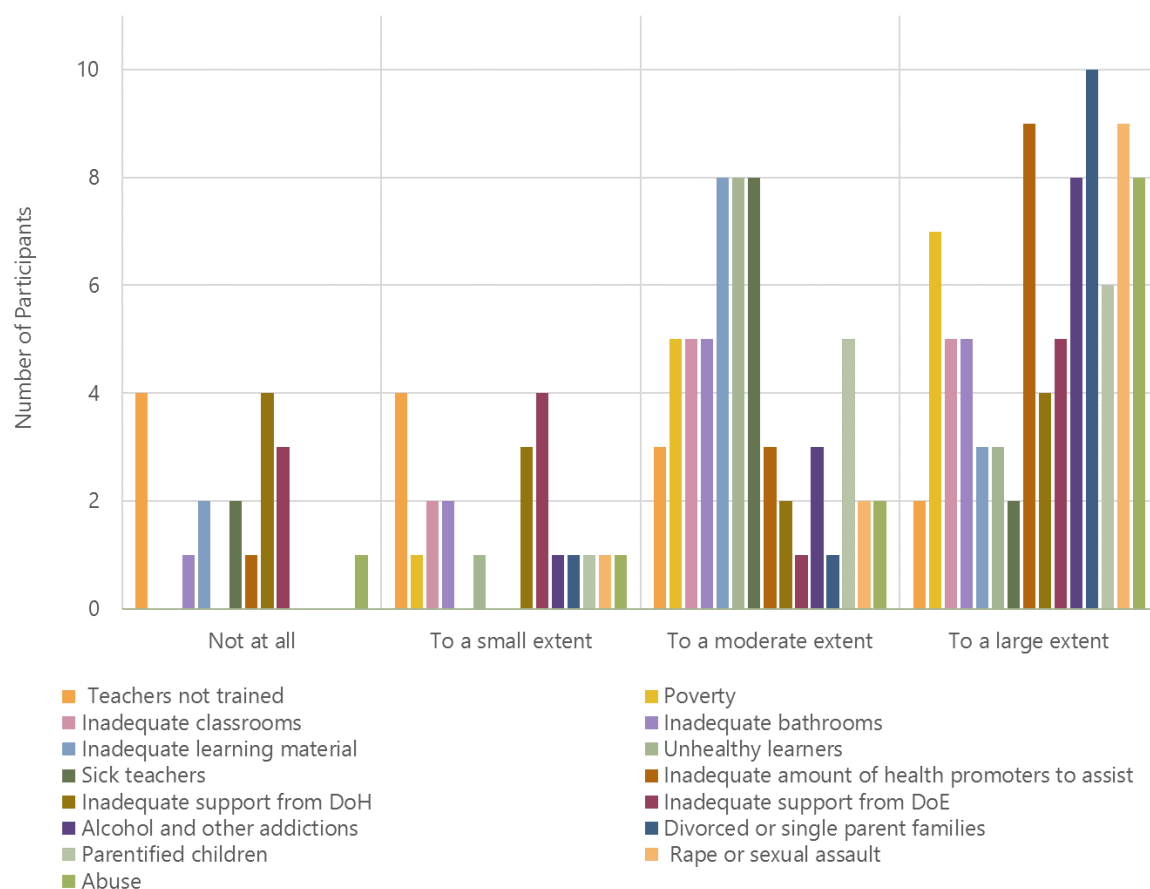


Figure 49: Barriers the health promoter encounters in schools

Summary of Barriers section: Most participants experience conflict with their supervisors. Conflict with fellow workers, schools and own families are restricted to a small extent. Further major barriers that participants experience in the execution of health promotion duties include divorced or single parent families, rape or sexual assault, inadequate health promoters to assist, abuse, alcohol and other addictions, poverty, parentification, sick teachers, unhealthy children and inadequate learning material. Inadequate bathrooms and classrooms seem to be a moderate barrier with the training of teachers as the least of their barriers.

5.2.10 Coping

Section J of the health promoters' questionnaire was aimed at determining to what extent health promoters cope with their current work situation as well as the coping strategies they use.

All participants stated that they enjoy their work to a large extent with 92.4% participants who experience satisfaction after finished projects (Figure 50).

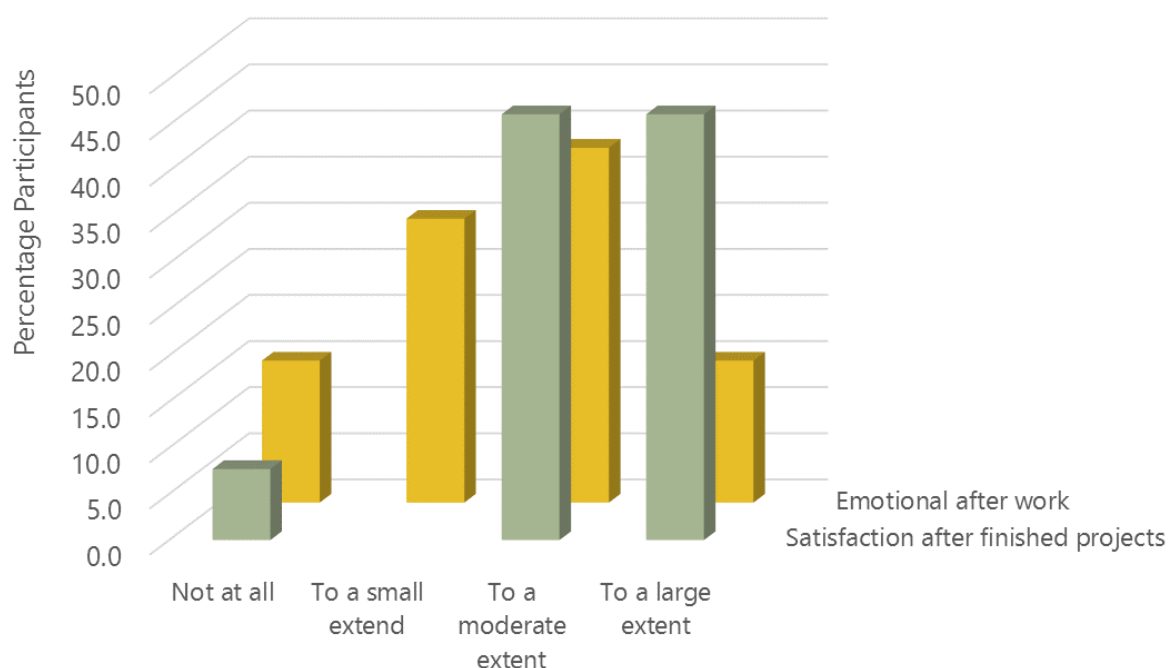


Figure 50: The health promoter's indication of satisfaction related to work

Although all participants indicated that they enjoy their type of work, the majority of participants specified that they feel emotional after a day's work.

Question 50 investigated with whom participants talk to in order to help them cope with work related problems. The data in Figure 51 reveals that most participants talk to co-workers in an effort to manage work related difficulties. Participants also confided in friends and family and sometimes to supervisors about issues related to work. Most of the participants do not make use of professionals to talk about issues related to their work.

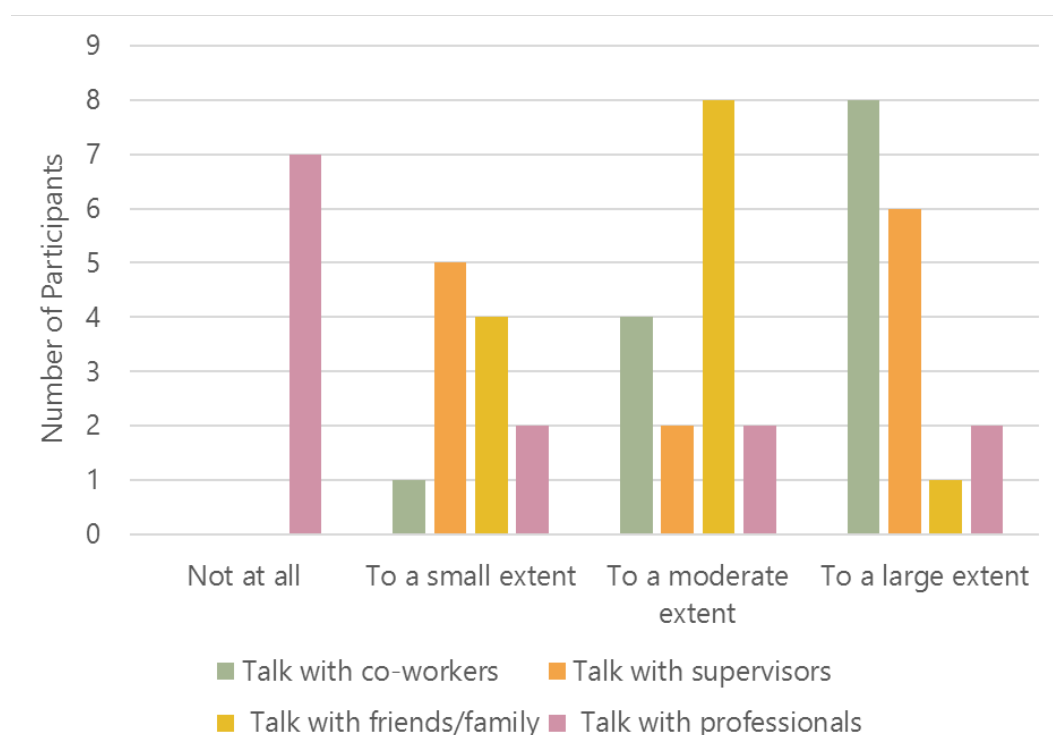


Figure 51: Who the health promoter talks to in order to cope with work related problems

The next question determined who participants talk to in order to cope with personal problems. Data set out in Figure 52 reveals that most participants use their own family and friends when they need help to cope with personal problems. Some participants will confide in fellow workers, but most of them do not use schools or supervisors to help them deal with personal issues.

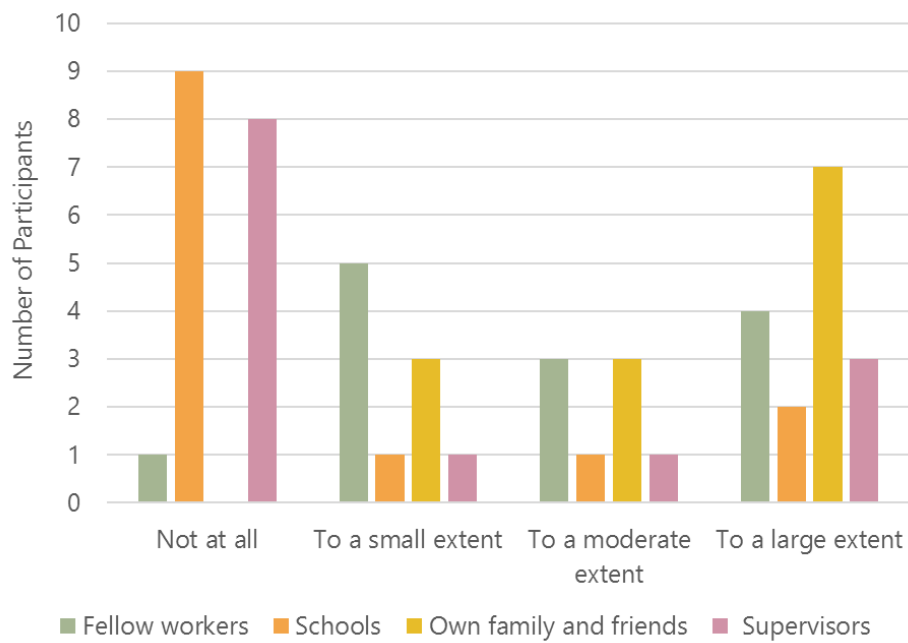


Figure 52: Who the health promoter talks to in order to cope with personal problems

The data from question 49 revealed that health promoters do experience emotionality due to work related issues. Data set out in Figure 53 revealed how health promoters act out on their emotionality. It does seem as if participants speak out when they encounter problems, but they also cry, yell, feel inadequate or yell.

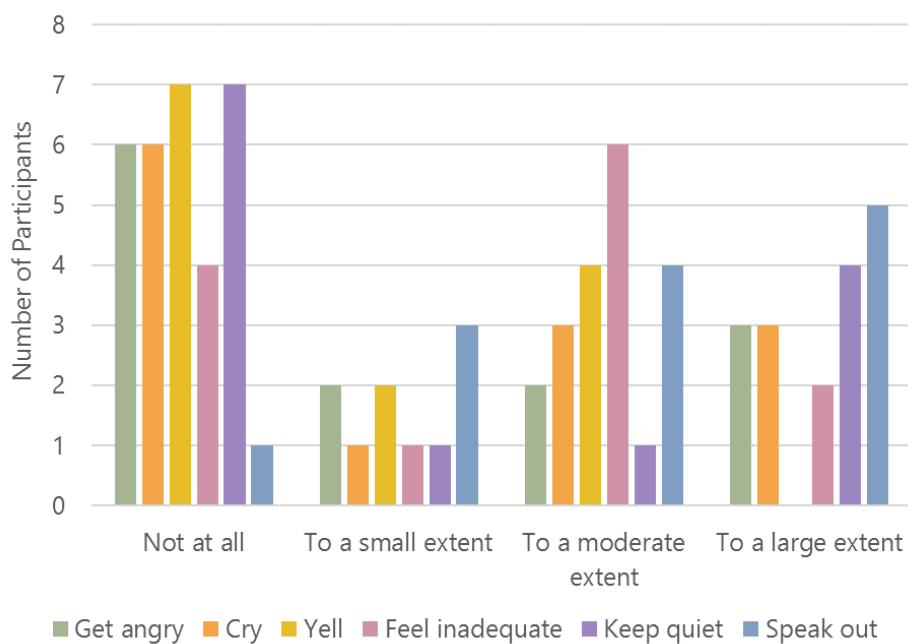


Figure 53: Means of acting out on work related problems by the health promoter

Summary of coping section: All participants enjoy their work and feel satisfied when they finished projects, but the majority of them feel emotional after a day's work. Most participants also speak out to handle emotional issues, but they also feel inadequate, keep quiet, yell, cry or get angry. Participants cope with work related problems by talking with co-workers and sometimes supervisors or family/friends. They do not make use of professionals. When handling personal problems, they confide in own family/friends for support.

5.2.11 Personal health

Section K of the health promoters' questionnaire aimed to determine the health of health promoters and the kind of help they seek when encountering health problems.

Question 53 of the health promoter questionnaire explored if participants experienced stress due to their work and results are illustrated in Figure 54 below.

Data indicates that participants experience high levels of stress due to work related circumstances as almost half of them (46.2%) specified that they experienced stress to a moderate extent with a further 30.8% signifying stress to a large extent.

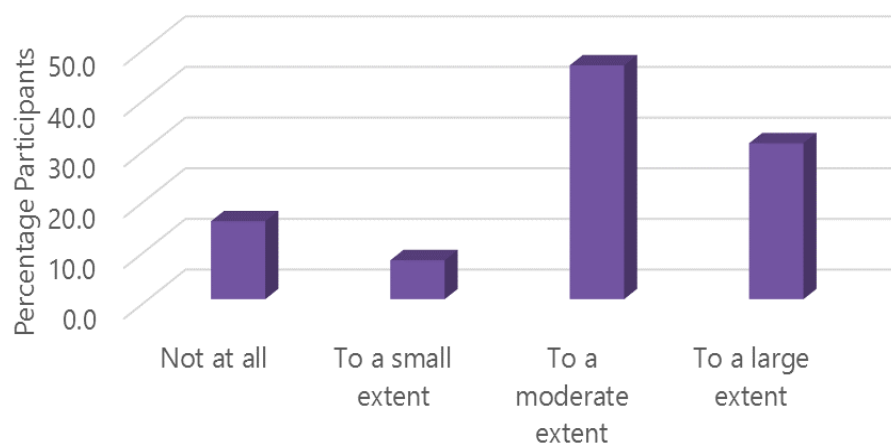


Figure 54: The amount of stress the health promoter experiences at work

Question 54 investigated the stress related health symptoms which participants experience. Figure 55 below, illustrates these results. Most of the participants experience sleeplessness (insomnia) and irritability. The data further displays that more than half of the participants suffer from chest cramps and stomach cramps to a moderate to large extent. The data also signifies that most participants do not have problems with weight gain, angina, spastic colon or hyper tension.

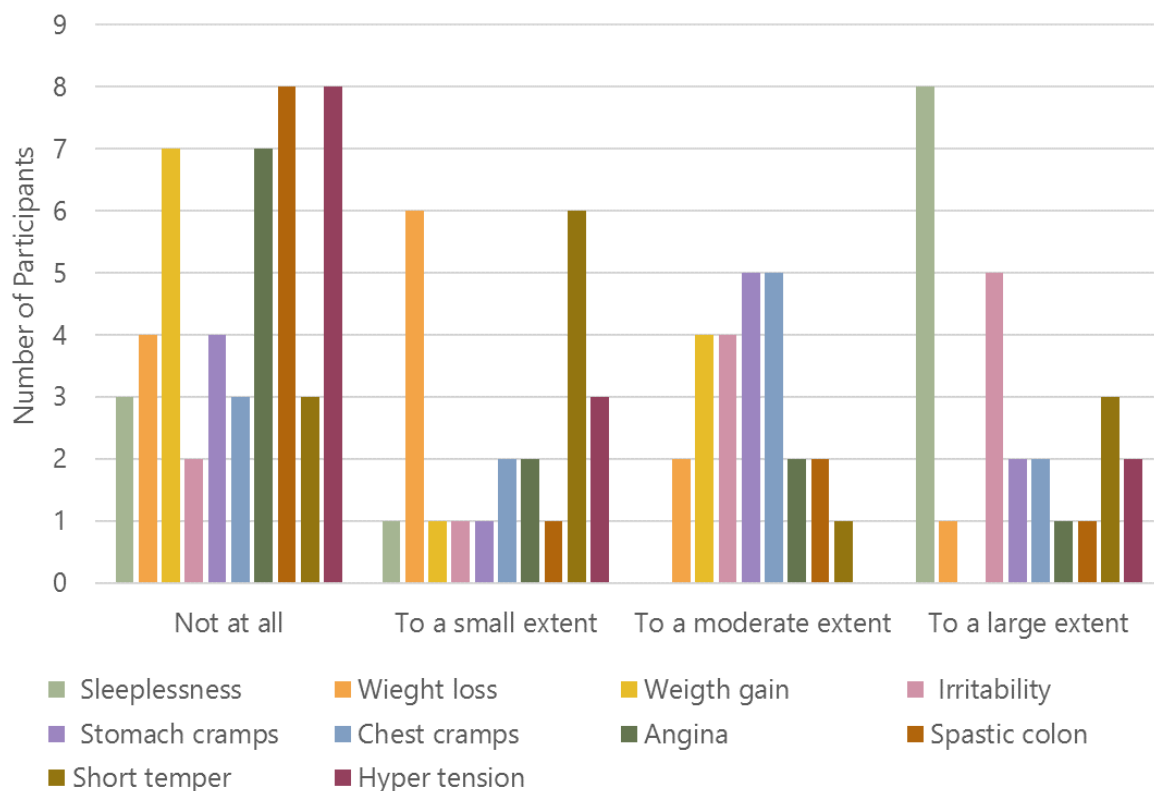


Figure 55: Stress related symptoms which the health promoter experiences

Questions 55-57 of the health promoter questionnaire investigated if health promoters used any stress related medication, how long they are using it and if it is beneficial for their health problems. The results in Figure 56 stated that 84.6% of the participants do not use any medication for stress at all.

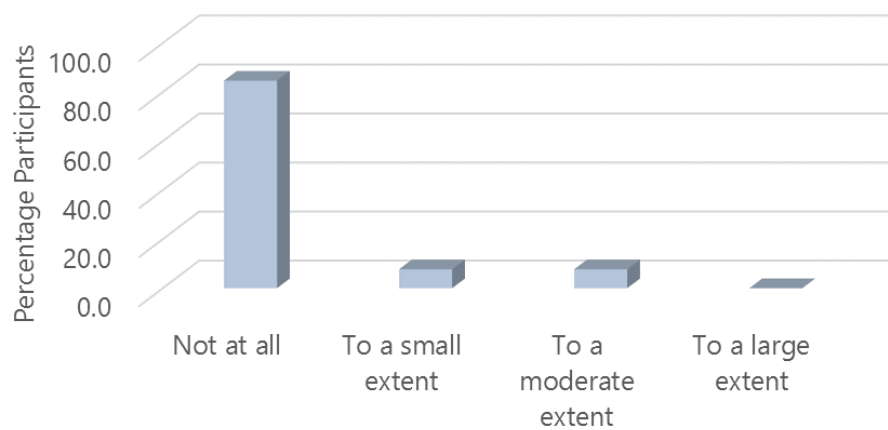


Figure 56: Use of medication by the health promoter for stress related symptoms

A total of 69.2% of the participants indicated that they did not have a medical aid with only 4 (30.8%) participants having a medical aid (Figure 57).

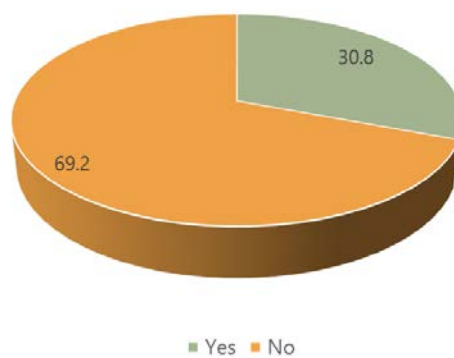


Figure 57: The health promoter and medical aid

Although most of the participants do not have a medical aid, 46.2% of them visit a doctor 2-5 times per year (Figure 58).

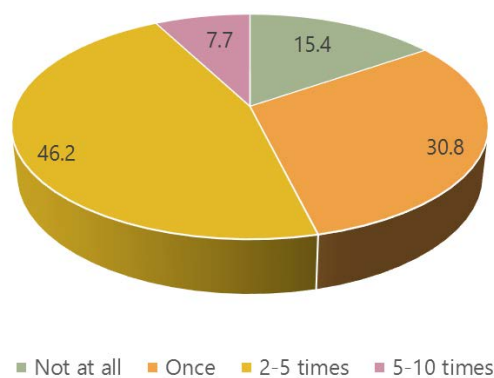


Figure 58: Number of visits to medical doctor per year by the health promoter

A further 23% of participants visit a traditional healer more than 2 times a year (Figure 59).

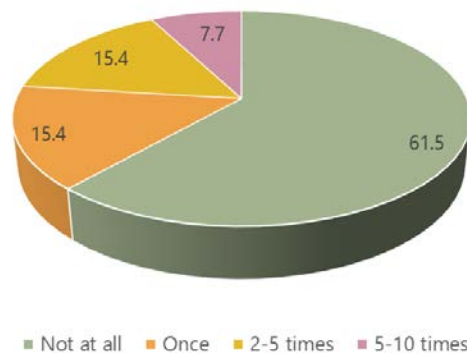


Figure 59: Number of visits to traditional healers per year by the health promoter

Summary of Personal Health section: Participants experience high levels of work related stress and experience sleeplessness and irritability in response to it. Other symptoms which health promoters experience include chest cramps, stomach cramps. Most participants do not use any medication for stress related symptoms. Participants do not have medical aids, but visit doctors or traditional healers regularly.

5.3 DISCUSSION

In constructing a profile of the biographical information of the health promoter in the Dr. Kenneth Kaunda District, North West Province, it was established that all participants are Black Africans. This is not surprising given that 89.8% of the North-West province's population are Black Africans (Statistics South Africa, 2011) and redistributive policies and legislation regarding employment in South Africa post-1994 is race-based.

The large number of males employed as health promoters is unusual since 50% of the South African health promoters are female (Wills and Rudolph, 2010). The occurrence of male dominance in workplaces are however not unusual given the gender inequalities still prevalent within some vocations in South Africa (Albertyn, 2011). Although women have benefited from race-based policies in the past, the absence of gender-based policies still place black women at the bottom of the socio-economic

hierarchy as can be seen in the data from this study (Albertyn, 2011). The reasons for the dominantly male employment of health promoters in this district are unclear, but the employment of female health promoters needs to be considered in order to minimize this inequality. As there is only a small number of participants (N=13) no inferences could be made based on age alone. It is however noteworthy that the majority of health promoters in this study are relatively young.

The distribution of language efficacy of health promoters across the North-West province coincides with the national Census data of languages spoken in the North-West Province (Statistics South Africa, 2011) since most of the health promoters are sufficient in English, Setswana and at least one other official language.

Most of the biographical information of the health promoters can therefore be regarded as a positive notion for the health promotion movement in this district as health workers with the same ethnicity, language and life experiences as the community they work in are regarded as fundamental to ensure community acceptance and ownership (Lehmann & Sanders, 2007).

The lack of training in health promotion practises are no surprise given that previous research identified training as a major global challenge in the health promotion movement (Stewart & Wang, 2012; Van den Broucke *et al.*, 2010). The lack of experience as indicated by the data from this study is however concerning as only 45% of the health promoters have experience in either HIV counselling or community health promotion. This experience is possibly also limited given the young ages of the majority of participants and the lack of formal training of community workers. Similarly, Wills and Rudolph (2010) specified that there is a huge gap in adequate skills and formal training for health promoters, with 50% of South African health promoters only having matric certificates. In the Dr. Kenneth Kaunda District this number is even bigger with 77% of health promoters only having matric certificates. Except for one health promoter who previously worked as an auxiliary nurse, the rest of the health promoters who indicated that they had additional training have no training in health-

related occupations. This proves to be problematic as the National Directorate recommended as early as 2004 that health promoters should have a post matriculation qualification (Wills & Rudolph, 2010).

Although health promoters lack formal training, they did indicate some form of training in specific themes while employed by the Department of Health. Themes related to physical health seem to get more attention than themes related to other dimensions of health such as emotional and social health (St Leger, 2006). This is problematic as health promotion initiatives should focus on all the dimensions of health as indicated in the paragraph regarding the definition of health. Other research in South Africa similarly identified human resource development as one of the main barriers in health promotion (Van den Broucke, 2010) with health promoters themselves emphasising the need for in-service training and skills development (Mthobeni & Peu, 2013). The willingness of participants in this study to gain additional knowledge is clear as all of them indicated an eagerness for training in almost all the health promotion themes specified.

Although a Standards Generating Board was suggested more than 10 years ago to develop training programmes and unit standards in the direction of accredited qualifications, minor improvement has been made in this regard (Wills & Rudolph, 2010). The Department of Health is also aware of their obligation in the provision of training as they recognised the harmonisation of training at training institutions in the NHPPS (Department of Health, 2014). The fact that only four participants specified that they feel comfortable with their current knowledge, further confirms the need for training also in the North West Province. The strengthening of skills and knowledge of health promoters are therefore identified as one of the main issues to address for the successful promotion of health in the Dr. Kenneth Kaunda District.

Although all themes (alcohol and drug prevention, mourning, HIV/AIDS, sexuality, nutrition, STD prevention, suicide prevention, violence prevention and trauma) received interest for further training the topics on injury prevention, sun safety and

legislation received a slightly reduced interest. The relevance of these training themes in health promotion is supported in literature because of the complexities of social and health concerns in South Africa. For example, the HIV/AIDS epidemic still encompasses major challenges for the health sector as South Africa has the highest number of TB/HIV co-infections globally (WHO, 2013). The HIV/AIDS epidemic is connected to nutrition, sex education and risk-taking behaviour. Therefore sex education is a relevant topic to better prepare young people to accept safer sexual practices (Wood & Roller, 2014) along with a focus on risk-taking behaviours in adolescents. Additionally, risk-taking behaviour, is linked with school violence and also poses a threat to learners' health and well-being (Mampane, Ebersohn, Cherrington, and Moen, 2013). This example illustrates that the training themes are all inter-related and should therefore all be included in additional formal training initiatives for health promoters in schools.

Considering the relevance of above mentioned themes and the inter-relatedness of these complex topics, it is of paramount importance that health promoters have a job description. A job description will aid health promoters to keep focus and to know what it is they do when they have to promote health. The Department of Health has indicated that it is their goal to develop the professional health promoting programme outcomes by adding job descriptions for health promoters and having it available for all health promoters between 2015-2019 (Department of Health, 2014). It seems as if this target is mostly on track since 61% of health promoters in the Kenneth Kaunda District specified that they have job descriptions. The remaining health promoters either unsure or unaware of job description poses as a problem since a lack of a job descriptions could contribute to poor work performance (Department of Health, 2014a; WHO, 2013).

The extent to which health promoters recognise the different key responsibilities within their job description was also examined. The fact that health promoters consider working with other stakeholders as a significant part of their job description

can be considered as a positive outcome for health promotion practices in the Kenneth Kaunda District as the collaboration with all stakeholders is becoming increasingly vital in public health (Pucher, Candel, Boot, van Raak & de Vries, 2015). Health promoters also considered training of the school community as part of their job description with slightly smaller number of participants considering the education of school staff as part of their responsibilities. According to the ISHP and NHPPS one of the main responsibilities of health promoters includes provision of education about health topics (Department of Health and Education, 2012) and to familiarize school staff about HPS (Department of Health, 2014a). Health promoters in the Kenneth Kaunda District should be made aware that the facilitation of workshops for parents, learners and teachers about the implementation of the HPS programme are part of their job description and therefore these health promoters should also receive training on how to do so (Department of Health, 2014a).

It is significant to notice that almost 30% of health promoters viewed life skills training as less significant in their responsibilities in regard to other training skills or that this was something not included in their job description. The World Health Organisation (1999) regards life skills training as a preventative measure in the health promotion movement

The responses of participants confirmed that 84.6% of them create support groups as part of their job description. Support groups can be used to better equip people with knowledge and resources to make informed decisions regarding their health and wellness. The National School Health Strategy and Policy confirms that health promoters should use guidelines to provide and create support (Department of Health, 2014a) which Wills and Rudolph (2010) similarly confirmed earlier by stating that health promoters should set up support groups according to specific topics and needs.

Participants also indicated that most of them had distribution of support materials such as VCT (voluntary counselling and testing) kits as part of their job description but not the distribution of VCT kits. In line with the results of this study the National Health

Promotion Policy and Strategy states that the spreading of support material, such as IEC material (Information, Education and Communication) are one of the key roles of health promoters (Department of Health, 2014a). The distribution and use of VCT kits are not included in the job description or responsibilities set out by the National health promotion Policy and Strategy (Department of Health, 2014a). The spreading and use of VCT kits can be further investigated as VCT kits are proved to support HIV prevention efforts (Family Health International, 2004).

As part of the Work section of the health promoter questionnaire, some questions focused on participants' salary and their view about their current career. Although most participants were fulfilled in their careers a small number of them indicated that they were not fulfilled at all. The reason for this discontentment needs further investigation as the job satisfaction of all health promoters are of paramount importance since job satisfaction has a direct influence on job performance (Hsieh, 2016). Job satisfaction is also directly linked to employees' intentions to leave a career (Ramoo, Abdullah & Piaw, 2013). While 38% of participants indicated that they would not leave their job at all, the rest of the participants all considered leaving to various degrees.

Job satisfaction together with financial compensation can have a significant impact on health promotion in the Dr. Kenneth Kaunda District. Health promoters did indicate that their salaries are insufficient considering the work they have to do. Imbalances between hard work and minimal incentives such as salary or career prospects and opportunities have been proved to influence people's choices to leave a career (Lavoie-Tremblay, O'Brien-Pallas, Gelinas, Desforges & Marchionni, 2008).

Above mentioned job satisfaction and financial compensation's direct link with people's choice to leave a career could be a major loss for the health promotion profession given the current human resource shortage. The Department of Health acknowledges this problem as they stated that human resources and their salary levels differ significantly across different provinces and that clear norms and standards of

employment need to be formed in order to move health promotion forward (Department of Health, 2014). This situation thus needs to be highlighted and addressed before the Dr. Kenneth Kaunda District loses health promoters to other career prospects. The loss of these health promoters can be an even greater loss since most of the participants of this study had the view that they made a difference in promoting peoples' health. Their positive view can be regarded as an important outset for health promotion as positive work reflections are linked to improved work performance (Binnewies, Sonnentag & Mojza, 2009).

In the literature review section, it was argued that communication and regular meetings form an integral part in ensuring that the outlines and objectives set out in different health promotion policies are met. The results of this study did indicate that health promoters contact schools regarding upcoming visits mostly via phone calls and sometimes WhatsApp/SMS, e-mail or fax. These methods of communication are in line with technological trends as the use of SMS/WhatsApp are becoming more popular in work settings as it is cost effective and receivers of messages usually responds quickly (Kiddie, 2014).

To further enhance clear and regular communication in the health promotion profession, the Integrated School Health Policy suggested regular meetings with the different stakeholders responsible for executing the school health programme to ensure the outlines and objectives set out in the policy are met (Departments of Health and Education, 2012). Meetings with other health promoters seem to be adequate, but meetings with health promotion management, sub-district offices posed different results. The infrequent meetings between these entities could have an impact on effective implementation of health promotion since regular meetings ensure that stakeholders discuss information and experienced knowledge, allocate tasks and preserve resources (Hung, 2014). The limited meetings between the Department of Health, Department of Education and health promoters are worrying for the same reasons as mentioned above, especially since these departments co-direct and support

the health promotion initiative with over-arching policies such as the Integrated School Health Policy (Departments of Health and Education, 2012). The School Health Policy specified that school health promotion should be an integrated part of other health care services and these services had to be delivered in collaboration with the Departments of Health and Education (School Health Policy, 2009). The National Health Promotion Policy and Strategy equally emphasises the importance of collaboration between different departments (Department of Health, 2014a). The collaboration between these stakeholders is not possible without regular meetings as the coordination and administration of tasks and resources could not be managed effectively.

Meetings together with active planning are a crucial part of the effective implementation of the health promotion programme. The fact that most of the participants indicated that they receive an events calendar and updates it yearly can be interpreted as a positive notion towards better health promotion. Inadequate planning is however present given the absence of rotation-based plans for school visits. These rotation-based plans are intended to be used as a schedule to ensure that no schools are omitted and that follow up visits take place where necessary. This data shows similarities with international health promotion problems as the WHO recognised that irregular and insufficient school visits and follow-ups are key problems in executing the health promotion strategy (WHO, 2013; Shung-King, 2009). The Department of Health likewise recognised this issue and included the monitoring, evaluation and reviewing of progress into the key responsibilities of health promoters (Department of Health, 2014). Although this is included, no practical information or guidelines on how this should be done could be found.

When school visits do take place, the majority of health promoters spend between 30 to 60 minutes per school. Although the National Health Promotion Policy and Strategy sets out certain responsibilities for health promoters, the policy does not give an indication of a specific timeframe for these activities and responsibilities. However, all

the responsibilities could not possibly be effectively executed in 1 hour or less. This is further evident as participants indicated that they do not always plan for or schedule follow-up visits. The reasons for these short visits are unknown but the lack of human resources could be a possibility. It would be suggested that the reasons for these short visits gets further attention.

While health promoters visit schools, it seems as if they have minimum contact with learners. This issue also needs to be addressed as the education and training of learners on health promotion topics are one of their key responsibilities (Department of Health, 2014). A positive outcome of the results was the fact that health promoters had the view that learners felt that they could approach the health promoters when they had the need.

One of the surprises which emerged from the data is the intimidation health promoters experience to not report misconduct. No literature regarding intimidation in health promotion could be found. The NHPPS and ISHP also had no indication of intimidation or responses on how health promoters should handle or address intimidation. International health promotion policies likewise didn't have any references towards intimidation. The question therefore arises if this is a trend or problem only in the Dr. Kenneth Kaunda district, North West Province or a widespread problem in health promotion. The fact however remains that health promoters in the Dr. Kenneth Kaunda District should be assisted on how to effectively handle these types of situations.

From the 54% of health promoters who do experience intimidation to not report misconduct, a further 30% do not report misconduct. The Children's Act 28 of 2005 is clear on reporting misconduct. This act states that 'any person who on reasonable grounds believes that a child is in need of care and protection may report that belief to the provincial department of social development, a designated child protection organisation or a police official' (Act no.38 of 2005). The ISHP also mentions this act by stating that it is mandatory to report any form of child abuse, neglect and

exploitation (Departments of Health and Education, 2012). This highlights the fact that health promoters need training on legislation as well as the effective handling of conflict situations and where and how to report misconduct.

The type of schools health promoters visit are in line with the ISHP as it stated its target group for the school health programme as including all learners, but that the primary target group covers children attending formal learning sites thus including Gr.R, Gr1-12. The NSHPS includes children under five years in their target audience, but other programmes such as the Integrated Management of Childhood Illness (IMCI), Household Community Component and Key Family Practices are addressing health promotion programmes for these children together with Early Childhood Development Centres (ECDC's), parents, caregivers and health services (Department of Health, 2014).

In order to visit all the above mentioned schools, health promoters need adequate transport on a regular basis. The data regarding a lack of transport or difficulty of transport is not surprising as various literature indicated absence of transport for health promoters as a major barrier in promoting health (Mthobeni & Peu, 2013; Shung-King, 2009). The results on transport from this study can further be regarded as problematic as the NNHPS stated health promoters should be activists for health promoting resources such as transport (Department of Health, 2014). This serves to be a dilemma in their responsibilities as health promoters do not have adequate transport themselves. The ISHP additionally recognises that health promotion outcomes will only be successful if they attend to resource availability such as transport for health promoters (Departments of Health and Education, 2012).

Another problem constantly surfacing in the literature is the collaboration aspect of the health promoter with different stakeholders. Collaboration with different school groups and school staff together with the inclusion of the broader community, for example parents, to participate in health promotion proves to be more valuable for implementing health promotion themes (Testa, 2012; Williams & Mummery, 2015,

Department of Health and Education, 2012). The results from this study indicated that health promoters do receive some support from the DoH, principals and teachers with a lesser amount of support from parents. The inclusion of parents into health promotions practises shows similarities with other studies who indicated a resistance or lack of partnerships with parents (Schellack *et al.*, 2011).

Although health promoters indicated support from the DoH, they did specify in a later question that support are still lacking when it comes to emotional, physical, financial and medical support. Although the DoH provides some workshops to advance knowledge and skills, it is still insufficient as it was indicated previously. Goals set out for health promotion by the Department of Health includes the provision of sustainable financial support as well as the provision of recourses to health promoters, (Department of Health, 2014) which are lacking in the Dr. Kenneth Kaunda District.

Support from the Department of Education is worrying given that the collaboration between stakeholders and the provision of services were set out in 2009 to be delivered by the Departments of Education and Health (South African School Health Policy, 2009). The successes of health promoters depends on collaboration, support and assistance from all stakeholders including the DoH and DOE, teachers, health workers, governing bodies, learners, the community and all other persons in the school community (Hung *et al.*, 2014; WHO, 1996). The results discussed above therefore prove that participants still lack support in various instances and that the lack of support will influence health promotion in the Dr. Kenneth Kaunda district negatively.

Collaboration with the wider community such as professional health personnel like doctors, occupational therapists, dentists, and/or psychologists are crucial where learners are in need of further assistance outside the skill or scope of practice of the school health team (Departments of Education and Health, 2012). Results from this study confirm that health promoters are in need to build networks and relationships with professionals to effectively refer learners in need for professional assistance. From related literature, it is clear that health promoters encounter problems with referrals

due to a lack of access to professional staff (Mthobeni & Peu, 2013) or inadequate referral systems (Shung-King, 2009). No inferences can however be made on the reasons why participants did not contact these professionals for support or assistance, but this should receive attention to ensure suitable support to all learners.

Given the lack of support and difficult circumstances health promoters work in, it is of paramount importance that participants receive support in their workplace. The conflict participants experience with supervisors consequently needs to be addressed as conflict in the workplace has been linked to workplace bullying (Baillien *et al.*, 2015). Conflict in the workplace can also result in decreased productivity and job satisfaction (Ayoko, 2014) which will have a negative impact on health promotion.

Together with the above-mentioned barriers are additional wide-ranging barriers faced by health promoters. These barriers are however similar to barriers health promoters face in other provinces in South Africa (Davids, Roman & Leach, 2015; Janssen, van Dijk, Al Malki & van As, 2013; Mthobeni & Peu, 2013; Shung-King, 2009). This outcome of results confirms the need for further training in specific themes previously specified as well as the following additional themes: family support (divorce or single parent families), rape or sexual assault and abuse. The Departments responsible for health promotion should also re-evaluate their support and the resources they provide as health promoters need assistance as many families and learners are poor, teachers are sick, they have inadequate learning materials as well as a lack of human resources (for instance more health promoters to relieve the workload).

Although health promoters face all these challenges they still enjoy their work and experience satisfaction after finished projects. This can be interpreted as positive for health promotion in the Kenneth Kaunda district as an increase in job satisfaction has a direct link to increased job performance (Chandra & Priyono, 2015).

Even though all participants showed that they enjoy their type of work, the majority of participants specified that they feel emotional after a day's work. No inferences can

be made about their reasons for emotionality as this data is insufficient for this kind of conclusion. Literature does indicate that older workers have better emotional regulation competences to process emotions after work (Scheibe, Spieler & Kuba, 2016). It could be that the health promoters' age (which was previously identified as relatively young) could be a contributing factor to the way they handle their emotions. Another derivation that could be made is that participants do need some type of emotional outlet as data obtained indicated that there were high levels of emotionality after work.

Mthobeni and Peu (2013) previously identified a lack of mental support for health promoters as problematic as they do not have any debriefing sessions. No literature could be found regarding coping strategies for health promoters, but an interesting study executed in 1998 revealed that a strong sense of coherence among social workers reduces the incidence of burnout as particular stressor can be identified and appropriate resources can be chosen (Gilbar, 1998). This is interesting given the fact that health promoters mostly talk with co-workers and sometimes friends/family about work related problems.

Participants also experienced high levels of stress and it could have a negative effect on their health as well as the effectiveness of the programme (Laranjeira, 2012). Not only is the results from the stress data alarming for the health of participants but stress also have an impact on work as it reduces levels of energy, involvement, and efficacy (Schaufeli, 2012).

The health of health promoters seems to be problematic given the high levels of insomnia. Insomnia is identified as a risk factor to develop mood disorders or/and anxiety (O'Keeffe, 2016) and therefore has a correlation with irritability. A further concern rising from the sleeplessness data that participants presented are the correlation with physical health issues such as type 2 diabetes, cardiovascular diseases and cancer as well as symptoms such as 'decreased daytime functioning, fatigue, daytime sleepiness, problems with concentration or memory, mood disturbance,

reduced motivation and proneness to errors or accidents (O'Keeffe, 2016). The regular visits to doctors and traditional healers are further indications of health promoters' ill health.

5.4 CONCLUSION

In this Chapter 5 the results of the Health Promotion Questionnaire were presented and integrated with literature in order to create a profile of the health promoter in the North West Province, Dr. Kenneth Kaunda District. The findings were presented in pie charts, tables and graphs in order to gain an integrated profile of the health promoters

This chapter did reveal that there are many similarities between health promoters in the Dr. Kenneth Kaunda District and other health promoters. These similarities include the wide-ranging barriers that health promoters face when promoting health. These barriers comprised of personal barriers like health, coping strategies and insufficient training; work related barriers including transport and collaboration with stakeholders; as well as external barriers, such as the circumstances they have to promote health in. The results also posed a few surprises which had no correlation with previous studies about health promotion. This included the occurrence of conflict with their supervisors and intimidation by school staff to not report misconduct.

A few positive contributions also occurred with the first one being health promoters' biographical information placing them within the communities they work with. The fact that health promoters mostly enjoy their work and feel that they make a difference can be seen as a further advancement for health promotion in the Kenneth Kaunda District.

In the next Chapter these findings will be synthesized in a holistic understanding of who the health promoter in the Dr. Kenneth Kaunda District is and what the key related aspects are in terms of their role as a health promoter working in schools. Lastly, some recommendations in terms of health promoters are made as well as suggestions for further research.

THE PROFILE OF THE HEALTH PROMOTER IN SCHOOLS IN THE NORTH WEST PROVINCE: A SYNTHESIS

The aim of this chapter is to conclude and synthesize the research project as a whole in terms of the stated research aim. This will be done by reviewing the key findings and accompanied conclusions made. The findings regarding the profile of the health promoter in the Dr. Kenneth Kaunda District, North West Province is key to this chapter and will be presented in a summarised illustration to get a better understanding of who the health promoter is. Also, an indication will be given of the limitations that hampered the project. Finally, some suggestions are being made for future research as well as recommendations regarding the profile of health promoters and their execution of health promoting duties.

To achieve the key aim of the research project, namely to construct a profile of the health promoter in schools, an overview of the concepts health and health promotion as well as Health Promoting Schools were necessary. This was done while also exploring the global and national needs successes and shortcomings of Health

Promoting Schools. First, an integrated definition of Health Promoting Schools was formulated from the various definitions in different disciplines. Health promotion is therefore defined as the action of empowering people with control, resources, support, equity and healthy environments in order for them to be mindful in making choices for optimal physical, mental and social well-being (WHO, 1986; WHO, 1997; Viner & Macfarlane, 2005; Naidoo & Wills, 2009).

Significant for the actions of health promotion, is the fact that health is regarded as a basic human right and therefore all stakeholders, including policy makers, government as well as community members should take serious action against situations that attributes to poor health. Since health is also recognised as something occurring within interrelated circumstances influenced by different individuals, families and communities, it is vital to include social, economic, political and environmental factors when considering health promotion actions.

Considering health as a basic human right and the interrelatedness which can influence health, it was clarified that schools are one of the key settings where children can be reached to not only educate them about health topics, but to also instil values and a culture of healthy life choices and the resources to do so. It is thus apparent that a healthy school environment and health promotion strategies are essential in supporting learners and school communities to reach optimum health. South Africa has great policies and legislation in place for executing these health promotion programmes, but there are still many barriers to consider.

To investigate above mentioned barriers, it is important to consult stakeholders directly working within health promotion programmes. Health promoters are regarded as one of the key human resources in executing health promotion actions. The term health promoter in international contexts as well as national contexts was described in detail in Chapter 2. Finding a detailed definition and clarification of health promoters proved to be difficult, as a number of terms were used to refer to health promoters working in different settings. Contributing to the difficulty in finding a definition is the

fact that various studies used the term health promoter when referring to any health or education professional contributing towards health promotion (*Hung et al., 2014*). To differentiate between health workers, community health workers, health promoters, public health officers, environmental health officers, health educators, health planners, and health communicators also contributed to the complication (Tengland, 2010).

Next, the responsibilities of health promoters were explored to create an outline for what is expected of them. It was concluded that health promoters have a substantial amount of work to do when they have to promote health. These responsibilities set out by the NHPPS and the ISHP are clearer than before since specific actions are linked to specific health promoting settings such as schools. Although these activities are clearer, some responsibilities such as the implementation of health promoting programmes needs better clarity and coherence.

Chapter 5 went on to investigate the profile of the health promoter in the North West Province, Dr. Kenneth Kaunda district in a quantitative investigation concluded from their biographical information, training and qualifications, work/job description, communication, planning, school visits, transportation, barriers, coping and personal health. Since health promoters play such a vital role in the establishment of Health Promoting Schools, their profile is significant in establishing what health promoters need in fulfilling their duties. Figure 60 below demonstrates the findings regarding the profile of the health promoter in the Dr. Kenneth Kaunda district in a summarised illustration in order to form a better understanding of who the health promoter is.

A profile of the Health Promoter in the Dr. Kenneth Kaunda District

Biographical information	• Black, male, South Africans, between the ages of 31 and 50 • Single with 1-2 children of their own • Setswana speaking and competent in English and at least one other language. • Background in some type of counselling and 31% with no experience
Training & Qualifications	• Completed Gr.12 with no additional formal training • Received training while employed as health promoters (HIV/AIDS and STD prevention) • Inadequate training: TB, Alcohol and drug prevention, violence prevention, death and mourning and suicide prevention • Not comfortable with current knowledge, eager to gain needed knowledge
Work/ Job	• A large number of health promoters lack a clear job description • Core responsibilities: Collaboration with stakeholders; training; creating awareness, events and support groups; distribution of support material • Fulfilled in their career and most wouldn't consider other career prospects. • They make a difference in promoting peoples' health but have an inadequate salary
Communication	• Preferred method of communication with schools: telephone, SMS & WhatsApp • Meetings with health promoters, sub-district offices and management take place occasionally • Sometimes receive paperwork after meetings • Number of meetings varied between 0-2 per week
Planning	• Receive events calendars from the Department of Health • Compile own planning from calendar and updates it yearly • The participants do their individual planning on a monthly basis • Rotation-based plan to schedule school visits and records for follow-ups are absent
School visits	• School visits mostly take place at primary, secondary and PSPP schools and sometimes at combined schools, day-care facilities and pre-schools. • A school visitation takes between 30min-1hour per school • Contact with learners are minimal, but takes place in group discussions or when teachers inform HP about problems. (Learners can approach HP if necessary) • HP are familiar with school staff, but almost half of them stated that they are intimidated by staff to not report misconduct. • When they do report misconduct, they report to teachers/principal or their manager.

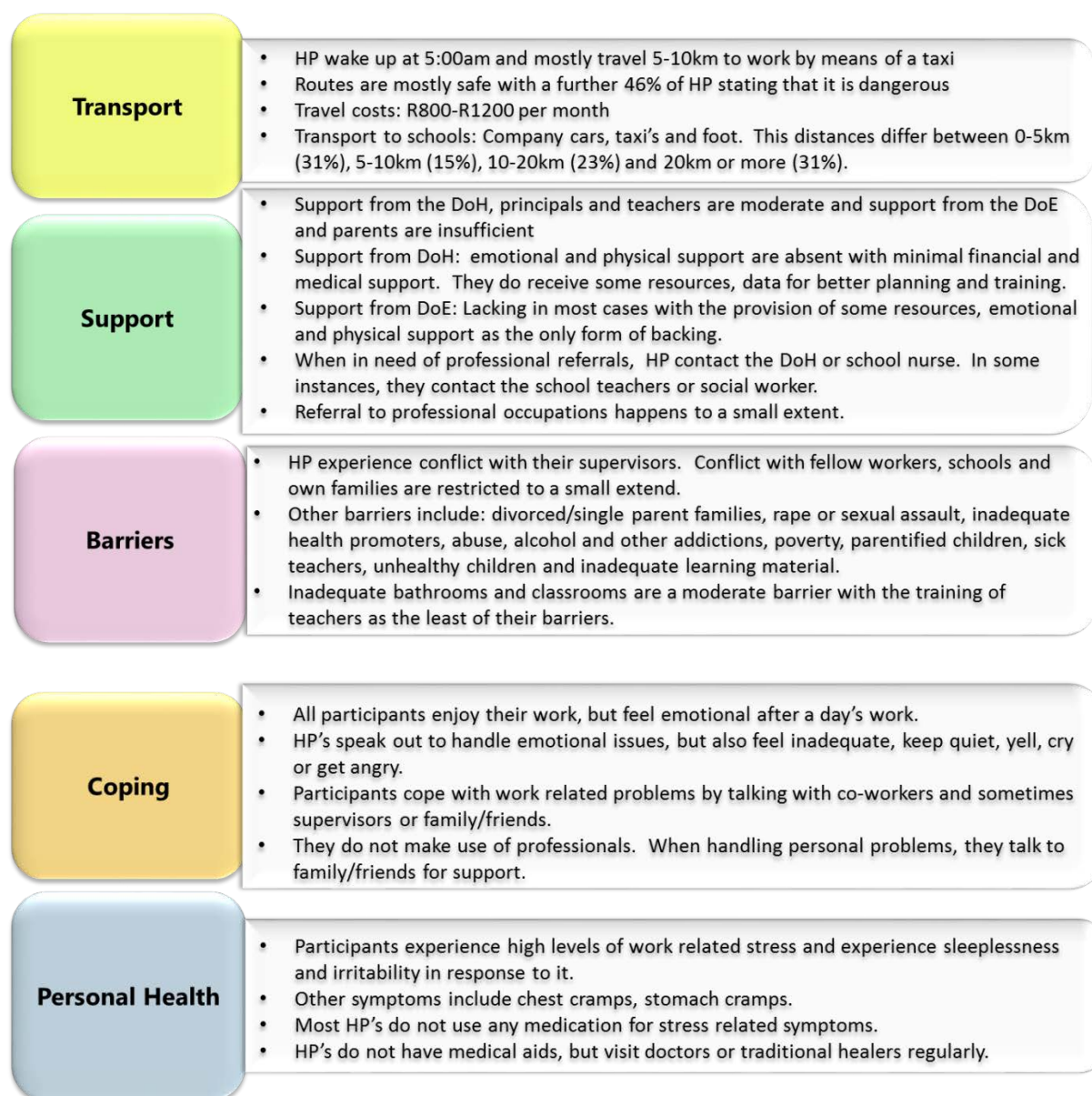


Figure 60: A profile of the health promoter working in schools in the North West Province

Who is the health promoter?

By exploring the health promoter's biographical information, key findings such as age, gender, race, marital status and language were established. Although these categories were in no means used to differentiate between individuals, the data is important to ensure the practicality and quality of health promotion duties. Questions that arose from this data were if certain members of school communities would feel comfortable to confide in individuals that have different ages or are from the opposite sex. Since

health promoters have the duty to educate school learners as well as school staff about topics such as sexuality and sexual health, it is important that the receivers of such information as well as the presenter are comfortable with each other. Although this study gives no indication of gender issues that could contribute to problems of openness, the feelings of school community members should be considered. It was established however, that health promoters in the Dr. Kenneth Kaunda District share languages and cultural background with the communities they serve which are positive for health promotion regarding the fact that they share values, culture and a communal understanding of obstacles.

The question of who the health promoter is could be synthesised as follows: The health promoter in the Dr. Kenneth Kaunda District is a member of the community they serve as they share characteristics such as culture, language and viewpoints. These characteristics improve the impacts of health promoters as they can provide culturally appropriate care and better recognise influencing health effects (Pinto *et al*, 2012; McDermott-Levy & Weatherbie, 2012). Extracting from definitions of health promoters and above mentioned characteristics, it can be said that these health promoters have a leading and influential role in school communities to motivate, support and educate community members through effective counselling, auxiliary and communication skills.

The training and qualifications of the health promoter: an expressed need

Training of health promoters emerged as one of the main themes in this research project. First it was concluded that although health promoters have a matriculation certificate, that most of them had no additional formal training or education. They did however receive some training on specific themes provided by the Department of Health. Onya (2009) stated that countries in Africa aim to strengthen health promotion by the professionalisation of health promoters and by frequently renewing skills and competencies. This is however still a challenge in the North-West Province as indicated by the lack of training which health promoters themselves identified. It is however

noteworthy that all the health promoters in this study are eager to acquire new skills and knowledge regarding health promotion related topics such as violence prevention and alcohol and drug prevention.

Apart from these specific themes identified as interests, are the additional training themes which emerged from different section of the Health Promoter Questionnaire which includes effective communication, operative planning, managing intimidation, making referrals to professionals, managing conflict, copings skills and taking care of personal health. These additional themes will be discussed underneath the corresponding headings as they are equally important for health promoters to execute responsibilities effectively.

The job description of the health promoter: a matter of concern

Although the Department of Health is committed to develop job descriptions for health promoters in South Africa (Department of Health, 2014), some health promoters in the North-West Province, Dr. Kenneth Kaunda District indicated that they have no clear job description. They did however indicate that collaboration with stakeholders, training the school community regarding health topics; life skills training; creating awareness and events for better health promotion; creating support groups; distribution of support material e.g. IEC material is part of their responsibilities.

While consulting Chapter 3 which gave a detailed outline of responsibilities for health promoters working in schools, it can be concluded that the terminology used and responsibilities outlined in health promoters' job description could be simplified. Given the education and training skills of health promoters as indicated by themselves, it should be difficult to grasp abstract terms and actions outlined in their job description. Duties such as the supervision of the HPS programme, training and introducing school staff regarding health promotion, and the evaluation of the programme are all vague abstract themes which poses as difficult concepts since practical actions are excluded. No policies could be found that indicate what it is health promoters should do when they implement HPS programmes or train school staff

regarding this topic. The effective implementation of these concepts together with duties such as creating support groups, coordination health campaigns, assessing the needs of schools, designing action plans and the supervision of these plans all need adequate and specific skills such as problem solving and counselling skills to execute them effectively.

A further possible contribution towards poor work performance, are the participants' indication that they do not receive adequate payment for services rendered and that some would consider other work. It was concluded that this will cause an even bigger problem for health promotion implementation as there already is a lack of human resources. Adequate payment for services rendered has to be considered to avoid this dilemma as financial compensation has been identified as an incentive for health promoters (Cherrington, 2010).

The way the health promoters communicate, plan and conduct school visits: training and collaboration needed

The Integrated School Health Policy suggests regular meetings between stakeholders and health promoters. Participants however, indicated that meetings with managers and sub-district officers are not held often. Collaborative meetings between the Department of Health, the Department of Education and Health promoters are also not held regularly. This is problematic as collaboration between these stakeholders is encouraged and reemphasised by the formulation of the Integrated School Health Policy. Clear communication is of utmost importance if the different departments and categories of staff want to work collaboratively. Clear communication would also help with support towards health promoters to form a clearer understanding of their responsibilities and to reduce the incidence of responsibilities overlapping. As human resources were established as a shortcoming in health promotion and health promoters indicated that their responsibilities sometimes overlap with the responsibilities of health promoters working in other settings (Mtobeni & Peu, 2013), it is even more important for stakeholders to communicate. Effective communication

would result in health promoters knowing exactly what it is they should do and where it is they should perform these duties.

Communication tasks of health promoters which raises the importance of the training theme once more, is health promoters' function to invite various stakeholders and organisations to the health promoting initiative and by arranging sponsorship meetings. Additional responsibilities include the incorporation of other health programmes within the HPS model by inviting those responsible. Once again, health promoters need specific skills and training on how to approach these individuals and to effectively communicate the importance of health promotion programmes.

As part of their communication with the Department of Health, participants also indicated that they receive calendars for planning. These calendars suggest topics per week or month which health promoters should include when educating learners. Health promoters further indicated that they mostly construct their own planning about other health promotion topics. This raises the question regarding the quality of planning especially since clear job description and responsibilities are lacking. It should also be reconsidered as why the planning concerning vital health decisions are done by individuals with a matriculation certificate as their highest qualification and if their subsequent training were enough.

A further possible contribution to the low number of Health Promoting Schools present in the North West Province, is the absence of rotation-based schedules to visit schools. Without these plans it is possible to omit certain schools without anyone noticing especially since the Dr. Kenneth Kaunda District serve 206 schools with the help of 16 health promoters. The absence of these plans and evaluations will also contribute to the lack of follow-up visits. Without effective evaluation and follow-up visits where problems were identified, there is no way in which health promotion programmes could be effective. These rotation-based plans could assist health promoters to construct temporary solutions regarding the lack of human resources.

Although health promoters indicated that they visit schools, the visits take about 30 to 60 minutes. This can also be a contributing factor to the low number of Health Promoting Schools in the North West Province as 30 to 60 minutes will not be nearly enough time to complete the myriad responsibilities outlined in Chapter 3. The lack of human resources could be a contributing factor as 16 health promoters serving 206 schools limits time frames considering that each health promoter is responsible for health promotion in more or less 13 schools. These schools are also not situated next to each other and with a lack of transport as indicated in Chapter 5, illustrates why these health promoters couldn't possibly do effective work.

Significant data showed that half of the participants are subject to intimidation when they try to report misconduct. Alarming, 30.8% of health promoters indicated they do not report misconduct at all. The incidence of intimidation and the reasons for failed reporting needs further investigation. The lack of training could be a contributing factor as health promoters indicated an interest in legislature as a training theme. Health promoters need to be informed about relevant legislature especially regarding children and who to contact should such an issue arise. The establishing of collaborative relationships with social workers also needs attention. Additional training which could benefit health promoters is the management of conflict situations and particularly assisting them with problem solving skills regarding intimidation.

The way the health promoters engage with transportation to and from the work site: a mixed bag

In this study health promoters travel between schools and their office by means of company cars, taxis and by foot. These means of transportation are however not always safe. Health promoters receive no compensation or financial assistance for travels between schools and their offices, which shows similarities with literature that indicated that health promoters in developing countries use personal resources to meet the health needs in their communities (*Pinto et al., 2012*).

As seen in the section above, health promoters without company cars and own transport could not possibly serve 206 schools successfully. Using taxis would make them dependent on taxi schedules and traveling by foot will limit time-frames for school visits even more. The Department of Health is responsible for recourses to assist health promoters with their duties. The Department of Health therefore needs to re-evaluate the distribution of resources or should come up with alternative plans to assist health promoters to reach schools without wasting valuable time.

Support to the health promoters working in schools: needs serious consideration

In accordance with literature health promoters are of the opinion that support from the Department of Education and parents in the school community are insufficient, while they receive some support from the Department of Health, principals and teachers. Interestingly, health promoters indicated that they mainly lack emotional and physical support. Given the difficulties health promoters encounter, it is no surprise that they are in need of support. Previous mentioned difficulties such as lack of training, lack of clear job descriptions, limited communication with various stakeholders, uncertainty about planning, experiences with intimidation and a lack of transport are all contributing to their indication for emotional and physical support.

The issue of support needs serious consideration especially since these health promoters indicated that they are not considering other work prospects. The fact that they encounter these difficulties daily and still remain in this profession, could be ascribed to the fact that they feel they make a difference. These individuals can therefore be regarded as a valuable resource in creating Health Promoting Schools in the North West Province.

Although referral to qualified professionals is required by the Department of Health, not all health promoters refer cases outside their scope of practice. Although the reasons for insufficient referrals are unclear, this highlights the issue of training once more since there is a possibility that health promoters do not know when, how or to whom to make referrals. Effective communication is also once again brought forward

as health promoters need necessary skills to include these professionals as stakeholders within the health promoting programme. Health promoters therefore need the skills to build relationships with professionals in order to successfully assist learners in need.

Health promoters and the barriers experienced in their work: in dire straits

Although health promotion programmes has been implemented with some success stories, there are still major barriers in some cases (Stewart & Wang, 2012). The barriers that were identified by health promoters in the Kenneth Kaunda District, North West Province are similar to barriers identified in the literature (Chapter 2). These challenges included divorced or single parent families, rape or sexual assault, inadequate health promoters to assist, abuse, alcohol and other addictions, poverty, parentification, sick teachers, unhealthy children and inadequate learning material. A barrier which did not surface in any previous literature is the health promoters' in the Dr. Kenneth Kaunda Districts' experience of conflict with their supervisors.

As seen in Chapter 2, health promoters should not be viewed as separate entities but interact in complex systems which co-exist in associations with other systems. This interrelated system can be viewed in the barrier and work sections of the health promoters' questionnaire. The myriad barriers they experience together with work conflict and inadequate salaries can all contribute to poor work performance. Despite these experiences, health promoters indicated that they feel fulfilled in their career, made a difference in health promotion and most wouldn't consider other career aspects.

Imbalances between hard work and minimal incentives such as salary or career prospects have however been proved to influence people's choices to leave a career (Lavoie-Tremblay *et al.*, 2008). There is no assurance that health promoters would not reconsider career prospects if these barriers continue without the necessary support indicated in the previous section. All these difficulties together with the added conflict

with their supervisors could be a major loss for the health promotion profession given the current human resource shortage also identified in the barrier section.

How do health promoters cope in the execution of their work: a bumpy journey

Health promoters in the Kenneth Kaunda district indicated that they enjoyed their work, but still feel emotional after a day's work. To cope with emotional matters, the health promoters talk with co-workers and sometimes their family or friends. They do not make use of any professionals like psychologists although they experience feelings of inadequacy or act out by crying, yelling or getting angry.

Once again, the interrelatedness of different factors contributing to the problems health promoters experience are visible. Inadequate training, poor communication between stakeholders and the lack of transport can all contribute to health promoters' difficulty with coping with emotional problems. Adequate support as well as effective debriefing sessions is necessary in assisting health promoters in their pursuit to create Health Promoting Schools.

The personal health of the health promoters: a demanding vocation

Health promoters in the Kenneth Kaunda district experience high levels of stress due to their work and as a result experience sleeplessness and irritability. Some of the health promoters also experience chest cramps and stomach cramps, yet they do not use any medication. These findings are a further extension regarding the interrelatedness of an individual's ecological sub systems as these stress related symptoms can have an effect on their work performance due to ill health as health promoters in the Kenneth Kaunda District do not have medical aids, but visit doctors or traditional healers between 2-5 times a year. Consistently with above mentioned synthesis, it is highlighted that health promoters need support in various areas including their own health.

6.1 RECOMMENDATIONS

- To effectively contribute to health promotion, it is recommended that an exclusive and context specific term should be used when referring to health promoters (participants of this study) who's main responsibility, income and job title is that of health promoter. The use of a context specific term will set them apart from other professionals promoting health (community health workers, teachers, doctors, nurses etc.) which in turn will help in the clarification of roles and a detailed job description.
- Although health promoters fit the demographic profile of most citizens in the Dr. Kenneth Kaunda District, it is recommended that further studies investigate the occurrence of mainly male health promoters, inconsistent with health promoter figures in other provinces in South Africa.
- In accordance with data received regarding lack in training themes relevant in the South African context together with health willingness to gain knowledge, it is recommended that health promoters in the Kenneth Kaunda district receive additional training in health promotion topics as well as training in effective communication, how and when to make referrals, managing conflict and intimidation.
- It is therefore also recommended that training programs should be standardized to fill the gap in skills and training while the gaining of knowledge can serve as motivational factor to fulfil their role as health promoters. As was seen in the biographical information, health promoters share cultural and language similarities with the communities they serve, therefore sufficient training is even more important as traditional views in cultures could have negative or positive impact on health behaviours.
- Although job descriptions for health promoters do exist, it is recommended that the Department of Health prioritize their commitment to educate and create awareness of these job descriptions to health promoters. It should also be

considered to simplify these job descriptions in a more suitable practical language which health promoters could interpret.

- A further recommendation would be the re-evaluation of salaries of the health promoters' in the Dr. Kenneth Kaunda District as they indicated inadequate compensation. Since different systems in an ecological framework are interrelated, inadequate salaries have been linked to workers seeking other career prospects.
- It is recommended that meetings between health promoting managers, sub-district officers and health promoters are regularly scheduled.
- The same recommendation would be beneficial for meetings between the DoH, DoE and Health promoters. The Integrated Health Policy together with the National Health Promotion Policy and Strategy equally emphasises the need for collaboration between different departments and other stakeholders to prioritise service delivery.
- Better planning regarding rotation-based schedules to ensure visits to all schools are also recommended in the Dr. Kenneth Kaunda District. This recommendation is further supported by the ISHP which states that capacity building in health promotion depends on 'active reporting, monitoring and evaluation' of the ISHP to ensure learner coverage and identify gaps and barriers to implementation (Department of Health and Education, 2012).
- Future studies could be executed on why health promoters don't use rotation based plans, especially since the monitoring, evaluation, reviewing, developing and reporting of systems are set out as a responsibility for health promoters
- The execution of further studies is recommended for investigating the school visits which health promoters perform. As was indicated in Chapter 5, 30-60 minutes seems as an inadequate timeline for the duties which health promoters should perform.
- The reporting of misconduct should be researched with regard to the health promoters in the Kenneth Kaunda district experiencing intimidation to not do

so. This issue could also be interrelated to the lack of training health promoters identified. It is therefore recommended that health promoters receive further training regarding legislature and how to report misconduct when necessary.

- It is recommended that the Department of Health re-evaluate transportation accessibility and safety of health promoters in the Kenneth Kaunda district as only a small number of them have access to company cars. The accessibility of transportation has been identified as an incentive for health promoters.
- Similar with other literature, health promoters in the Kenneth Kaunda District indicated insufficient support from the Department of Education and Health. Better collaboration and support between these sectors are recommended by means of scheduling meetings in order to prioritise and align goals with shared strategies and resources. It is suggested that stakeholders recognise health promoters' work and efforts and acknowledge the importance of their responsibilities.
- Another suggestion regarding support to health promoters would be the investigation of parent's lack of involvement and support. It could be valuable to determine why parents in the Dr. Kenneth Kaunda District do not support health promoters in order to change this notion.
- Although referral to qualified professionals is required by the Department of Health, not all health promoters refer cases. Specific procedures to assist health promoters with effective referrals are suggested.
- Further research is also suggested as to why there is a lack of referrals in the Kenneth Kaunda district as previously specified that health promoters did not refer due to a lack of access to professionals.
- A last suggestion on this theme would be the additional emphasis on the collaboration between the school, community, health and education sectors to provide backing for every child to reach their full potential.
- As mentioned earlier, health promoters in the Dr. Kenneth Kaunda district face similar barriers as those found in literature. To effectively address these issues

will consist of complex interrelated connections and solutions. As seen in Chapter 2, the Department of Health, Education and health promoters' management should view health promoters as entities which interact in complex systems which co-exist with other systems. Therefore, it is suggested that there could be a connection between training of health promoters and the barriers they face. By further investigation the training they should receive, it could be suggested that health promoters should be equipped with knowledge and skills to overcome some of these barriers. Because health promoters live within the communities they serve, they have a better understanding of the extent of barriers they face. Therefore, it is suggested that the perception of health promoters should be taken into account when developing socially appropriate health programs.

- Because health promoters work with many challenges in their daily duties, it is recommended that they should receive access to some form of debriefing or professional support.
- Health promoters are responsible for educating other people in their communities about health-related topics, yet they have inadequate medical support. They do not use medication and don't have medical aids but visit doctors or traditional healers 2-5 times per year. It is recommended that the Department of Health do a re-evaluation of the medical support they provide to health promoters as free health care has been identified as an incentive for health promoters.

6.2 LIMITATIONS OF THE RESEARCH PROJECT

Although the research was planned, organised and executed according to comprehensive scientific measures and strategies, the following limitations and shortcomings occurred during the progression of the study.

- *Political instability and unrest*

The study was initially planned for all the health promoters employed in the North West Province, but only participants in the Dr. Kenneth Kaunda district of the North West Province were included. This was decided due to the concerns of safety of the researcher during data collection. Data was collected during the same time as municipal elections (2016) and certain areas posed to be unsafe due to political protest and boycott activities.

- *Unexpected needs by the health promoters*

A further limitation of the study was some of the health promoters' requirement to receive financial compensation for completing the health promoters' questionnaire. Due to ethical considerations, these health promoters could not be included into the sample of participants.

- *Health promoters only questionnaire*

The health promoter questionnaires were only handed out to health promoters in the Dr. Kenneth Kaunda District, North West Province and therefore did not include opinions and viewpoints of their managers, school staff or other stakeholders in the Integrated School Health Programme.

- *Small sample size*

The sample for this study was small as only 13 questionnaires were completed in the Dr. Kenneth Kaunda District, North West Province. The total number of health promoters in this district are N=16. A bigger sample is suggested for future studies in order to get a clearer picture of the profile of the health promoter. The participants consisted of mainly black, male participants and can therefore not be a representation of the total health promoter population of the North West Province. It is unclear if the rest of the health promotion population has the same ethnicity, language and gender and therefore gender or cultural differences in data could be present.

6.3 CONCLUSION

To accomplish health for all, a unified definition of health promotion and education may help in uniting efforts in practicing of it internationally. This must be done by including a comprehensive approach to health needs to encompass all aspects of health, such as the determinants of health, various settings wherein health could be achieved as well as including different professionals.

It is clear that schools provide a setting for actively involving all stakeholders in health promotion to effectively change the lives of children and their families. Schools are also a valuable resource for future health and wellbeing as well as economic security as childhood health is linked to prosperity as an adult. Children in South Africa face a myriad of challenges which hinder their optimal health and chances to make healthy decisions. In efforts to decrease the inequalities prevalent in their health, environmental safety and health services available, health promotion and the Health Promoting School programme was embraced.

Since the adaptation of the Health Promoting School Initiative, some schools have had successes. Although some schools, especially in Gauteng and the Western Cape received status as Health Promoting Schools, there are still challenges in achieving this status for all schools. The North West Province is one of the geographical areas which face many challenges in achieving a healthy status. To support nurses and other stakeholders in advocating for health for all, the Department of health introduced health promoters.

Since it is of paramount importance that all stakeholders in the health promotion domain work collaboratively towards the common goal of enhancing the school community's health, the focus is placed on who the health promoter is and what it is they do when they promote health. The aim of this research project was to construct a profile of the health promoters working in the Dr. Kenneth Kaunda District, of the

North West Province. Constructing a profile could contribute to better application of health promoting programmes as policy makers will have a better grasp of who these health promoters are and what their unique needs includes.

This study provided a clear description of the health promoter in the Dr. Kenneth Kaunda District by exploring different aspects and not just biographical data. Although the biographical data provided insightful data, additional sections provided an elaborated profile of the health promoter. The interrelatedness of various aspects and factors contributing to difficult work conditions came forward in the synthesis of the data. It is therefore important for role players and decision makers to consider all aspects of health promoters' work, emotional and physical health when considering solutions for the barriers they face. Effective collaboration between different stakeholders and departments are considered as one such a solution as it is directly linked to operative communication, planning and the execution of planning.

These factors may inhibit the progress of implementing health promoting programmes in schools in the North West Province. However, data generated from this study could assist role players in the Kenneth Kaunda District to make better decisions regarding health promotion and especially regarding support for health promoters. One of the main themes that occurred which could assist role players in tackling barriers and moving forward are the need of training for health promoters. Data generated could also enable these key role players to plan, develop and implement sustaining training models. This study could also bring additional insights for directions which further research should take in effectively supporting health promoters to execute duties effectively. The effective execution of their duties will have a direct impact on health promotion and health of all members of the communities health promoters work in.

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ADDENDUM A

North West University

The profile of the health promoter in schools in the North West Province

Health Promoter Questionnaire

Health Promoter Questionnaire

PLEASE MARK ALL QUESTIONS WITH A **X**

For example:

1 Male	2 Female
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Section A

Biographical information:

1. Age

1 20-30 years	2 31-40 years	3 41-50 years	4 Older than 50 years
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2. Gender

1 Male	2 Female
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3. Race

1 Asian	2 Black	3 Colored	4 White	5 Other
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4. Marital status

1 Single	2 Married	3 Separated	4 Divorced	5 Live together
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5. How many children do you have?

1 0	2 1-2	3 2-5	4 6-8	5 More than 8
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6. Nationality

1 RSA	2 Mozambique	3 Namibia	4 Lesotho	5 Botswana	6 Zimbabwe	7 Swaziland	8 Other
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7. Mark your first/home language.

Afrikaans	1
English	2
Sepedi	3
Sesotho	4
Setswana	5
SiSwati	6
isiNdebele	7
isiXhosa	8
isiZulu	9
Tshivenda	10
Xitsonga	11

8. In which of the following languages can you effectively communicate in? Rate each of the mentioned languages below.

	1	2	3	4
	Not at all	To a small extent	To a moderate extent	To a large extent
a) Afrikaans				
b) English				
c) Sepedi				
d) Sesotho				
e) Setswana				
f) SiSwati				
g) isiNdebele				
h) isiXhosa				
i) isiZulu				
j) Tshivenda				
k) Xitsonga				
l) Fanakalo/Fanagalo				
m) Portuguese				
n) International languages				

9. What was your occupation before your current job? Mark only **ONE**.

Homemaker (Stay-at-home mother)	1
Domestic worker	2
Teacher at private school	3
Teacher at government school	4
Teacher at farm school	5
Nurse's aid	6
Nurse	7
Doctor	8
Social Worker	9
Secretary	10
Assistant	11
Lecturer	12
Shop assistant	13
Other, please specify below.	14

Section B

Training and qualifications:

10. Please mark your highest qualification. Mark only **ONE**.

Qualification	Mark
a) Standard 6 / Grade 8	1
b) Standard 8 / Grade 10	2
c) Standard 10 / Grade 12	3
d) Matriculated and completed a six week basic course	4
e) Health Promotion Diploma	5
f) Diploma in Education	6
g) Diploma in Health Studies	7
h) Degree in Education	8
i) Degree in Health Studies	9
j) Other, please specify.	

11. Please stipulate the kind of training you received as a Health Promoter concerning the following themes.

	1	2	3	4
	Not at all	To a small extent	To a moderate extent	To a large extent
a) Alcohol or other drug use prevention				
b) Death and mourning				
c) HIV/AIDS				
d) STD Prevention (Sexually Transmitted Disease)				
e) Suicide Prevention				
f) Violence Prevention in Schools (Bullying, fighting, Homicide, Rape etc.)				
g) TB (Tuberculosis)				

12. To what extent:

	1	2	3	4
	Not at all	To a small extent	To a moderate extent	To a large extent
a) Do you feel comfortable with the knowledge you have in your job?				
b) Would you like to participate in extra workshops to gain extra knowledge?				

13. If given the chance, in which of the following themes/areas would you like to be trained.

	1	2	3	4
	Not at all	To a small extent	To a moderate extent	To a large extent
a) Accident or Injury Prevention				
b) Alcohol or other drug use prevention				
c) Death and mourning				
d) Dental and oral health				
e) Environmental health				
f) First Aid				
g) Growth and Development				
h) HIV/AIDs				
i) Human Sexuality				
j) Immunization and Vaccinations				
k) Nutrition and Dietary Behaviour				
l) STD Prevention (Sexually Transmitted Disease)				
m) Suicide Prevention				
n) Sun Safety or Skin Cancer Prevention				
o) Violence Prevention in Schools (Bullying, fighting, homicide, rape etc.)				
p) Trauma (rape, abuse etc.)				
q) Basic knowledge about legislation (constitutional, children's & school's act etc.)				

Section C

Work/Job:

14. To what extent:

	1	2	3	4
	Not at all	To a small extent	To a moderate extent	To a large extent
a) Do you have a job description in your contract				
b) Are you happy and fulfilled in your current job				
c) Do you feel that you are making a difference				
d) Would you leave your current job if you could get another job with immediate effect				
e) Do you feel that you earn your current salary				
f) Do you think your pay is enough for the job you are doing				

15. What does your job description as a Health Promoter consist of?

	1	2	3	4
	Not at all	To a small extent	To a moderate extent	To a large extent
a) Collaboration with other stakeholders in the community				
b) Education and training of school staff				
c) Education and training of other members of the school community (parents etc.)				
d) Awareness event planning (Provincial/District)				
e) Forming support groups				
f) Distribution of support materials (books, condoms)				
g) Distribution of VCT kits (Clinics)				
h) Life skills training for youth and their communities				
i) Other, please specify.				

Section D

Communication:

16. How do the schools/communities you work with contact you when they encounter a problem?

	1	2	3	4
	Not at all	To a small extent	To a moderate extent	To a large extent
a) Call your manager				
b) SMS/WhatsApp your manager				
c) E-mail your manager				
d) Fax your manager				
e) Call you				
f) SMS/WhatsApp you				
g) E-mail you				
h) Fax you				
i) Other, please specify				

17. How do you usually contact the schools/communities you work with?

	1	2	3	4
	Not at all	To a small extent	To a moderate extent	To a large extent
a) Telephone				
b) SMS/WhatsApp				
c) E-mail				
d) Fax				
Other, please specify				

18. To what extent:

	1	2	3	4
	Not at all	To a small extent	To a moderate extent	To a large extent
a) Do you and the other Health Promoters meet on a regular basis				
b) Do you have regular meetings with your management				
c) Do you have meetings at the sub-district offices				
d) Do you receive paperwork after meetings for your own records and future reference				
e) Do you have one specific person who attends all meetings during the year to assure continuance				

19. How many meetings do you have per week?

1	2	3	4
0-2	2-5	5-10	10 or more

20. To what degree do you (The Health Promoter), the Department of Education and the Department of Health have meetings?

1	2	3
No meetings	Some meetings	Regular meetings

21. Are these meetings noted for future and past reference and to check progress?

1	2	3
Yes	No	Don't know

Section E

Planning:

22. Do you receive an events calendar from the department?

1	2
Yes	No

23. To what extent:

	1	2	3	4
	Not at all	To a small extent	To a moderate extent	To a large extent
a) Do you compile your own events calendar for the year				
b) Is this events calendar updated every year				
c) Is there a rotation-based plan to visit every school in order not to miss one				
d) Do you have records where rotation-based plans are updated and problems highlighted so that these schools can be revisited in order to see if the problem has been sorted				

24. When do you usually do your planning? Please mark **ONE** option.

In the mornings before work	1
In the afternoon before going home	2
During meetings	3
After receiving documentation from your supervisor	4
After speaking to another Health Promoter	5
Your assistant does it for you	6
Other, please specify.	7

Section F

School Visits:

25. How do you/your management usually let schools know that you will be visiting them? Please mark **ONE** option.

SMS/ WhatsApp	1
Telephone call	2
E-mail	3
Fax	4
I don't know	5
I visit schools without notice	6

26. What is the time frame for each school visit?

1	2	3	4
0-30min	30min-1hour	1-2hours	2 or more hours

27. Do you have contact with learners at different schools?

1	2	3	4
Not at all	To a small extent	To a moderate extent	To a large extent

28. In which of the following ways do you have contact with the learners? Please mark **ALL**.

	1	2	3	4
	Not at all	To a small extent	To a moderate extent	To a large extent
a) Group discussions				
b) One-on-one discussions in private				
c) The learners usually come to you if they have a problem				
d) The teachers have to tell you about the problem, and then you speak to the learners				

29. To what extent:

	1	2	3	4
	Not at all	To a small extent	To a moderate extent	To a large extent
a) Do children tell you about problems they encounter at school/home				
b) Have you ever been intimidated by staff of schools not to report any misconduct				
c) Do you know the teachers at the different schools you work at				

30. Do you report misconduct? If yes, who do you notify?

1	2
Yes	No

31. Identify the types of schools you work at. Please mark **ALL**.

a) Day Care Facilities	Yes	No
b) Pre-school	Yes	No
c) Primary School	Yes	No
d) Secondary School	Yes	No
e) Combined Schools	Yes	No
f) PSPP (Farm Schools)	Yes	No
g) Private Schools	Yes	No
h) Other	Yes	No

Section G

Transport:

32. How far do you live from your place of work/ office?

1	2	3	4
0-5km	5-10km	10-20km	20km or more

33. How far do you have to travel between schools and your place of work/office?

1	2	3	4
0-5km	5-10km	10-20km	20km or more

34. What is your mode of transport between your home and workplace/office?

a) Foot	Yes	No
b) Taxi	Yes	No
c) Bicycle	Yes	No
d) Bus	Yes	No
e) Train	Yes	No
f) Carpool	Yes	No
g) Own car	Yes	No
h) Company car	Yes	No
i) Spouses car	Yes	No

35. What is your mode of transport between your workplace/office and schools you have to visit?

a) Foot	Yes	No
b) Taxi	Yes	No
c) Bicycle	Yes	No
d) Bus	Yes	No
e) Train	Yes	No
f) Carpool	Yes	No
g) Own car	Yes	No
h) Company car	Yes	No
i) Spouses car	Yes	No
j) No transport available	Yes	No

36. What time in the morning must you get up to get to your place of work in time?

1	2	3	4
04:00am	05:00am	06:00am	07:00am

37. Is your journey safe to travel or do you travel through troubled areas?

1	2	3	4
Very safe	Safe	Somewhat dangerous	Very dangerous

38. What does it cost to get to work and back per month?

1	2	3	4
R0-400	R400-R800	R800-R1200	R1200 or more

39. What financial support do you receive for your transport costs per month?

1	2	3	4
R0	R1-100	R200-R400	R400 or more

Section H

Support:

40. Do you have your own assistant at your office?

1	2
Yes	No

41. To what extent do you work in conjunction with:

	1	2	3	4
	Not at all	To a small extent	To a moderate extent	To a large extent
a) The Principle/Headmaster				
b) Teachers				
c) Parents				
d) Children				

42. To what extent:

	1	2	3	4
	Not at all	To a small extent	To a moderate extent	To a large extent
a) To what degree do you receive support from the Department of Education				
b) To what degree do you receive support from the Department of Health				
c) To what degree do you receive support (collaboration) from the Principals at the schools you work with				
d) To what degree do you receive support (collaboration) from the teachers at the schools you work with				
e) To what degree do you receive support (collaboration) from the parents of the children you work with				

43. To what extent do you receive support from the Department of Health in the following:

	1	2	3	4
	Not at all	To a small extent	To a moderate extent	To a large extent
a) Financial support				
b) Workshops to better yourself				
c) Emotional support				
d) Physical support				
e) Data to do better planning				
f) Resources				
g) Medical support for self				

44. To what extent do you receive support from the Department of Education in the following:

	1	2	3	4
	Not at all	To a small extent	To a moderate extent	To a large extent
a) Financial support				
b) Workshops to better yourself				
c) Emotional support				
d) Physical support				
e) Data to do better planning				
f) Resources				
g) Medical support for self				

45. Who do you contact when there is a medical/health/social related problem at a school?

	1	2	3	4
	Not at all	To a small extent	To a moderate extent	To a large extent
a) Department of Education				
b) Department of Health				
c) Headmaster of School				
d) Speech Therapist				
e) Physiotherapist				
f) Doctor				
g) Nurse				
h) Psychologist				
i) Occupational Therapist				
j) Social Worker				
k) Teacher				
l) I handle it myself				
m) Other, please specify				

46. In terms of support given by persons mentioned above, to what degree did each of them support you/ respond to your need?

	1	2	3	4
	Not at all	To a small extent	To a moderate extent	To a large extent
a) Department of Education				
b) Department of Health				
c) Headmaster of School				
d) Speech Therapist				
e) Physiotherapist				
f) Doctor				
g) Nurse				
h) Psychologist				
i) Occupational Therapist				
j) Social Worker				
k) Teacher				

Section I

Barriers:

47. To what extent do you experience conflict in your work environment with:

	1	2	3	4
	Not at all	To a small extent	To a moderate extent	To a large extent
a) Your fellow workers				
b) The schools you visit				
c) Your own family				
d) Your supervisors				

48. To what extent do you experience the barriers/problems in the schools you attend/work at?

	1	2	3	4
	Not at all	To a small extent	To a moderate extent	To a large extent
a) Teachers are not trained				
b) The learners and their families are poor				
c) Not enough classrooms				
d) Not enough bathrooms				
e) Not enough learning material for all the learners in the school				
f) Learners are sick				
g) Teachers are sick				
h) Not enough health promoters to assist with problems				
i) Not enough support from the department of Health				
j) Not enough support from the department of Education				
k) Alcohol and other addictions				
l) Divorced or single parent families				
m) Parentified children (Children acting as parents).				
n) Rape or sexual assault				
o) Abuse				
p) Other, please specify				

Section J

Coping:

49. To what extent:

	1	2	3	4
	Not at all	To a small extent	To a moderate extent	To a large extent
a) Do you like your work/job				
b) Do you think you cope well with work related problems				
c) Do you feel satisfied after every finished project				
d) Do you feel emotional after a day at work				

50. How do you cope with your work related problems?

	1	2	3	4
	Not at all	To a small extent	To a moderate extent	To a large extent
a) Talk with co-workers				
b) Talk with supervisors				
c) Talk with friends/family				
d) Talk with professional (psychologist, etc.)				
e) Other, please specify				

51. Who helps you to cope with your personal problems?

	1	2	3	4
	Not at all	To a small extent	To a moderate extent	To a large extent
a) Your fellow workers				
b) The schools you visit				
c) Your own family				
d) Your supervisors				

52. How do you deal with your emotions?

	1	2	3	4
	Not at all	To a small extent	To a moderate extent	To a large extent
a) Get angry				
b) Cry				
c) Yell				
d) Feel inadequate				
e) Keep quiet				
f) Speak out				

Section K

Personal Health:

53. Do you think that you suffer from stress due to your job?

1	2	3	4
Not at all	To a small extent	To a moderate extent	To a large extent

54. If yes, to what extent do you experience the symptoms:

	1	2	3	4
	Not at all	To a small extent	To a moderate extent	To a large extent
a) Sleeplessness				
b) Weight loss				
c) Weight gain				
d) Irritability				
e) Stomach cramps				
f) Chest cramps				
g) Angina				
h) Spastic colon				
i) Short temper				
j) Hyper tension (High blood pressure)				

55. Are you currently using any medicine for the above problems?

1	2	3	4
Not at all	To a small extent	To a moderate extent	To a large extent

56. If yes, how long have you been using this above mentioned medicine?

1	2	3
0-2 years	2-5 years	More than 5 years

57. Do you feel that this medicine is beneficial to your health? (Are you feeling better?)

1	2	3	4
Not at all	To a small extent	To a moderate extent	To a large extent

58. Do you have a medical aid?

1	2
Yes	No

59. How many times per year do you consult a medical doctor?

1	2	3	4	5
Not at all	Once	2-5 times	5-10 times	More than 10 times

60. How many times per year do you consult a traditional healer?

1	2	3	4	5
Not at all	Once	2-5 times	5-10 times	More than 10 times

ADDENDUM B

26 November 2014

The profile of the health promoter in schools in the North West province

CONSENT TO BE A RESEARCH PARTICIPANT

(We are a team of researchers from the North-West University working on the profile of health promoters in schools in the North West. We would like to invite you to give consent and participate in our study. To follow is information about the study so that you can make an informed decision.

1. PURPOSE OF THE STUDY

The purpose of this study is to give a profile of the health promoter working in schools in the North West province. You are being asked to participate in this study because you are a health promoter and the information you can provide are very valuable to us.

2. PROCEDURE

If you agree to be in this study you will be expected to do the following:

- Fill out a multiple choice questionnaire that will take about one hour to complete.

3. RISKS/DISCOMFORTS

Some of your privacy might be lost during this study but your name will never be made known to anyone. Your data will be handled as confidential as possible and kept in a safe place. No individual identifiers will be used in any publications resulting from this study and only the team of researchers will work with the information that you shared. All sensitive information will be protected by locking it up and storing it on a password protected computer.

4. COSTS

There will be no cost to you as a result of your participation in this study.

5. PAYMENT

You will receive no payment for participation.

6. QUESTIONS

You are welcome to ask any questions to a member of the research team before you decide to give consent. You are also welcome to contact the team leader dr. Charles Viljoen, if you have any further questions concerning you consent at 082 440 7482.

7. FEEDBACK OF FINDINGS

The findings of the research will be shared with you if you once the project is completed. You are welcome to contact us regarding the findings of the research. We will be sharing the findings with you as soon as it is available.

CONSENT FORM

PARTICIPATION IN THIS RESEARCH IS VOLUNTARY.

You are free to decline to be in this study, or to withdraw at any point even after you have signed the form to give consent without any consequences.

Should you be willing to participate you are requested to sign below:

I _____ hereby voluntarily consent to participate in the above mentioned study. I am not coerced in any way to participate and I understand that I can withdraw at any time should I feel uncomfortable during the study. I also understand that my name will not be disclosed to anybody who is not part of the study and that the information will be kept confidential and not linked to my name at any stage. I also understand what I might benefit from participation as well as what might be the possible risks and should I need further discussions someone will be available.

Date

Signature of the participant

Date

Signature of the person obtaining consent

ADDENDUM C

Private Bag X6001, Potchefstroom
South Africa 2520

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

Education Psychology
Tel: 018 299 4767
Email: villera.leroux@nwu.ac.za
18 February 2015

Dear Mr. Motara

I'm currently a registered student at the North West University and aim to complete my master's degree in Educational Psychology at the end of 2015. For the completion of my master's study I will be investigating the profile of health promoters working in schools in the Dr. Kenneth Kaunda District in the North West province.

In order to achieve this objective, the following aims will also be pursued:

- To gain information about the personal background (age, male/female, race, marital status, children, nationality, etc.) of the health promoters.
- To obtain data concerning the nature and extent of the training and qualifications of the health promoters.
- To acquire the official job description of the health promoters in terms of the schools.
- To explore the possible methods of communication that are being utilized by the health promoters.
- To establish the nature and access to transport facilities in order to execute the health promoting activities in schools.
- To ascertain the nature and scope of the support needed, and received by the health promoters, in order to execute their health promoting activities in schools.
- To determine what the perceived barriers and challenges of the health promoters are that might impact negatively on the execution of the health promoting activities in schools.
- To determine from the health promoters what can be suggested as possible solutions to the barriers and challenges in promoting health in schools.
- To establish how, the health promoters cope as individuals, within the context of them working in schools.
- To determine if, personal health problems are experienced by the health promoters, what is their cause of action in finding appropriate solutions?

These aims will be obtained by administering questionnaires to health promoters working in schools in the Dr. Kenneth Kaunda District. I hereby request authorisation to conduct the research in schools.

Kind regards

Villera le Roux (Student researcher)
072 873 9450

Dr. Charles T. Viljoen (Supervisor)
018 299 4767
Email Charles.viljoen@nwu.ac.za

The profile of the health promoter in schools in the North West Province

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Date

Signature of the participant

Date

Signature of the person obtaining consent

ADDENDUM D



Education and Sport Development

Department of Education and Sport Development
Departement van Onderwys en Sport Ontwikkeling
Lefapha la Thuto le Tlhabololo ya Metshameko

NORTH WEST PROVINCE

Temane Building
8 O.R. Tambo Street, Potchefstroom
Private Bag X1256,
Potchefstroom 2520
Tel.: (018) 299-8216
Fax: (018) 294-8234
Enquiries: Mr H. Motara
e-mail: hmotara@nwpg.gov.za

DR KENNETH KAUNDA DISTRICT

OFFICE OF THE DISTRICT DIRECTOR

02 March 2015

Ms V le Roux
Student researcher
North West University – Potchefstroom Campus

PERMISSION TO CONDUCT RESEARCH (EDUCATIONAL PSYCHOLOGY) AT SCHOOLS IN DR KENNETH KAUNDA DISTRICT

The above matter refers.

Permission is hereby granted to you to conduct your research at schools in Dr Kenneth Kaunda District under the following provisions:

- The activity you undertake at the schools should not tamper with the normal process of learning and teaching; and will take place after school hours.
- You inform the principals of your identified schools of your impending visit and activity;
- You provide my office with a report in respect of your findings from the research; and
- You obtain prior permission from this office before availing your findings for public or media consumption.

Wishing you well in your endeavour.

Thanking you

MR H MOTARA
DISTRICT DIRECTOR
DR KENNETH KAUNDA DISTRICT

cc Mr S S Mogotsi – Area Manager: Matlosana
Mr H T Molefhe – Area Manager: Maquassi Hills
Ms S S Yssel – Area Manager: Tlokwe

ADDENDUM E

Private Bag X6001, Potchefstroom
South Africa 2520

Tel: (018) 299-4900
Faks: (018) 299-4910
Web: <http://www.nwu.ac.za>

Institutional Research Ethics Regulatory Committee

Tel +27 18 299 4849
Email Ethics@nwu.ac.za

ETHICS APPROVAL CERTIFICATE OF PROJECT

Based on approval by **Ethics Committee of the Faculty of Education Sciences**, the North-West University Institutional Research Ethics Regulatory Committee (NWU-IRERC) hereby approves your project as indicated below. This implies that the NWU-IRERC grants its permission that, provided the special conditions specified below are met and pending any other authorisation that may be necessary, the project may be initiated, using the ethics number below.

Project title: A profile of the health promoter in schools in the North West Province																															
Project Leader:	Dr C Viljoen																														
Student:	V le Roux																														
Ethics number:	<table border="1"> <tr> <td>N</td><td>W</td><td>U</td><td>-</td><td>0</td><td>0</td><td>1</td><td>8</td><td>9</td><td>-</td><td>1</td><td>4</td><td>-</td><td>A</td><td>2</td> </tr> <tr> <td colspan="3">Institution</td> <td colspan="6">Project Number</td> <td colspan="2">Year</td> <td colspan="4">Status</td> </tr> </table> Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation	N	W	U	-	0	0	1	8	9	-	1	4	-	A	2	Institution			Project Number						Year		Status			
N	W	U	-	0	0	1	8	9	-	1	4	-	A	2																	
Institution			Project Number						Year		Status																				
Approval date: 2015-02-26	Expiry date: 2020-02-25																														
Category	N/A																														

Special conditions of the approval (if any): None

General conditions:

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, please note the following:

- The project leader (principle investigator) must report in the prescribed format to the NWU-IRERC:
 - annually (or as otherwise requested) on the progress of the project,
 - without any delay in case of any adverse event (or any matter that interrupts sound ethical principles) during the course of the project.
- The approval applies strictly to the protocol as stipulated in the application form. Would any changes to the protocol be deemed necessary during the course of the project, the project leader must apply for approval of these changes at the NWU-IRERC. Would there be deviated from the project protocol without the necessary approval of such changes, the ethics approval is immediately and automatically forfeited.
- The date of approval indicates the first date that the project may be started. Would the project have to continue after the expiry date, a new application must be made to the NWU-IRERC and new approval received before or on the expiry date.
- In the interest of ethical responsibility the NWU-IRERC retains the right to:
 - request access to any information or data at any time during the course or after completion of the project;
 - withdraw or postpone approval if:
 - any unethical principles or practices of the project are revealed or suspected,
 - it becomes apparent that any relevant information was withheld from the NWU-IRERC or that information has been false or misrepresented,
 - the required annual report and reporting of adverse events was not done timely and accurately,
 - new institutional rules, national legislation or international conventions deem it necessary.

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

Yours sincerely

Linda du Plessis

Digitally signed by Linda du Plessis
DN: cn=Linda du Plessis, o=NWU,
ou=Vaal Triangle Campus,
email=linda.duplessis@nwu.ac.za,
c=ZA
Date: 2015.06.23 10:12:18 +02'00'

Prof Linda du Plessis

Chair NWU Institutional Research Ethics Regulatory Committee (IRERC)