

**PROCESS EVALUATION OF THE HEALTHKICK ACTION PLANNING PROCESS IN  
DISADVANTAGED SCHOOLS IN THE WESTERN CAPE**

JILLIAN HILL



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Supervisor: Ms Suraya Mohamed

Co-supervisors: Dr Anniza De Villiers

Dr Whadi-ah Parker

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## **Abstract**

The prevalence of diabetes is increasing globally. In South Africa the mortality rate associated with diabetes increased from 176 to 240 per 100 000 between 1985 and 2000. In response to the growing burden of diabetes and other non communicable diseases the World Health Assembly adopted the “Global Strategy on Diet, Physical Activity and Health (DPAS) in May 2004, in order to reduce the impact of major risk factors such as unhealthy diet and physical inactivity. As one measure, DPAS called upon Member States to develop and implement school policies and programmes that promote healthy diets and increased levels of physical activity (WHO, 2008).

The HealthKick programme in the Western Cape of South Africa is such a programme. It aims to improve nutrition behaviours and increase physical activity in disadvantaged primary school settings by improving the school environment and surrounding community through various channels. These include developing curricula focusing on healthy eating and optimal physical activity and training educators to implement it. In order to describe and document the enablers and challenges of its implementation, the implementation process of the HealthKick programme required evaluation. This was done using process evaluation.

In this study a process evaluation of the action planning process of the HealthKick programme in disadvantaged primary school settings in the Western Cape was conducted.

A qualitative methodology was adopted to best determine the experiences of the participants and the underlying factors involved. Four schools were randomly selected to participate. Four focus group discussions were conducted with educators, and four in-depth interviews were conducted with principals and champions at schools, (champions are either an educator or school governing body member selected to be the driver of the project at each school, as well as the liaison person between the school and the HealthKick project team). Semi-structured interview guides were used to steer the discussions. Interviews and focus groups were audio taped and transcribed verbatim. The data was thematically analysed with the assistance of Atlas ti computer software.

The results of this study indicated that the action planning process did not take place as designed by the project team. Several challenges were identified and experienced by participants. The results further indicated that the challenges of time, workload and competing priorities were intrinsically linked. Positive experiences were also reported and various enablers to the process were identified, such as the facilitation process, the receipt of the resource toolkit as well as the

complementary nature of the HealthKick curriculum to the normal academic curriculum.

A number of recommendations were drawn from the study, among others; integrating the HealthKick curriculum in the normal curriculum; to explore the issue of parent involvement in order to maximise and sustain parent involvement as well as to further develop educators' skills and confidence to be effective agents of change.



**Declaration**

I declare that “Process Evaluation of the HealthKick Action Planning Process in Disadvantaged Schools in the Western Cape” is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources that I have used have been indicated and acknowledged by means of complete references.

Full Name: Jillian Hill

Date: .....

Signed: .....



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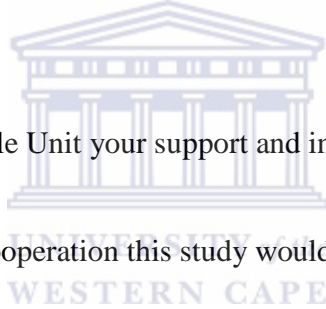
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## **Definitions:**

**Action planning process** - a planning tool to support the integration of physical activity and healthy eating initiatives into the school culture. This involves educators in setting annual goals and identifying and planning actions.

**Barrier** – Any condition that makes it difficult to make progress or to achieve an objective.

**Challenge** – Difficulty in a task that is thought-provoking to one engaged in it.

**Champion** – the driver of the action planning process at the school and liaison for the project team.

**Diabetes** - is a condition in which a person has a high blood sugar (glucose) level as a result of the body either not producing enough insulin, or because body cells do not properly respond to the insulin that is produced. Insulin is a hormone produced in the pancreas which enables body cells to absorb glucose, to turn into energy. If the body cells do not absorb the glucose, the glucose accumulates in the blood (hyperglycaemia), leading to various potential medical complications.

**Enabler** – To make the intervention feasible or possible.

**Extent** – The degree which the intended audience participates in an intervention.

**Facilitator** – A facilitator is part of the project team, allocated to a specific school to guide and assist them through the action planning process.

**Fidelity** – The extent to which the intervention was delivered as planned.

**Project team** – This team is the research/intervention team.

**School team** – This team consists of school staff i.e. educators, voluntary workers, school governing body members etc.

**Strength** – The successes of the intervention/programme.

**Type 1 diabetes:** results from the body's failure to produce insulin, and presently requires the person to inject insulin.

**Type 2 diabetes:** results from insulin resistance, a condition in which cells fail to use insulin properly, sometimes combined with an absolute insulin deficiency.

**Gestational diabetes:** is when pregnant women, who have never had diabetes before, have a high blood glucose level during pregnancy. It may precede development of type 2 diabetes.

**Non-communicable diseases** - is a disease which is not infectious. Examples of non-communicable diseases include heart disease, cancer, asthma, diabetes, allergies, and stroke. Risk factors such as lifestyle, genetics, or environment are known to increase the likelihood of certain non-communicable diseases.

**Quintile** - One of five groups into which all South African public schools are placed, and where the grouping is according to the socio-economic status of the community around the school.

**Resource toolkit** - provides schools with a range of resources for nutrition and physical activity resources. It includes a list various organizations that provide information on healthy lifestyles as well run programmes that assist in the promotion of healthy lifestyles.

**Zones** – the school environment and curriculum were placed in seven areas i.e. zones; School Health and Policy Environment Life Orientation; Food and Nutrition; Physical Activity; Health Promotion for Staff; Family and community involvement; and School health services.



## **Abbreviations**

BMI – Body Mass Index

CAQDAS – Computer Aided Qualitative Data Analysis Software

CDC – Centre for Chronic Disease

CHAD – Community Syndrome of Hypertension and Diabetes

CHIPS – Community Health Intervention Programmes

DPAS - Diet Physical Activity and Health

ED – Education District

EDC - Education Development Centre

ENHPS – European Network of Health Promoting Schools

FAO – Food and Agriculture Organization

HPS – Health Promoting Schools

NFCS – National Food Consumption Survey

NIDDM – non-insulin dependent diabetes mellitus

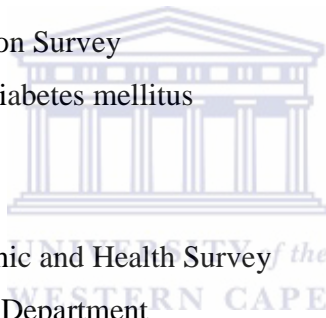
PA – Physical Activity

SA – South Africa

SADHS – South Africa Demographic and Health Survey

WCED – Western Cape Education Department

WHO – World Health Organization



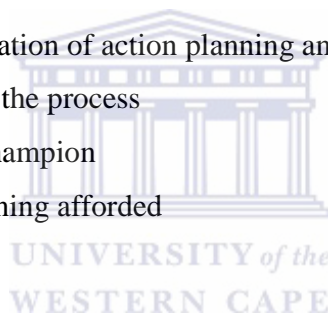
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# CHAPTER 1

## INTRODUCTION

### 1.1 Introduction

Globally, about 124 million people were living with diabetes in 1997, of whom 7.8 million lived in Africa; 4.5 million in Northern Africa, 1.08 million in Western Africa, 1.05 million in Eastern Africa, 0.26 million in Central Africa and 0.82 million in Southern Africa (Mollentze & Levitt, 2006). In 2004 authors estimated that the global prevalence of diabetes will have doubled to 221 million by 2010. In Sub-Saharan Africa alone, it is estimated that there will be an increase of 18% between 1995 and 2025 (Steyn & Levitt, 2004). The increased prevalence is already evident in South Africa as the mortality rate due to diabetes increased from 176 to 240 per 100 000 between 1985 and 2000, across all ethnic groups, with an overall mortality of 54 per 100 000 (Bradshaw et al., 2003). The mortality rate per 100 000 deaths increased throughout all races in whites from 15 to 22, in black South Africans the rate doubled from 28 to 56, from 43 to 59 in those of mixed ancestry and from 90 to 103 in Indians who experiences the highest burden of diabetes.

Increased urbanisation has resulted in lifestyle changes with particular reference to dietary intake, low levels of physical activity, higher stress levels, increased nicotine and alcohol consumption. Amid increased urbanization in developing countries, traditional diets are fast giving way to the “western” diet; as a result, overweight is already a significant problem in these countries (Steyn & Levitt, 2004). In South Africa in 2003, 31% of urban women and 11% of urban males were obese (BMI  $\geq$  25) with 21% rural women and 5% of rural men being obese, this statistics supports this view (SADHS, 2003). Furthermore the National Food Consumption Survey (NFCS) of 1999 indicated that 17% of South African children aged 1-9 years were overweight (Steyn et al., 2005). This predisposes them to non communicable diseases (NCDs) as a result of increase in weight, and subsequent obesity which are the major risk factors responsible for the rising prevalence of diabetes and associated chronic diseases (Steyn & Levitt, 2004). Global studies have established a strong association between obesity and type 2 diabetes (WHO/FAO, 2003). Sufficient evidence exists to confirm that obesity which commences in infancy and childhood persists into adulthood, since body mass index (BMI) levels in childhood

are strongly predictive of adult obesity (Dietz, 1998).

In response to the growing burden of non communicable diseases, the World Health Assembly adopted the “Global Strategy on Diet, Physical Activity and Health (DPAS) in May 2004, in order to reduce the impact of major risk factors such as unhealthy diet and physical inactivity. As part of its mandate, DPAS called upon Member States to develop and implement school policies and programmes that promote healthy diets and increase levels of physical activity (WHO, 2008). Paragraph 49 of DPAS states: “School policies and programmes should support the adoption of healthy diets and physical activity. Schools are encouraged to provide students with daily physical education and should be equipped with appropriate facilities and equipment. Governments are encouraged to adopt policies that support healthy diets at school and limit the availability of products high in salt, sugar and fats” (WHO, 2008:1). In an attempt to contribute to the aforementioned policy in SA, the HealthKick healthy lifestyle school-based programme was designed.

## **1.2 Background to the HealthKick Study**

The “100 Schools” study funded by the World Diabetes Foundation got underway in the education districts (EDs) of Metropole North and the Breede River/Overberg Western Cape in May 2007. The collaborators on the project at that stage were the Medical Research Council, Universities of Cape Town and the Western Cape, The Heart and Stroke Foundation of S.A., and very importantly, the Western Cape Education Department. Phase one of this project was designed to describe and understand the school “health environment”, with its challenges and opportunities. This was necessary so that the project team could, in collaboration with school authorities plan a sustainable intervention that would create school environments that would encourage healthy nutrition and physical activity behaviours. Fifty schools from each ED were randomly selected to participate in the research. Phase one included a survey of the school environment, focusing particularly on issues relating to a healthy school environment, physical activity, nutrition and smoking.

After the completion of the formative assessment 16 schools, (8 from the urban ED and 8 from the rural ED) were purposefully selected to become part of the HealthKick programme. These 16

schools were then randomly allocated into eight control and eight intervention schools. The schools that formed part of this study are located in three of the eight EDs of the Western Cape namely the Metropole North ED (urban) and the Overberg and Cape Winelands EDs (rural). Initially schools were selected from only two EDs but subsequently the rural ED was split in two separate EDs. The participating schools fall into quintiles 1-3; which means they are from the lowest socio-economic areas<sup>1</sup>. HealthKick is a whole school programme (i.e. it does not necessarily involve all the learners in the school; however, it targets the curriculum for some grades, the school environment as well as the parents and the community). For purposes of this study, as stated in the proposal, only the intermediate phase (grades 4-6), are targeted in the curriculum part of the intervention. The HealthKick programme is a primary school based intervention programme aimed at promoting the uptake and adoption of healthy lifestyle behaviours (healthy eating and optimal physical activity) for the prevention of diabetes. This programme was developed and based largely on the Pathways programme (Caballero et al., 2003), and is a holistic, multi-component programme, which aims to improve the school environment and surrounding community. The HealthKick programme is currently being implemented by the HealthKick project team which is a collaboration between the Medical Research Council, the Human Sciences Research Council, Sports Sciences Institute, University of Cape Town and the Western Cape Education Department.

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<sup>1</sup> **“National quintile for public schools.** One of five groups into which all South African public ordinary schools are placed, and where the grouping is according to the poverty of the community around the school. Quintile one is the most poor quintile, quintile two is the second-poorest quintile, and so on. Each national quintile encompasses one-fifth of the learners enrolled in public ordinary schools” (Government Gazette, 2006: 24). “...to judge whether a school falls into a certain category: (a) schools in the first (highest subsidy level) category would typically be located in townships, deep rural areas, or informal settlements and serving the residents in these areas. (b) schools in the second category would typically be in inner city or transitional suburban areas, catering largely for township and informal sector clientele or the urban lower middle class. (c) schools in the third and fourth categories would be middle and upper middle class schools with good facilities with a local clientele. (d) schools in the fifth category would be well established schools with excellent facilities and a national or regional clientele and very low learner: educator ratios” (Government Gazette, 2006: 50).

The intervention schools are participating in an action planning process based on the conceptual framework of Action Schools BC (Naylor, 2006) and the National Center for Chronic Disease Prevention and Health Promotion's (CDC) School Health Index (Staten et al., 2005). The action planning process is a tool that is used to create individualised action plans that contribute to the health of children at the intervention schools. The Action Planning Process as described by Naylor (2006) includes the following steps:

Step 1: Identify a school "champion" to guide the self-assessment process/intervention process

- The school champion has to be chosen according to set criteria by school staff and/or community members (Examples of criteria: highly respected person, excellent listener, skilled group facilitator)

Step 2: The champion identifies team members who will be responsible for completing the self-assessment and developing an action plan

- The team may be a new team, or an existing one e.g. school governing body
- A variety of people may be selected to complete the different action zones.

Step 3: Meet with the chosen school team members

- Explain the process and its purpose
- Encourage the school team members to answer all questions as accurately as possible
- Explain that the results of the self-assessment is not to compare their school to another school but that it is for their own school's improvement
- Explain that the process is an important process to help bring people together to improve a school's policies and programmes. It can make a big difference in the lives of the school's learners

Step 4 (a) This stage is the self assessment stage. Review and compile an action plan for the seven action zones (school physical and policy environment, life orientation, food and nutrition, physical activity, family and community involvement, school health services and health promotion for staff)

- Each zone is divided into themes for discussion
- Discuss, prioritise and agree on a time frame for the implementation for each identified action within the action plan

Step 4(b): Compile an action plan to improve the specifically identified areas for action

- List several recommended actions to improve the learners' and the schools community's



knowledge, attitudes and behaviour regarding the discussed action zone

- Prioritise each action by ranking them according to its importance (1 = most important, and 5 = least important)
- List the sequence of implementation for each action that will be addressed
- Discuss how to monitor progress and when the school team will meet again

Step 5: A resource guide and toolkit is provided to the school. From this guide and the kit, the school will be able to access resources needed to assist with the identified actions from the action plan.

Step 6: Communicate the action plan goals within the school community as well as the surrounding community.

Actions can range from choosing curricula developed by the project team focusing on healthy eating and optimal physical activity to educators accessing resources and identifying different organisations to assist schools to attain their goals. As referred to in step one, a champion is identified at each school to facilitate this intervention process. The champion drives the action planning process at the school and acts as the liaison for the project team. The programme trains educators to conduct a health profile, which prioritises their learners' health needs. The project team facilitates this process by guiding schools through a self-assessment process in terms of the seven zones. This is followed by the planning of actions and implementation strategies. See Step 4 (b).

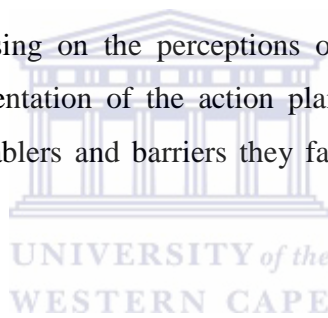
Control schools also referred to as self-implementation schools in the programme simply received tips for healthy schools in which they received guidelines on how to kick-start diabetes prevention in their schools through improved physical activity and nutrition. In addition they received a resource guide which includes a list of accessible resources, including internet resources. They however did not receive any physical resources, equipment or any facilitation in their process.

### **1.3 Problem statement**

The schools in the HealthKick sample are located in disadvantaged communities and as such these communities are afflicted by numerous social issues such as unemployment, teenage

pregnancy, substance abuse, and so forth. More often than not, these issues filter through to the school community. Educators in these schools therefore not only act as educators but also have to manage social welfare issues such as hunger and illness. These issues inevitably take preference over education and only once they have been addressed, can educators revert to teaching (Kelly & Colquhoun, 2003). Kelly and Colquhoun (2003) are of the opinion that one of the huge pressures for educators is the range of things that they are expected to teach, as schools are seen as a 'cure-all' for all societies' problems. Shalem and Hoadley (2009), highlights three analytical categories of educators in SA, with 60-70% of educators falling in the first category. In this category educators work in schools in which children are generally ill-prepared for school, suffer from poor health and who cannot depend on their parents as role models and parents who are not able to interpret the instructions from school to assist their children (Shalem & Hoadley, 2009).

This specific study will be focusing on the perceptions of educators, school principals and champions regarding the implementation of the action planning process described in section 1.2.2, including the perceived enablers and barriers they faced while implementing the action planning process.



#### **1.4 Rationale**

If the HealthKick Programme is successful and cost-effective, it could be rolled out to more schools in SA. However it is not only a pilot programme, it is also a multi-component programme which is fundamentally complex and the implementation thereof holds many challenges. As such the process needs to be evaluated in order to describe and document the enablers and challenges of its implementation.

Like many other multi-component interventions, the HealthKick programme requires a thorough process evaluation to assess whether the intervention was delivered *and* received as intended (Young et al., 2008). Process evaluation data is imperative to assess the strength, extent and fidelity of the implementation of the programme. The results of a process evaluation will inform the research team and implementers whether the programme design needs modification or continue as is. This study therefore aims to use process evaluation to describe specifically the

HealthKick action planning process which involves educators in setting annual goals, identifying and planning actions to support the integration of physical activity and healthy eating initiatives into the school culture. It will also seek to explore the challenges, barriers and enablers which influenced the process including the barriers to implementation of the action plans.

## **1.5 Thesis Outline**

**Chapter 1:** The orientation to the study includes an introduction to the study, some background, the problem statement, as well as the purpose of the study.

**Chapter 2:** The literature review chapter comprises a review of all relevant literature to the study. This chapter discusses the burden of non-communicable diseases globally, in South Africa (SA), Type 2 Diabetes, international healthy lifestyle programmes and finally the situation in SA with regard to healthy lifestyle multi-component interventions.

**Chapter 3:** The research methodology section discusses the study design, the study sample, the data collection process, the data analysis procedures and the ethical considerations of the study.

**Chapter 4:** This chapter will present the findings.

**Chapter 5:** In this chapter a discussion of the relevant findings and relevant literature will be reviewed.

**Chapter 6:** The conclusion and recommendations of the study will be presented in this chapter.

## CHAPTER 2

### LITERATURE REVIEW

#### 2.1 Introduction

This chapter will review the literature associated with this study. This chapter comprises the data and findings of researchers in the field on what is known about the research area and elucidates what still needs to be researched. The literature in this study includes the burden of non-communicable diseases globally, in SA, Type 2 Diabetes, international healthy lifestyle programmes and finally the situation in SA with regard to healthy lifestyle multi-component interventions.

#### 2.2 The burden of Non-Communicable Diseases globally

The burden of non-communicable diseases (NCDs) is growing at an exponential rate such that the NCDs pandemic is the lead cause of mortality and morbidity globally (Magnusson, 2007; Habib & Saha, 2010). According to Habib and Saha (2010), an estimated 35 million deaths, equivalent to 60% of all deaths globally, occurred as a result of NCDs in 2005. Eighty percent of these deaths occurred in low income and middle income countries, with 16 million of those deaths in people under the age of 70. It is estimated that deaths due to NCDs will increase by an additional 17% by 2020 (Habib & Saha, 2010). Similarly, Boutayeb and Boutayeb (2005), estimates that NCDs will be the cause of seven out of 10 deaths in developing countries by the year 2020. The main known risk factors for NCDs include unhealthy diets, physical inactivity, tobacco and alcohol use. By adopting healthier lifestyles to address these risk factors it would be possible to prevent roughly 80% of premature heart disease and stroke, 80% of type II diabetes and 40% of cancers (Habib & Saha, 2010). In addition to these risk factors, increased life expectancy has contributed to the increased prevalence of NCDs (Boutayeb & Boutayeb, 2005; Habib & Saha, 2010). It was once believed that NCDs were diseases associated with prosperity and affluence (Boutayeb & Boutayeb, 2005). However, this is no longer the case as Bradshaw et al. (2006) have stated that NCDs seem to be developing more rapidly in developing countries than in developed countries and that NCDs are increasingly affecting younger populations and the poorer communities in these countries. These authors have attributed the rapid increase in developing countries to the demographic transition that these countries are currently

experiencing (Bradshaw, Schneider, Norman & Bourne, 2006).

### **2.3 The burden of Non-Communicable Diseases in South Africa**

As early as the 1950's it was observed that the co-existence of lifestyle related ailments are closely associated to the urbanisation of the African population. Kark (1989), assigned the "Community syndrome of hypertension, atherosclerosis and diabetes (CHAD)" to depict the diseases stemming from the changing lifestyle of the population (Bradshaw et. al., 2006). South Africa is currently one of four developing countries whose projections suggest that cardiovascular disease in these countries will not only affect people at a younger age but will also affect the lower socio-economic populations in these countries (Bradshaw & Laubscher, 2001 in Bradshaw et. al., 2006). According to Mayosi et al (2009:1) "South Africa is in the midst of a health transition that is characterised by the simultaneous occurrence of epidemic infectious diseases and a rise in non-communicable diseases, in a population facing a heavy burden of perinatal and maternal disorders, injury and violence". Thus SA has a quadruple disease burden.

In 2004, the WHO estimated that NCDs constituted 28% of the total burden of disease in South Africa (WHO, 2008). In the South African Burden of Disease Study of 2000 it was estimated that 37% of deaths were due to NCDs (Bradshaw et. al., 2006). In a global burden of disease prevalence study it was projected that diabetes would rise from 21 751 in 1995 to 24 799 in 2000 and to 44 663 for number of adults (20 – above 65 years old) with diabetes (King, Aubert & Herman, 1998). According to WHO estimates, SA has a NCD burden two to three times higher than that of developed countries which places it in the highest burden quintile (Groenewald et al., 2008). It would appear that the distributions of NCDs are displaying socioeconomic disparities, with an increase in the rural communities and the highest burden in poor urban communities (Mayosi et al, 2009). The situation in SA confirms earlier global projections that NCDs affect poorer communities. A study conducted in Cape Town of age standardized mortality show this disparity where people living in a poor area in Khayelitsha have a mortality rate of 856 deaths per 100 000 due to NCDs which is double the mortality rate of 450-500 per 100 000 in wealthier suburbs in Cape Town (Groenewald et al., 2008). This increase in mortality and morbidity associated with NCDs places a huge strain on the country's health care services and budget.

One of the main or most common NCDs is type 2 diabetes. The study in question evaluated aspects of a diabetes prevention intervention and as such a brief overview of the burden of diabetes in SA will be provided in the following section.

“Diabetes is a chronic disease, which occurs when the pancreas does not produce enough insulin, or when the body cannot effectively use the insulin it produces. This leads to an increased concentration of glucose in the blood (hyperglycaemia)” (WHO, online). Type 2 diabetes generally develops in adults but a growing number of overweight children and adolescents are also developing type 2 diabetes (Puoane, Tsolekile, Sanders & Parker, 2008). Bradshaw et al estimated that more than 20 000 deaths in South Africa in the year 2000 were attributable to diabetes. This 20 000 deaths accounted for 4,3% of all deaths in South Africa in 2000, which means diabetes is the seventh most common cause of death in South Africa (Bradshaw, Pieterse, Norman & Levitt, 2007).

#### **2.4 The appropriateness of school settings for Diabetes prevention programmes**

Typically non communicable diseases, such as diabetes emerges later in life from middle age onwards, however, its risk factors are rooted in unhealthy lifestyles which are present before birth or develop during childhood (Steyn, Fourie & Temple, 2006). While interventions aimed at treatment and management of NCDs can be aimed at an adult population, interventions aimed at the prevention of NCDs should thus be aimed at children, before they establish unhealthy lifestyles. In this regard, a school environment provides the ideal setting for such an intervention. As Glasauer (2003:27) states, “Schools are ideal settings for nutrition programmes and services, because nutrition and education are closely linked, and because dietary, hygienic and exercise habits that effect nutritional status are formed during the school-age”.

#### **2.5 Best practice school-based interventions**

A systematic review was conducted by the Medical Research Council and the Sport Science Institute of South Africa to establish best-practice interventions for promoting healthy diets and increased physical activity (Steyn et al., 2009). These authors concluded that the contributing factors central to the success of school interventions appear to be a multi-component

programmes which includes a nutrition-based curriculum component, a physical activity programme, a parental component and a food service component. They further concluded that school interventions were more likely to be successful if they were offered at primary schools and implemented by qualified educators to children in grades 4-7. These factors contributed to most of the best practice clinical, psycho-social and behavioural outcomes. In addition, all best practice studies were based on a firm theory of behaviour, such as cognitive, social or stages of change theories. Multi-component school-based programmes seem to encompass all of the aforementioned elements.

Multi-component programmes aim to incorporate both school and home environments and provide education directed at knowledge (creating awareness) and specifically behavioural change. Such programmes should be of adequate time and duration and include messages specifically targeting programme goals and be founded on a fitting theoretical framework (Bere, Veiered, Bjelland & Klepp, 2006). Examples of international multi-component school-based healthy lifestyle interventions include the Pathways programme, the CATCH intervention, and the High 5 project which will be discussed briefly. The Action Schools BC! programme will be discussed in some detail as the HealthKick programme is based on the Action Schools BC! programme. The Health Promoting School concept and examples thereof will also be discussed in detail as this is an important, globally accepted and practiced model for school interventions.

The Pathways study was a school-based, randomised controlled trial for the prevention of obesity in American Indian schoolchildren, grades 3-5. The study had four components; a dietary, physical activity, curriculum and family component (Caballero, et al., 2003). The curriculum component focused on healthy eating and lifestyle and was the most successful. Ninety percent of the Pathways curriculum lessons were successfully taught in grades 3-5. Part of the success of the Pathways programme was attributed to the curriculum being culturally appropriate for the target group, the curriculum could be integrated in existing curricula and it made use of existing educators (Steckler et al., 2003). The educators also found the training they received with regards to the curriculum very helpful; it made them aware of why the learners need to be educated about nutrition. Another enabling factor was that they could integrate the Pathways curriculum with their other subjects. The programme also proved successful in the physical activity component.

Again educators found the training on physical education helpful, it made them aware of the need for physical activity, the goal of three to five physical education lessons per week as well as to realise the cultural significance of including indigenous American Indian games as part of the physical education curriculum (Steckler et al., 2003). The food services component with regards to behavioural guidelines was achieved, compliance increased from 51% in the first year to 87% in final year. However, the family component was not as successful. Family events had an attendance rate of less than 50%. The parents who attended the events however found the activities worthwhile and entertaining learning opportunities (Steckler et al., 2003).

The CATCH-Eat Smart Food Service Intervention also had best practice behavioural outcomes (Steyn et al., 2008). The programmes research sample included 96 schools (40 controls and 56 interventions) in four areas; California, Louisiana, Minnesota, and Texas (Edmundson et al., 1994). CATCH intervened with food service staff and administrators, to decrease total fat, saturated fat and sodium in meals served at schools. The various food service staff received training to provide meals at the school in accordance with the low-fat objectives. This appeared to be a successful method in decreasing total fat and saturated fat intake. Five years later 50% of intervention schools were still adhering to the low-fat objectives, in comparison with just 10% of schools in the control group (Osganinan et al., 1996; Hoelscher, Mitchell, Dwyer, Elder, Clesi & Snyder, 2003). According to Perry (2009), the approach CATCH used was successful because it intentionally created a supportive social environment conducive to behaviour change, as well as using the community as the unit of intervention.

The High-5 Project was a multi-component intervention programme with the aim to increase fruit and vegetable consumption among fourth-graders. The programme had a food service component, school curricula and a parental involvement component (Reynolds et al., 2000). The process evaluation indicated that curriculum component was very successful and described it as “excellent implementation and utilization of the classroom component” (Reynolds et al., 2000: 184). The authors however caution the readers by saying that the program was delivered under optimal conditions, it would also be important to note that the classroom component was delivered by well trained High 5 personnel and not educators (Reynolds et al., 2000). The



programme was implemented by project coordinators, and they were assisted by educators. In addition, project coordinators trained food service staff and coordinated parent involvement. The cafeteria implementation was good and well received by cafeteria workers who were very excited and interested in bettering the delivery of fruits and vegetables to learners. After one year considerable increases were found in the intake of fruit and vegetables, fibre, beta-carotene and vitamin C in the intervention group (Reynolds et al., 2000). The programme was effective in most sub-samples, suggesting that the programme could be generalized to different groups (Steyn, 2008).

Action Schools! BC is a best-practice physical activity model intended to aid primary schools in generating context specific action plans to endorse healthy living among learners in British Columbia. The Action Schools! BC model grants resources and recommendations for the formation of context specific action plans that incorporates physical activity and healthy eating into the school environment (Mc Kay, 2004). The process evaluation of Action Schools! BC was specifically embarked on to evaluate the enablers and barriers of the model, unanticipated positive and negative impacts and the satisfaction level of major stakeholders for implementation of the Action Schools! BC model. Data was collected both quantitatively and qualitatively. Qualitative data included focus groups with educators, administrators, parents, students and advisory committees, as well as minutes of the school advisory committee meetings and from monthly facilitator interviews and semi-structured individual interviews with school administrators, educators, parents and student participants (Mc Kay, 2004).

Some of the key findings of the process evaluation included a high level of satisfaction for the training of educators and trainers. The benefits of the training and support were improvement of educators' beliefs in their abilities to implement activities in their classroom and their intentions to deliver healthy activities (Mc Kay, 2004). Educators and administrators deemed access to resources, positive reception of the programme, programme design, the Action Schools! BC support team and school staff support as key facilitators in the programme (Mc Kay, 2004).

Educators' identified barriers such as curriculum demands, difficulty remembering, and

preparation time requirements, report cards, physical barriers, scheduling and coordination difficulties and time constraints as the major barriers to the Action Schools! BC model. However in most instances educators were able to identify strategies to overcome these barriers (Mc Kay, 2004). Unfortunately the article does not describe any of these strategies.

### **2.5.1 Health Promoting Schools (HPS)**

The HPS concept is an international concept developed by the World Health Organization's (WHO) School Health Initiative and based on the Ottawa Charter for Health Promotion (Swart & Reddy, 1999). A health promoting school is a school which creates a platform which enables learners, educators and other staff, parents and the broader community to take action for a healthier life, school and society (WHO, 1996). The five key components of the HPS based on the Ottawa Charter are: engaging with and networking with all appropriate services and resources; building healthy policies that guide and direct activities; creating a safe and healthy environment for living, learning and working; developing the necessary skills of all members of the school community and strengthening interaction between the school and the surrounding community. The five steps to an HPS include introducing the concept to the school; to conduct a needs assessment, to establish a vision for your HPS and develop an action plan; commence implementation of action plans, always documenting what is happening; and monitoring and evaluating the process from the outset (Departments of Education & Health Papua New Guinea in collaboration with WHO, 1999). The HPS approach can be used to address a wide range of issues pertaining to health including; mental health, aggressive behaviour, healthy eating, physical activity, substance use and abuse, depending on the needs of the school (WHO, 2006).

In November 1997 a National Health Promoting Schools Workshop was convened and was attended by provincial representatives from the departments of health, education and welfare. The goal of this workshop was to clarify the HPS concept as it applies in South Africa (Swart & Reddy, 1999). Subsequently the National Department of Health prioritised the development of the school health policy. The process began in 1998 (National Department of Health, 2002). In 1999, an inter-sectoral task team was commissioned for the purpose of the development of suitable policy as well as guidelines for the favourable implementation thereof. From the end of 2000 to mid 2001 nine provincial and one national workshop was held to examine issues

pertaining to the advancement of a new school health service. Policy drafts which developed from these consultations were disseminated and comments were used to refine the drafts. The policy was then presented at both provincial and national combined health and education forums to further enhance the advancement of appropriate health services functioning within the education sphere (National Department of Health, 2002). The school health policy is the result of considerable efforts to integrate new initiatives for key sectors to optimise the development of children in the school setting (National Department of Health, 2002).

After extensive literature searches no published articles pertaining to process evaluation on HPS or any other evaluation regarding HPS in SA could be found. Thus we will briefly report a few international examples of lessons learned with regards to HPS implementations.

In a review of evaluations conducted on HPS by Mukoma and Flisher (2004) they found only 18 possible studies of which none were found in Africa. The study found that, it is possible to integrate health promotion into the school curriculum and policies successfully (Mukoma & Flisher, 2004). The reports from China and Scotland both focused on nutrition, whereas the systematic reviews looked at HPS interventions in general.

The Chinese Ministries of Health and Education appealed for assistance in the development of a HPS intervention with a specific focus on nutrition, in 1999. The WHO tasked the Education Development Center (EDC) with the responsibility of granting technical assistance in the area of health promotion in schools. The Food and Agriculture Organisation (FAO) joined the project, providing expertise in the area of school-based nutrition education and together with the EDC, guidance on project planning, implementation and evaluation (Glasauer et al., 2003). Amongst the lessons learned in the China HPS project five themes were highlighted. Firstly they found that a health promotion approach strengthens the efficacy of nutrition education (Glasauer et al., 2003). In general the HPS concept advocates a comprehensive approach which includes the entire school, the parents, as well as the community, and the experiences of the China HPS project wholly verifies the importance of this concept. Parents are the care givers and food providers in the home environment, thus parents are key when aiming to change learners eating behaviours. The authors also found that local or community action is attainable, however

acquiring support at the national level is more advantageous (Glasauer et al., 2003). Pilot schools with limited outside support and technical assistance, planned and implemented a remarkable range of activities with the involvement of learners, educators, the whole school as well as families and communities. However, efforts from provincial and local health officials to assist in mobilizing governmental, parental and community resources could have played a major role in accomplishing good quality project implementation with positive results. The authors stressed that nutrition education should be incorporated into the classroom curriculum (Glasauer et al., 2003). Nutrition education and health training for learners and educators has to contend with a range of other vital academic and professional development subjects. Health related topics can be marginalized easily when contending with conventional academic subjects and even with enticing extracurricular activities. Quality support materials may not be made available to schools unless nutrition and health education is integrated into the standard curriculum (Glasauer et al., 2003). A number of programme facilitators and a few barriers were presented in the article of which a few are presented in the box below.

**Table 1: Lessons Learned from the China HPS project**

**SUCCESS FACTORS/STRENGTHS**

**Support**

- Good and supportive school management (leadership)
- Government support and adequate funding
- Collaboration of schools with the municipality and with health-care institutions (e.g. nutritionists, hospital dieticians for menu preparation)

**Processes**

- Giving students a role in communicating with parents and the wider community
- Using interactive approaches and encouraging active roles for students and educators
- Integrating nutrition education into other school subjects (e.g. in “moral education”)

**Participation**

- Full involvement and maintenance of close ties with parents and the community
- Regular meetings with students and parents

**Plans and standards**

- Good standard (if necessary, improvement) of school facilities, equipment, etc.
- Clear and detailed programme and work plan set by the school management; helps to overcome initial scepticism on the part of other school staff and educators

### **Materials and activities**

- Producing a variety of own materials on food, nutrition and health
- A wide spectrum of activities, involving many different communication channels for teaching and outreach to families and the community

### **Communication channels**

- Conveying nutrition messages through a wide range of different communication channels at school and in community outreach: classroom lectures; student newspapers and health broadcasts with student, and in some cases, parent participation; posters carrying health and nutrition information (sometimes as part of a drawing competition); student performances on topics related to healthy nutrition and physical activity

### **CHALLENGES**

Resources (including time and materials)

- Burden on individual educators can be considerable
- Lack of written teaching/learning materials
- Insufficient integration of nutrition education into the regular curriculum (greater integration was mentioned as an important condition for the continuation and/or improvement of the project, because of nutrition education being in conflict with the timetabling requirements of other subjects)

### **Training and outreach**

- Educators need to receive nutrition training prior to their project involvement in order to prevent them conveying nutrition messages that are technically incorrect
- Training of students *and* educators needs to be simultaneous and ongoing
- Poor nutrition knowledge and attitudes among the general population (can diminish the positive effect of nutrition education among students)
- Overwhelming need for health and nutrition information in families and communities, which schools alone are not able to satisfy.

Box 1: Adapted from Glasauer et al., 2003

A four year process evaluation was conducted in Scotland within the European Network of HPS. The aim of the programme was to enable schools to develop and implement the HPS concept in a flexible way responsive to locally identified needs (Inchley, Muldoon & Currie, 2006). Health promotion theory emphasises the importance of including all stakeholders and practitioners in a community in the development and implementation process. Schools in the study did not follow a pre-determined protocol, schools decided on their own priorities founded on the primary needs assessment. This approach to health promotion should promote a sense of ownership and improve sustainability through the means of perceived competence (Koelen et al., 2001 in Inchley, Muldoon & Currie, 2006). The study reports on four key themes that may contribute to the adoption of HPS principles and factors that may translate HPS principles into practice: ownership and empowerment; leadership and management; collaboration and integration. The findings are summarised in Table 2.



**Table 2: Key Themes for Adoption of HPS Principles**

<b>Theme 1: Ownership &amp; Empowerment</b>	<b>Theme 2: Leadership &amp; Management</b>	<b>Theme 3: Collaboration</b>	<b>Theme 4: Integration</b>
<p>Likely to 'buy in' when project is rooted in the school</p> <p>Control over development &amp; implementation</p> <p>Member of staff as project coordinator</p> <p>Involving educators, catering team, learners &amp; parents</p> <p>Control over finances</p>	<p>Project coordinator – generally a lead educator or a member of senior management</p> <p>↓</p> <p>Senior management – gave project status</p> <p>↓</p> <p>Involvement crucial to effective implementation – even if not involved in operational level</p> <p>↓</p> <p>Benefits – keeping the HPS concept alive in the school through development planning – providing resources – delegating responsibilities to key staff – liaison with external agencies</p>	<p>An underdeveloped HPS concept in most schools</p> <p>Only 2 out of the 4 schools engaged in collaborations</p> <p>Process of forming collaborations valuable experience – important steps toward establishing effective alliances were made</p> <p>Partnership working with professionals</p> <p>Pupil participation</p> <p>Parental involvement – most challenging area of partnership</p>	<p>Integrating new initiatives into existing school life is crucial to sustainability</p> <p>Staff lose interest if results not immediately apparent</p> <p>HPS to be viewed as being part of all aspects of school life &amp; links to core objectives of the school</p> <p>Some schools find difficulty in identifying ties within existing practices</p>

(Inchley, Muldoon & Currie, 2006)

The authors conclude that: “Without attention to the various influences that facilitate translation of the approach into practice, the potential for the real change is unlikely to be realized” (Inchley, Muldoon & Currie, 2006).

In a synthesis of systematic reviews the WHO Regional Office for Europe’ Health Evidence Network (2006) concluded that programmes should be sustainable, multi-factorial, whole school interventions that provide suitable training irrespective of the issue, such as mental health, healthy eating and physical activity.

## **2.6 The situation in South Africa with regard to healthy lifestyle multi-component interventions for children**

Presently, there are not many multi-component healthy lifestyles programmes in progress in SA. A multitude of awareness programmes (e.g. Love Life, Fetal Alcohol Syndrome Awareness) are in operation, all with a single specific focus, among others HIV/AIDS awareness, substance abuse, none taking a holistic approach to health and well being. There are however two multi-component interventions programmes focused on healthy lifestyle within schools in SA, namely the Health Promoting Schools (which was discussed as part of international interventions) and the Healthnutz programme.

### **2.6.1 The Healthnutz Programme**

The Community Health Intervention Programmes (CHIPs) project was developed by the Sports Science Institute of South Africa in response to the growing prevalence of chronic or non-communicable diseases. The project aims to promote health through regular physical activity. There are five programmes in the project that target different age groups. One programme is Healthnutz which is offered at schools to learners of foundation phase, grades 1-3, ages five – 12 years, as part of the school curriculum in 14 schools (Draper, Kolbe-Alexander & Lambert, 2009).

In a retrospective evaluation conducted by Draper, Kolbe-Alexander & Lambert (2009), the educators reported a number of benefits of the Healthnutz programme; it affords a constancy that



learners do not necessarily get in the other areas of their lives; it created a space for educators to practice a healthier lifestyle as they were conscious of the fact that they are role models for the learners; learners were eager to participate in Healthnutz as living in disadvantaged areas affords them limited exposure to and participation in sport. Children in these communities are faced with many social ills, where children are faced with for example crime, poverty, unemployment, and abuse. The exercises engaged in, in the Healthnutz programme, was seen as a healthy channel for any pent up aggression learners may have as a consequence of their circumstances.

The challenges experienced by educators included; difficulty in conveying the messages of exercise and healthy eating through to parents; the practicalities of running the exercise sessions and retaining discipline in big groups of highly strung learners was difficult for educators. Educators experienced burn out as a result of their workload and time limitations. However educators appreciated the friendly treatment and support received by CHIPs staff. Another key factor to Healthnutz success was the integration of the programme in the curriculum for grades 1-3. The lesson plans received from CHIPs, were described as helpful and easy to follow. The training manual provided to educators was perceived as lucid and logical, which enabled them in becoming leaders in the programme (Draper, Kolbe-Alexander & Lambert, 2009).

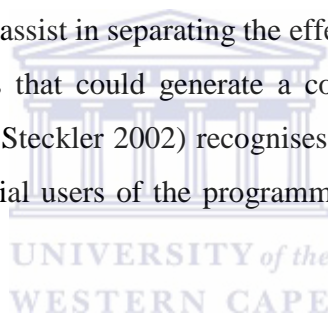
The Western Cape Education Department (WCED) believed that the programme's success was due to its strong links to the learning outcomes and assessment standards of the Life Orientation curriculum. The role of educators and principals was regarded as vital to the success of the programme. The WCED representative emphasised that for the continued success of the programme educators must believe that their participation is valuable (Draper, Kolbe-Alexander & Lambert, 2009).

## **2.7 Evaluation of intervention programmes**

The success of a programme is influenced by the level of motivation of the implementers and recipients (Young et al., 2008). It is thus vital to understand what motivates both these groups to facilitate the implementation of an intervention programme. Some form of evaluation should

thus take place to gain an understanding of these factors. Various forms of evaluations exist, each with its own intent or purpose. These include formative evaluation, process evaluation, impact evaluation, outcome evaluation and summative evaluation (Rossi, Freeman & Lipsey, 1999).

As with the studies mentioned above, programme administrators often focus on and pursue outcome evaluation which provides information as to how well a programme has worked. However, it does not provide an understanding of how and why certain aspects of a programme were successful, while others were not. “Only by understanding and measuring whether an intervention has been implemented with fidelity can researchers and practitioners gain a better understanding of how and why an intervention works, and the extent to which outcomes can be improved” (Carroll et al., 2007: 40). This understanding can be achieved by conducting process evaluation. Process evaluation can assist in separating the effects of each component as well as to explain the probable relationships that could generate a combined effect (Linnan & Steckler 2002). Patton (1997 in Linnan & Steckler 2002) recognises the importance of keeping in mind the needs and wants of the potential users of the programme to make process evaluation most effective.



### **2.7.1 The value of process evaluation**

Process evaluation is a widely used form of evaluation that assesses the fidelity (extent to which the project was implemented as originally planned) and effectiveness of programme implementation (Young et al., 2008; Rossi et al., 1999). Process evaluation was used in this study as it facilitates the objectives of this study, as part of the study is to ascertain and understand what worked well and what did not. This understanding would enable adaption and improvement of the action planning process. Process evaluation evaluates the process, activities and operations of the programme. It aims to establish how well the programme is functioning (Rossi et al., 1999). It often includes the assessment of how fitting the services are with the goals and objectives of the programme, whether services delivered were to the intended target group, the sound organisation of service delivery, the efficiency of programme administration and the application of programme resources (Rossi et al., 1999). Process evaluation is regularly applied

as a once off evaluation study, but it should be evident that similar measures can be applied routinely as a management tool (monitoring) (Rossi et al., 1999).

Studies that have conducted process evaluation on their school-based interventions have suggested a few key components or elements that result in or facilitate a successful intervention. This will be discussed in the following section.

### **2.7.2. Process evaluation results for international interventions: What makes programmes work?**

Peters et al. (2009) identified five key elements of school health promotion, across three behavioural domains; substance abuse, sexual behaviour and nutrition. These include 1) the utilization of theory; 2) addressing social norms; 3) addressing cognitive-behavioural skills; 4) the training of facilitators; and 5) having multiple components. Parent involvement and an increased duration was also found to be positive elements across the three domains but on the basis of interpretation-based method of analysis it deemed inconclusive results in one domain and thus it was not included as part of the key elements.

Knai, Pomerleau, Lock and McKee (2005), corroborate Peters' findings when they found that multi-component interventions have the strongest evidence base for success. These authors conducted a systematic review to identify successful intervention components that promote the increase of fruit and vegetable consumption among children. Their review further highlighted the following intervention components as key factors for interventions set in developed countries; 1) the duration of the intervention must be for at least 12 months; 2) an increase in exposure of fruit and vegetables among the whole school community; 3) educators training should be integrated within the curriculum; 4) inclusion of leadership and encouragement by peers and the food service staff; and 5) the involvement of parents at school and at home. In addition their review identified the following barriers to school interventions: 1) the intervention competing against other school priorities; 2) nutrition not being perceived as a priority in increasingly packed curriculum. Furthermore, they state that interventions can be seen as too demanding and that they may receive inadequate support due to poor communication and coordination between key role

players such as educators, parents and school staff (Knai, Pomerleau, Lock & McKee, 2005).

At the end of year one, evaluation of a school-based promotion of fruit and vegetable consumption in a multi-culturally diverse, urban schools intervention, established that the programme was well received and implemented with high levels of integrity by school staff (Blom-Hoffman, 2008). The characteristics that led to the successful implementation and high acceptability of the program included: having a school-based champion; a programme design that included low-cost, attractive, interactive materials; the inclusion of many school staff members to facilitate a culture of healthy eating and dividing implementation responsibilities among multiple staff members so that everyone's involvement was time efficient. The key role of the school-based champion was to ensure that the programme did not disappear among the competing school priorities as well as to address implementation barriers as they arise. In this particular intervention the champion was a former college athlete employed for this specific role. The author advises that in schools that do not have the resources to employ a champion to specifically promote physical activity and healthy eating, the school can make use of a regular staff member to encompass this role as it is important to have someone to manage and coordinate the programme and advocate the importance of promotion efforts. This individual should be respected and valued by staff, understand the school ecology and have good communication and organizational skills (Blom-Hoffman, 2008).

## **2.8 Conclusion**

The escalating burden of NCDs including diabetes is alarming. Investments in proven best practice strategies need to be able to establish if it will be effective and is feasible in the South African context.

Results from multi-component studies have shown success of programmes to variable degrees. The above discussions highlight the complexities of school-based intervention programmes and indicate that the use of best practice intervention designs do not ensure desired results. Linnan and Steckler (2002), argues that the only method of improving and sustaining interventions is to

not only identify key components of an effective intervention, but also recognising and understanding why and to whom it is effective and under what conditions is it effective. Multi-component interventions are intrinsically complex, so the researcher does not only want to know the degree to which the intervention happens at each level but also wants to understand the relationship among the various program components.

Although the HealthKick programme has been based on international best practise interventions and the developers have taken cognisance of the various difficulties highlighted by the literature, SA has a varied cultural and socio-economic environment which might present its own set of challenges. Thus this study explored the perceptions and experiences of key role players such as champions, principals and educators; highlights the barriers, challenges and successes of a unique SA environment, and will be able to inform implementers regarding possible modifications or improvements.



## **CHAPTER 3**

### **METHODOLOGY**

#### **3.1 Introduction**

This chapter details the research methodology applied in the study and to introduce the aims and objectives of the study. The following areas are addressed in this chapter: research design, the value of process evaluation, case studies and evaluation, the study population, sampling, data collection, data analysis, rigour, ethical considerations and study limitations.

#### **3.2 Objectives and Aim of the Study**

##### **3.2.1 Aim:**

To conduct a process evaluation of selected steps of the action planning process of the HealthKick programme in disadvantaged primary school settings in the Western Cape.

##### **3.2.2 Objectives:**

- To describe the experiences and perceptions of principals, champions and educators regarding the action planning process.
- To explore the enablers of the implementation of the action planning process.
- To explore the barriers the participants encountered during the process.
- To explore their perceptions about the barriers to implementation of action plans.
- To explore the participants recommendations for improvement of the action planning process.

#### **3.3 Research design**

A qualitative research design was chosen as it allows the researcher to use an interpretive, naturalistic approach to the area of exploration. Qualitative researchers study phenomena in their natural settings, endeavouring to make sense of, or understand, phenomena in terms of the meanings that people attach to them (Denzin & Lincoln, 1994 in Jones, 1995). The premise of qualitative research stems from accepting that there are various ways of making sense of the world and accordingly is interested in uncovering meanings as held by those who are being researched and by understanding their worldview instead of the researcher's views (Jones, 1995).

In this study, qualitative methodology was used to explore the experiences, perceptions and opinions of key role players in the action planning process. The information derived from data collection assisted the researcher in developing an in-depth understanding of the relevance of the planning process for the specific schools and informed the research team and implementers as to whether the programme design requires modification or could continue as is.

### 3.4 Study population

Brink (1999) states that the study population should consist of complete groups, persons or entities that are of significance to the research. Since the main focus of the programme is grade 4-6; the intermediate phase, the study population consisted of three participant groups; all the grade 4-6 educators, champions and principals participating in the action planning process in the eight intervention schools.

### 3.5 Sampling

The researcher intended to randomly select two intervention schools from the Metropole North area and two from the Overberg/Breederiver area for participation in this study. However, random selection was not possible because of the short period that was available at the end of the school year for the research to be conducted. The researcher experienced difficulty securing appointments and therefore resorted to convenience sampling. All principals, champions and grade 4-6 educators who were involved in the action planning process were invited to participate in the study. Four principals, four champions, and 11 educators responded and formed the study sample.

**Table 4: Sampling**

Rural intervention schools				Urban intervention schools			
Name of school	Participants			Name of school	Participants		
	P	C	E/TE		P	C	E/TE
School A	1	1	3	School C	1	1	3
School B	1	1	3	School D	1	1	2

P = Principal; C = Champion; E/TE = number of Educators out of Total number of Educators

### **3.6 Data Collection**

Data collection took place from October to December 2009. The methods employed included both individual interviews and focus group discussions. Document review was employed as an additional method of data collection. Interviews and focus groups took place at the school, mainly in the staff room and in the principal or deputy principal's offices. All interviews and focus groups were conducted in Afrikaans by the researcher herself who is fluent in Afrikaans, as this was the language medium used in these schools. Interviews and focus groups were conducted face-to-face and audio-recorded. Interviews and focus group discussions allowed for open discussions, thus allowing respondents to convey their own perspectives (Bles & Higson-Smith, 2000). Eight individual interviews and four focus group discussions were conducted in this study.

#### **3.6.1 Individual, semi-structured interviews**

An individual interview according to Babbie and Mouton (2001: 289) "...differs from most other types of interviews in that it is an open interview which allows the object of study to speak for him/herself rather than to provide the respondent with a battery of own predetermined hypothesis-based questions". Although the interview is driven by the researcher, the researcher attempts to draw out the participant's meaning and depth of coverage rather than leading the participant through a range of organized questions. The researcher used prompts and probes to explore the initial responses further. The administration of the interview is of such a nature that researchers often keenly pursue unanticipated issues that arise (Chopra & Coveney, 2008). Individual interviews were conducted with champions and principals. A semi-structured interview schedule (Appendix 1), was used as a guide to steer the interview. The semi-structured interview schedule covered all the steps in the action planning process and was developed with inputs from the research team. The interview schedule was piloted with an education expert and revised before data collection commenced. Principals and champions spoke freely. Principals were always pressed for time, and the researcher tried best to accommodate this.



### **3.6.2 Focus group discussions**

Focus group discussions create an environment in which individuals can explore and determine meaning together rather than on their own. Focus group discussions provide information that a researcher would otherwise not be able to gain in an individual interview. Focus group discussions are open-ended and frequently look for fresh lines of inquiry linked to a central issue. People with different opinions are given the opportunity to discuss opinions and listen to others, and in this way shape and reshape their opinions. Furthermore, focus group discussions allow the researcher to acquire direct evidence showing similarities and/or differences in the focus group participants' opinions and experiences instead of establishing these conclusions after data analyses (Babbie & Mouton, 2001). The development of the focus group schedule followed the same process as the development of the semi-structured interview schedule mentioned above.

The researcher experienced some difficulty with the focus group discussions. Educators in the focus group discussions were usually not aware of the researcher's visit. The researcher made the appointments through the principal and champion and was always assured that educators were aware of the visit. Often participants were not prepared and not entirely willing to participate, but were also too courteous to leave. The researcher thus had to work very hard to engage all participants. Group dynamics is an important aspect of this method (Coreil, 1995). Each focus group discussion had a dominant participant and often other participants relied on them to bring their experiences across. The researcher tried to counter this by always asking the other participants their opinion and often they would just agree with what the other said.

Focus group discussions were conducted with educators that participated in the action planning process. Initially focus group discussions were meant to be conducted with a minimum of three and a maximum of six educators. However, because of the relatively small number of educators participating in the action planning process at each school, most focus groups consisted of three participants while one consisted of only two participants.

### **3.6.3 Document review**

Document review was employed as an additional method of data collection. To generate a more complete view of the action planning process the reflective reports of facilitators were reviewed as well as the weekly minutes of the project teams meetings. The document review was conducted in view of the outcomes of the interviews and focus group discussions to identify comments that supports or refutes the information generated from the interviews and focus group discussions.

### **3.7 Data analysis**

The process of data analysis according to Marshall and Rossman (1995) is the progression of bringing order, structure and meaning to the gathered data. Individual interviews and focus groups were transcribed, after which a summary of each interview and focus group was written. These summaries were given to the researcher's supervisors as part of the supervision process.

The researcher familiarised herself with the data by reading each transcript several times and then used the Computer-Aided Qualitative Data Analysis Software (CAQDAS) package Atlas ti 5.2 to assist in managing data. "Such software allows for basic 'code retrieval' of data, and more sophisticated analysis using algorithms to identify co-occurring codes in a range of logically overlapping or nesting possibilities, annotations of the text, or the creation or amalgamation of codes" (Pope, Ziebland & Mays, 2000: 115). The 12 transcripts were loaded onto Atlas ti 5.2 as 12 primary documents. The researcher then commenced the coding process by reviewing the transcripts and allocating codes and giving them a concise label (open coding) (Babbie & Mouton, 2001). After consultation with supervisors, the researcher then began reviewing all codes and began to merge and delete codes, this was done a few of times. The researcher then began grouping quotes under predetermined themes with summarising sentences, thus placing them into categories. Codes and their connected quotations were retrieved in an effort to explore patterns or tendencies. A comparison and analysis between the different categories of participants was then done.

### **3.8 Rigour**

The researcher conducted all interviews in Afrikaans, as all participants were Afrikaans speaking. Although the researcher is fully bilingual, authors argue that it is not possible to translate data into another language without losing depth/meaning (Smith, Chen & Liu, 2008; Regmi, Naidoo & Pilington, 2010). The researcher however analysed the data in its original language, then selected a number of quotes to support the findings. The researcher then worked through the findings and quotes with a supervising researcher to make sure quotes were representative of the findings. Only then did the researcher translated the quotes into English, thus minimal loss of meaning can be declared.

The researcher conducted all the interviews and focus group discussions and debriefed with members of the project team after each interview and focus group discussion. A summary of each interview and focus group discussion was written and submitted to the researcher's thesis supervisors. The use of CAQDAS improved the rigour by facilitating data capturing, data organisation and data retrieval (Pope, Ziebland & Mays, 2000).

#### **3.8.1 Triangulation**

Triangulation refers to the collecting of data in as many different methods possible as well as from various data sources (Terre Blanche & Kelly, 1999). The researcher employed method triangulation as well as source triangulation. The researcher used individual interviews and focus group discussions with participants with different roles in the process to explore the research problem. In a further attempt to improve triangulation, data from the bigger study (HealthKick) was used to validate findings i.e. reflective reports written by facilitators as well as minutes of weekly project team meetings.

#### **3.8.2 Credibility**

Credibility refers to the degree to which research findings are convincing and believable (Durrheim & Wassenaar, 1999). As a method to ensure credibility the researcher described and discussed the setting, the participants and themes of the study in rich detail (Creswell & Miller, 2000). According to Creswell and Miller (2000), a thick description allows the reader to construct realism, giving them the sense that they could or have experienced the events described

in the study.

### **3.8.3 Dependability**

“Dependability refers to the degree to which the reader can be convinced that the findings occurred as the researcher says it did” (Durrheim & Wassenaar, 1999: 64). The researcher commenced transcribing as soon as interviews and focus groups were completed. Member checking was employed as a method of credibility and trustworthiness. The researcher provided summaries of interviews to participants for them to check whether it was a true reflection of the interview and what they would have wanted to convey. None of the participants contacted the researcher to refute any of the information. Interviews and focus group discussions were transcribed verbatim so that no information was lost. The transcriptions were randomly checked by the researcher by listening to some of the recordings and comparing it to the transcripts. The supervisors also checked the codes, themes and categories for consensus.

### **3.8.4 Reflexivity**

Reflexivity is an action a researcher takes to critically engage in a self-reflection of how their own “social background, assumptions, and positioning can impact on the research process” (Finlay & Gough, 2003 in Ritchie, Amos and Martin, 2009: 3). Reflexivity was employed as a means to continuously take heed of the researcher’s role in the research activities. The researcher participated in a weekly project team meeting and used this space to reflect and debrief with team members.

### **3.9 Ethical considerations**

The proposal served before the University of the Western Cape’s Ethics Committee for approval and ethical clearance was obtained. The study was explained to each participant orally; in addition they received an information sheet (Appendix 2) with a detailed explanation of what was to be expected of them. A signed consent form was obtained from each participant with the knowledge that participation was voluntary and with the understanding that they could withdraw from the study at any time without any consequences. Confidentiality was assured by not using participants’ names in transcriptions and reports. In the focus group discussions, participants

were reminded that what was discussed within the group, especially personal matters should remain within the group. Prior to the commencement of the HealthKick study, permission was received from the two education districts involved and they remain an active part of the decision making processes.

### **3.10 Limitations of study**

In qualitative analysis the sample is chosen in accordance with the aim of the study; in addition in qualitative research the emphasis is on understanding and exploring unknown phenomena, selecting information-rich cases and this is not necessarily done by including great numbers (Durrheim, 1999). The findings stemming from a qualitative study are not considered as facts that are applicable to the population as a whole but to a certain extent as descriptions, notions, or theories relevant within (transferable to) a specific context (Malterud, 2001). In this study the sample was not selected because of generalisability, but rather to gain a better understanding of the characteristics and the factors that impact on these particular groups. The researcher could not apply random sampling as intended and had to resort to convenience sampling because of the nature of the end of the school year, the researcher experienced great difficulty in securing appointments for interviews and focus groups at schools.

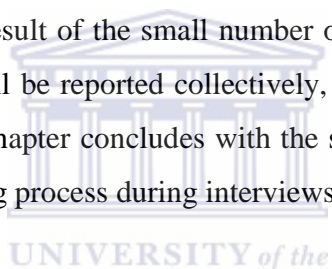
The researcher is an active team member of the HealthKick project team and participated in the planning of the project and the research activities such as administering of instruments and anthropometric measurement. Although the researcher was not a facilitator in the action planning process, she works closely with the rest of the team and thus knew what difficulties they experienced throughout the process. Not being part of the action planning did however provide enough distance in order to be objective in the interviewing process.

## CHAPTER 4

### RESULTS

#### 4.1 Introduction

This chapter presents the results of this study, which includes a description of the experiences and perceptions of principals, champions and educators regarding the action planning process (see figure 1). Where appropriate this information was validated with the reflective reports of facilitators. Information from minutes of weekly project team meetings were also used to provide additional perspective on the process. Perceptions to the introduction of the HealthKick programme and the action planning process are presented first, followed by a description of the action planning process (including the facilitation process). A description of experienced and perceived barriers and enablers, as well as the impact and successes of the action planning process are also presented. As a result of the small number of participants, the responses of the three categories of participants will be reported collectively, except where a particular category responded very differently. This chapter concludes with the suggestions participants offered for improvement of the action planning process during interviews and focus group discussions.



#### 4.2 Areas of the action planning process assessed and the implementation challenges experienced

**Table 3:** Implementation challenges experienced by project team

Action planning process step		Assessed in this research	Implementation challenges experienced by project team
Step 1	Identify school champion	No	The biggest challenge experienced during step 1 was that the champions were identified by the principals & did not volunteer for the position.
Step 2	Champion to identify team members	No	Champions were not sure of what was expected of them and the 'ideal' school team was never selected. The team consisted of mainly interested grade 4-6 educators.

Step 3	Project team meets with team – explain action planning process	Yes	This appeared to have gone well, but retrospectively champions, educators and principals were not entirely sure of what was expected of them.
Step 4a	Self-assessment of zones	Yes	The facilitators started the self-assessment at some schools, but because educators and champions were not sure of the exact process or what was expected of them, the project team decided to facilitate an educators' workshop to show educators how the HealthKick goals complement their curriculum.
Step 4b	Actions for action plan	Yes	Although educators enjoyed and appreciated the workshop, it was still not clear to them what was expected of them. Therefore very few schools did any action plans.
Step 5	Introduction of resource kit	Yes	Principals, champions and educators really appreciated the resource toolkit; the resources as well as the physical activity equipment. It remained uncertain to whether they accessed the resources.
Step 6	Communicate goals	No	

### 4.3 Experiences and perceptions to selected steps of the action planning process

#### 4.3.1 Introduction of the programme

Step one of the action planning process was to inform all stakeholders at the school about the proposed action planning. This information included a brief overview of the HealthKick programme and its goals, with a specific reference to the action planning process.

The introduction to the programme had a mixture of positive and negative responses, with the positive responses outweighing the negative responses. It would seem from the participants' remarks that the goals of the programme were clear. **Positive** responses included: “*excitement*”;

it elicited interest from participants and *“the fact that it pertained to health was refreshing as this is an area of neglect for most”*.

*“It will definitely work, it is something new and we are also learning from it.”*

Most participants, especially principals found the idea of the programme interesting and could immediately recognise that it could be beneficial to the children, themselves and the community as a whole.

*“...and it is something I think that we as a community, a school community and parent community have long been in need of, so I am optimistic about it.”*

A positive perception about the programme was that the zones were fitting; it complemented the existing curriculum and most participants were of the opinion that it was complementary to the life orientation curriculum.

*“Yes, yes it includes a lot of things in life orientation and especially with the new schedules we received which makes provision for an hour of formal physical activity per day.”*

The excitement, interest, appropriateness of the topic (health) reflected in these comments can be viewed as enablers of this process.

**Barriers** were mostly reflected in the following areas: workload and the socio-economic circumstances of the communities that the schools are located in. One concern was raised pertaining to the action planning zones. During focus group discussions the **concern** was raised that the programme/action planning process would increase the educators' workload. This concern was held by focus group participants and the perception was emphasised by two of the champions.



Further negative responses were not directed towards the programme or what the programme wanted to achieve but rather the concern stemmed from the socio-economic problems existing in these communities that would pose a great challenge to the implementation of the programme.

*“...to make this community aware of health will be a hell of a job, a hell of a challenge for what you want to do...”*

*“And I also thought when they first spoke about the tuck-shop and health, I thought that it won't work, because with these parents it is mostly about survival and they are not worried about what is healthy, as long as they can give the children something to fill them and I think especially in the poor areas if you are going to concentrate on health and healthy foods... I don't know if it will work here to be honest.”*

One educator felt that the zones are not comprehensive enough as it does not address the community's socio-economic circumstances.

The facilitators were of the opinion that participants were quite positive to the introduction of the programme, but not too excited about it as not many questions were asked during the briefing session. Facilitators also felt that participants were not fully aware of what would be expected of them with regard to the action planning process in terms of commitment, which proved to be a great challenge.

Initial perceptions of principals, champions and educators were therefore that the programme could be beneficial to children, educators as well as the broader community. The poor socio-economic circumstances of the communities and the possibility of an increased workload however raised concerns initially for the construction of action plans and ultimately the successful implementation thereof.

### 4.3.2 Facilitation provided by the project team

The role of the facilitator was to assist in the action planning process and provide guidance and support if and when the schools requested it. Most principals, champions and educators felt that the facilitation received was adequate and of a high standard. The facilitation, support, guidance and the presence of the project team at schools was much appreciated. One champion felt that “*each visit had a purpose*” and the inputs from the team were really appreciated. Also the rural schools are quite a distance from where the Medical Research Council is based and thus educators, champions and principals from these schools really appreciated the effort project team put in.

*“It was of great value for all of us. So I see it as good. You knew why you came; you knew what you came to do. And one could appreciate what you came to say to us.”*

A few participants felt there were some shortcomings with regards to the facilitation. One champion felt if there had been more follow-up, they might have implemented more successfully. Educators at another school felt that more frequent facilitation would enable them to adjust to the programme better, as the presence of the project team would sensitize the whole school to the programme.

*“...it was not enough. Yes what I actually want to say, assistance is never too much. So I would think if one gets more of it then one could sharpen in on it more, do you understand?”*

One facilitator felt that the facilitation had worked well as it enabled trust to build up over time, which in turn could facilitate various aspects of the intervention. Another facilitator felt that it was at times challenging to be a facilitator as often when meeting with a champion, the champion had not done what was previously discussed and this caused her some frustration. Another facilitator felt that the project team and the educators and champions did not share the same vision of where the process was taking them.

From the above it is clear that the facilitation and support was regarded as very important in the process and valued by principals, champions and educators. Shortcomings in the facilitation process were however pointed out by participants and some frustration by facilitators.

#### **4.3.3 Action planning**

The action planning entails a school-based self-assessment of the school health environment with respect to the seven zones: 1) school health and policy environment; 2) life orientation; 3) food and nutrition; 3) physical activity; 5) health promotion for staff; 6) family and community involvement and 7) school health services. Each zone has its own self-assessment and action planning booklet. The process was meant to result in goal setting, and the development of an action plan for each school.

According to the minutes of the HealthKick project team's meetings; attempts to start the action planning process; that is the self-assessment of zones and subsequent action planning, were endeavoured twice at one school. Facilitators then felt it would be best to have a workshop to make educators aware how exactly the HealthKick goals fit into their learning outcomes and to demonstrate to educators that it would not be such a tedious process as they perhaps thought it would be. The educators' workshops were run by an education expert and it had appeared to be successful. However, it appears from the minutes that facilitators continued with great effort to get schools to commit to first complete the self-assessment and then also to commit to actions. In a further attempt to show educators simple methods of incorporating HealthKick goals within existing life orientation and facilitate action plans, demonstration lessons were done at each school. The demonstration lessons appeared successful as educators and principals were very excited about it even weeks after, but it did not mobilise them to start the self-assessments and action planning.

It was clear when conducting the interviews and focus group discussions that the action planning process did not take place as envisioned by the project team. When participants spoke about the action planning process they did not distinguish the self-assessment step from the action planning. Most were not sure whether they started, attempted, or completed the process.

Educators admitted this and in their defence stated that they have competing priorities such as requirements from the Department of Education which they are assessed upon.

Educators perceived the action planning as additional work and this contributed to the process not being completed.

*“We never even got to it for the booklets that we had to answer the questions for; we had a lot of pressure at that time...”*

The action planning required a certain degree of commitment from participants as it requires participants to take some time for preparation beforehand. Each zone’s booklet had to be read to keep certain aspects and ideas for actions in mind. One champion said that educators did not appreciate extra work. However, another champion appreciated the fact that any new programme takes a bit of time initially to get it off the ground.

*“...and I understand that in the beginning of any process naturally it is going to take a bit longer, but once the process is in working. Look they did it accurately, they had small groups, I remember our school one afternoon, grade 4, 5 and 6, the educators were there one afternoon and we nicely worked through it.”*

A facilitator mentioned that at one school they seemed willing to engage in the action planning process and offered suggestions but again they were not very enthusiastic. Another facilitator was of the opinion that educators who participated in the action planning process were overwhelmed by what the process expected of them because this was not clear to them.

Those who did engage in the action planning saw the value of it only after the action planning had been completed.

*“...we have your programme now we know exactly where to fit it in for example; the posters that we just made then we know now if we get to that section of the work come*

*healthy eating then this is what we can do.”*

One champion felt that the project implementers had left the process too broad, there were too many possibilities. She felt that educators were shaped by the previous curriculum which was prescriptive, and in that respect it would be better if they were told exactly what was expected from them and then *“they will simply do it like that”*.

*“...we come from the old school where we received syllabus, I’m not saying we are stupid far from it, but we like cut and dried stuff.*

Another participant felt that when considering where the school is located, the programme is not fully able to address their needs. However the action planning programme was specifically designed so that each school could plan actions that would be applicable in their particular context.

The facilitators also felt that it was truly difficult to get the schools to set time aside for action planning as the schools programmes and educators’ schedules are very demanding. Facilitators also mentioned that it was difficult to get the required group of educators together in the same venue to actually start the process. When this was accomplished, little time remained for the action planning. Educators in most instances are not willing to remain after school.

As mentioned earlier the educators’ workshops were organized to assist educators in recognizing where the various zones fit into the learning outcomes of the curriculum, and also to demonstrate how creative educators are and how they can apply it when planning activities. One of the champions really enjoyed the experience of the workshop saying: *“...that we had with other schools? It was very relaxing, pleasant, yes and it was for me very exciting.”*

Whereas another champion noted how uneasy educators were with the concept.

*“...and sometimes you could see that the educators were not too comfortable with the*

*whole idea.”*

Discussions around the educators’ workshops did not emerge in most interviews and focus group discussions since the action planning steps were not clear to most participants; they could not really distinguish the one step from another without some explanation.

Both participants and facilitators pointed out that the action planning process did not take place as initially designed by the project team and in one school not at all. Time constraints and workload were major challenges in the process.

#### **4.3.4 Introduction of the Resource Toolkit**

The resource toolkit was an important part action planning process. The resource toolkit was introduced to the educators during the action planning process.

Participant’s comments showed that the toolkit was very well received. The resource toolkit was described as: *“a welcome, very useful and needed addition”*. Participants spoke about the resource toolkit with great excitement. It was not just the physical activity additions but also the reading material and resources that complemented the life orientation curriculum, especially the nutrition material that covers learning outcomes in the first quarter of the school year.

*“The toolbox, and obviously the equipment that is in it, is things that are desperately needed, that a person do not always have the necessary funds to acquire. So it is definitely a gain for us.”*

*“...the information pieces that we received is actually, was reasonably comprehensive.”*

Concerns expressed with regards to the resource toolkit dealt with the language of the material and the single toolkit provided per school. A couple of educators mentioned that familiarization with the toolkit would work to the benefit of the programme as well as the educator, and for this purpose one resource toolkit is not sufficient. Familiarization with the toolkit would entail

spending time with the material, perhaps taking it home. Also if more than one educator wanted to access the same resource at the same time this would not be possible.

*“So if for example we have a package like HealthKick in each classroom, as an educator it will benefit you, then you do not have to go borrow.”*

*“...the materials are all in English, I’m not saying there must, but if an adaption to Afrikaans can, we will actually appreciate it.”*

Therefore it seems that providing resources that support the action planning process in the form of a resource toolkit was appreciated by participants, but the value to the programme could be lessened because of the concerns of language limitations and quantity constraints.

#### **4.4 Experiences throughout the action planning process**

##### **4.4.1 Enabling experiences**

Participants discussed their various experiences throughout the action planning process. Most notable of these was the change in perception that was experienced in two of the four schools sampled, because initial reservations were replaced by a positive attitude to the process. The following experiences contributed to the shift in perception as noted by participants: the excitement they experienced in realizing the value of the programme. Educators also noted that familiarization with the programme played an important role in the educators recognizing the potential the programme had.

*“...so but when you are in the thing you realize that it is not what you thought it were. So I think at the end of the day everyone realized that the work, the programme is worth the effort and it is educating and the children can benefit by it.”*

One educator was of the opinion that the enthusiasm of the project team also played a role in their shift of perception and motivated them to do something.

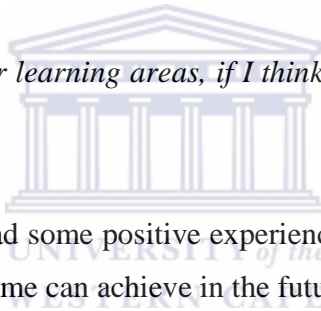
*“Like I said in the beginning ... we kicked off with very little zest but along the way we began to feel better about the programme.”*

The fact that the programme fits into and compliments the curriculum could have played a part in the change of perceptions that was experienced.

*“But if one first overcomes one’s initial doubt, did one see that it is something that can work because it is an integral part of life orientation.”*

*“It slots in with the work schedules the department sent through, so there is a place for it and it does not place unnecessary pressure on educators.”*

*“...integrates with the other learning areas, if I think about natural science, it comes out in that learning area.”*



Participants from all the schools had some positive experience to report even if it was a sense of excitement about what the programme can achieve in the future.

*“It is definitely working. One might not see the results now but it is definitely working, yes they are enjoying it.”*

The potential benefit of the programme to both the children and educators was appreciated by the participants.

*“You see it is not just for the children but also we as the adults are being educated in the process.”*

*“...that there are practical aspects that help the child and even the educator.”*



A number of the participants (all from the same school) mentioned how impressed they were with the physical activity demonstration lesson that was organized in an attempt to show educators an example of what could be done to engage children in movement.

*“And I really saw how they (the learners) enjoyed the exposure and you could actually see really interesting movements...How full of movement and creative they are and how some of them are not creative at all (laugh). So there I could actually see that they enjoy other people, they enjoyed the exposure, they actually enjoyed themselves.”*

*“...when they were here and they took the children at the back on the tar-surface, and presented a little programme, and there were different activities that took place, and you could see the children liked it. They enjoyed it and at the end of the day I spoke to the grade 4 educators and said if we could take the children out more often it might also change their behavior. So that is there. There is positivity to the programme.”*

Linked to this positivity was that a couple of the participants felt that HealthKick has just the right approach in the action planning process.

*“I cannot talk from your point of view but from my point of view, I do not believe it must change, because their approach is a healthy approach...”*

Educators were getting excited about their plans for next year.

*“...then we planning for next year, first quarter we want a fun walk...”*

*“...what I actually want to mention, we don't have a tuck-shop now, but I had talked to the parents and now a parent came with a presentation for the tuck-shop, with healthy things, sandwiches and everything that she identified, it gets placed before the governing body and they will decide who they are going to take, so I'm hoping they will, its a pity because I actually wanted to show you her presentation. Because I feel we are moving*

*with what she has done, that there's not only luxury going to be sold but also fruits and a sandwich as well."*

A number of the participants conveyed their sincere thanks. It was a privilege for some to have their school being chosen. It was interesting to note that the thanks came from the principals and champions mostly and not the educators. And in the school that did the least not the champion, principal or an educator conveyed any kind of appreciation.

#### **4.4.2 Concerns experienced: Barriers**

Although most participants were beginning to recognize the worth of the programme and the potential benefit it held for learners, educators and the greater community, some were still concerned that it would add to an already heavy workload because of the time demanded by the action planning process and the eventual implementation of the actions.

*"I would also not think that the educators would think now that it is an extra job ...even though we must keep up with the information."*

*"...we are already so overloaded."*

Some participants recognized the fact that their specific school had done very little where planning and implementation was concerned. One champion mentioned how guilty they felt when they saw the project team at the school and they knew that they have not done what they were supposed to do.

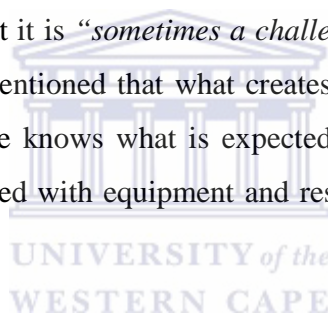
*"Many times we feel bad if we see you guys and say we have not yet implemented fully, but we hope to work towards it and fully..."*

*"...may I be so bold as to say we have not yet done justice to the programme."*

#### **4.4.3 The role of principals and champions**

Principals reported that they really wanted to get more involved with the programme, with one principal specifically noting that she has seen very little where the process is concerned, she wanted *“the programme to be more visible”* and see some results. Another principal voiced that he felt left out which was countered by the view of another principal who felt that *“one need not receive an invitation to get involved”*. Principals reported that thus far their experiences have been limited to being updated regarding the progress via the champion and receiving correspondence from the project team. While most principals alluded to their workload as a constraint to getting involved in the programme, two principals felt especially strong about the fact that: *“leaders should lead from the front”* and then the rest will follow.

When asked what difficulties champions faced in their role as champion, very few were identified. Two champions felt that it is *“sometimes a challenge”* to get everyone’s support and cooperation. Another champion mentioned that what creates a challenge for him is that he is a life orientation administrator so he knows what is expected of the educators and now he also knows that they have been equipped with equipment and resources for activities so there really should be no more excuses.



#### **4.5 Perceptions of barriers to implementation of action plans**

Most of the barriers identified were barriers to the implementation of the action plans and therefore caused a pause in action planning process, since educators could not conceptualise action plans that would work in their contexts. The following sections will present the barriers that educators identified with regards to implementation of action plans and not the action planning itself: the biggest barrier noted by most participants was the huge socio-economic factors that are rife in these communities; it was especially strongly conveyed by one principal and a couple of educators.

##### **4.5.1 Poor socio-economic circumstances**

Most participants felt strongly about the challenge healthy eating posed in these socio-economically disadvantaged communities.

*“But the dilemma, the challenge, the problem is, that the healthy foods cost money. And as a result of the unemployment, there is perhaps one person that works and sometimes there is no-one working, they are dependent on a grant from which they live.”*

The participants graphically described the desperate circumstances many households find themselves in.

*“This programme for the community is a, to their benefit because poorness, drug abuse is the order of the day here. And the parents they really do not care about their children, the children gets neglected, the children can do what they want, can eat what they want. A few minutes ago I told the previous lady, parents leave the children to their own devices and then what happens, to survive is he takes something to eat and just walks on. A plate of food does not get placed in front of them in the evening, because he is on the street, parents are drunk, and they do not know where their children are. This is a packet that a grandpa brought to me this morning, he scratched in the girl’s cupboard and this is what he found, it is marijuana.”*

Participants mentioned that healthy foods to most still seem expensive, so education on economic healthy eating is needed by educators, parents and children.

*“He has to survive miss, if he can find a piece of bread...anything to fill his tummy. He can’t be choosy; today I want vegetables or whatever else.*

Participants also pointed out that children’s choices are dependent on the availability of food at home and the need for parent education. Even if the parents leave them to their own devices children are dependent on the food purchased by their parents.

*“...a person should start with their parents because they are the people that are responsible for the preparing of the food...”*

*“...but at the end of the day the parents has to buy the food and the healthy foods and whatever else.”*

*“...but it does not help that we tell the children because the parents themselves need education around it.”*

Participants made it clear that the poor socio-economic circumstances from the schools' community do not only serve as a barrier to planning for nutrition action but it also impacts on planning for actions through the life orientation curriculum. Both the school and the parents often do not have the resources for the children's assignments.

*“We at the moment at this school, we do not have a working library, we are trying to get one going but we are still struggling to get sponsorships, so thus at this school resources are lacking.”*

*“And many of these children's parents cannot, will not, enable them to read a newspaper or magazine or whatsoever to use as a resource.”*

#### **4.5.2 Workload and time constraints**

As mentioned previously time constraints played a major factor in the difficulties experienced in the action planning process. Competing priorities were identified as a significant barrier which coincides with time constraints and is embedded in the requirements of the curriculum as prescribed by the Department of Education. Something the educators, champions, principals, and project team can do absolutely nothing about. One champion also noted that life orientation is not a big part of their roster. Again participants had the concern that this poses as a potential barrier in implementation of action plans as well, as most of the action planning zones fit best within the life orientation curriculum.

*“...life orientation is not such a big part of our roster, we could not work with it that*

*much.”*

*“...in the light of the nine areas that we do where are we going to find the time? Where are we going to find the time? We can hardly reach what we would like to reach.”*

*“...there are so many other priorities and learning areas that must receive its attention.”*

Aspects of the curriculum also hold challenges such as the reality that the curriculum is changing in 2011.

*“And because the curriculum is still new and is now busy changing back again, do you understand?”*

A few educators mentioned that the lack of training in physical education that most educators have will definitely and is posing a barrier to the implementation of physical activity. With the former curriculum physical education educators were specifically trained and only those educators instructed physical education classes, now physical education forms part of life orientation and all educators are expected to cope with an unfamiliar area.

*“Not one of us has formal training in P.E., now I’m talking about bodily developing movement, now if one just I feel people that received that training can get the children more active, then it will work better.”*

#### **4.6 Impact and successes of the action planning process**

Although most participants felt it was still too early to talk about successes, one school was however very excited about a very successful community event they held at their school. Everybody mentioned it with great pride; the champion, principal as well as the educators. They host a cup for cancer annually and this year they decided to combine it with diabetes as the theme for the year was healthy eating/fruits and vegetables and thus the goals of the two causes coincided. This event afforded the opportunity to convey the message of healthy living especially

eating to a very disadvantaged parent community. Also they were able to introduce economical ways of eating healthy by making use of in season produce for example fresh salads.

*“It was so wonderful that they could eat so nicely and they could see how tasty, how good it (fruit and vegetables) tastes.”*

A few other small but significant successes were mentioned, which includes awareness and self-efficacy. Children are now aware of the reasons why one should eat healthily; their purchases at the tuck-shop are healthier choices, facilitated by attempts to stock healthier items in the tuck-shop. The children are also bringing healthier lunches to school and they are also watching closely what the educators eat, which in turn encourages educators to eat healthier. So it is potentially a healthy cycle emanating as a result of the HealthKick process, to an extent instilling a sense of purpose and pride in both educators and learners.

*“...you see the idea comes up by them (learners), and why they must eat healthily, and the reasons why they must live healthily, must have a healthy lifestyle...”*

*“...they don't buy these chips anymore...”*

*“...the fact that the educator has to be aware of what he eats, because they are going to tell you, but sir you are then eating unhealthily, now so.”*

#### **4.7 Participant's recommendations for improvement of the process**

The following suggestions were made by the participants: the need for early planning was recognised by most educators. Educators also pointed out the break in communication (from principal and champion to educators) when it comes to visits from the project team that needs to be addressed. Recognition for the need of programme evaluation came from a principal and a champion. Principals, champions and educators called for the expansion of the action planning process to the whole school and not just grades 4-6.

*“Yes, look because a lot of the educators did not attend the meetings and workshops and so forth, it was a bit difficult for me you know ... Now the foundation phase and the grade 7’s and so forth, because they are not directly involved, it was difficult for them to also get enthusiastic and so forth. I don’t know if the future plans maybe include the whole school’s educators, but I think it might be better, because everyone is then directly involved and you know.”*

Most participants suggested that the programme curriculum be integrated into the normal curriculum which would make it easier for educators’ planning and would also save time.

There was a request for more demonstration lessons, by educators.

*“I would say if you can come in once per quarter, especially the physical education, the children enjoys it. I saw now last week when ... was here, I mean the children really enjoyed it...”*

The need for parent involvement in decision making/action planning and parent education was stressed by a principal, champion and educators all from the same school, as for the next several years the children’s food choices would be dependent on the food purchases and preparation of their parents.

*“...I would think one should make more contact with the parents, because that is where the five vegetables per day come from.”*

One principal felt that community involvement in a healthy lifestyle programme could benefit the whole community, the same principal also emphasised repeatedly that the programme must become *“a lifelong project”*.

One educator suggested that a data base for resources be created that the schools can access.



*“I would say somewhere we must create a database or a resource provider...”*

Suggestions from the facilitators’ side were with regards to the roles of champions and principals. As mentioned earlier champions did not necessarily volunteer for their role and as a result some champions might have been somewhat reluctant. The champion however plays a critical role and facilitators are of the opinion that champions should be invested in more with regards to training, as a motivated champion can facilitate and steer the action planning process more successfully, as was witnessed in two of the 8 intervention schools. Another suggestion was to perhaps allocate a champion for nutrition and one for the physical activity aspects of the action planning and implementation. Facilitators also felt that the project teams’ initial decision to separate the principal from the action planning process because they felt s/he might influence the self-assessment was perhaps not the best decision. Facilitators are now of the opinion that the principal’s active involvement in the process could be beneficial as the principal sets the example for the rest of the school.

#### **4. 8. Conclusion**

The findings of the process evaluation of the action planning show that the action planning did not unfold as it was designed. Even though the process was wrought with a number of challenges, such as time limitations and workload constraints it had some positive aspects. In the following chapters a discussion of the findings will be presented and possible ways of overcoming these challenges will be proposed.

## **CHAPTER 5**

### **DISCUSSION**

#### **5.1 Introduction**

The HealthKick approach to assisting principals, educators and supporting staff to improve the nutrition and physical activity environment at their school is of a participatory nature. The self-assessment and compiling action plans gives schools the opportunity to assess and prioritise their own needs and plan for contextual action. Inchley et al. (2006) promotes a participatory approach after a four year process evaluation in Scotland within the European Network of HPS, however the results of the current study indicate that this approach was not entirely successful in the action planning process of the Healthkick programme. Several challenges were identified and experienced by participants. There were however also positive experiences and perceptions reported and various enablers to the process were identified. This chapter aims to discuss these findings.

#### **5.2 Main barriers to the action planning and implementation**

The greatest barriers to the action planning process as well as the implementation were recognised by participants as time, workload, competing priorities and the socio-economic factors that plague the communities surrounding the participating schools.

The results indicate that the challenges of time, workload and competing priorities are intrinsically linked. It would seem that if sufficient time were available to the various role-players, workload and competing priorities would not pose a threat. Very little time was made available by schools for the action planning process and the reasons for this was curriculum demands and other competing priorities they get assessed upon by the Department of Education. Educators are in general stressed about their workload (Draper, Kolbe-Alexander & Lambert (2009), so the fact that they saw the action planning as extra work did not facilitate the process. The limited time available was worsened by the fact that educators are mostly not willing to remain after school. Similar findings are reported in the Action Schools BC! report, educators also reported not having sufficient time for planning, or meeting in order to schedule and

coordinate actions; competing for curriculum time, and educator overload (Naylor et al., 2006). The administrators of the Action Schools BC! programme also observed and reported on the unwillingness of educators to commit to the necessary time for programme tasks. Naylor et al. (2006) concluded that these findings signify the nature of schools and are likely to be encountered often. In a retrospective evaluation by Draper, Kolbe-Alexander and Lambert (2009), it was reported that educators experienced burnout as a result of their workload and time limitations. Thus time and workload is a real and extremely difficult concern to address and important to consider in interventions of this nature.

As mentioned previously all HealthKick schools are located in disadvantaged areas and socio-economic factors as barriers to implementation were recognized by all schools but particularly emphasized by participants from two schools in the sample. The main factor that was given by participants was the barrier to healthy eating. Another challenging factor is the high unemployment rate which means that there is not money for sufficient food, let alone healthy food (it would be important to bear in mind that often in these communities extended families stay together). These findings uphold the findings of the situational analysis of the '100 Schools project' in which principals prioritised social concerns as follows: Poverty and unemployment, crime and violence in the community and the school environment as well as child abuse (De Villiers et al., unpublished). Participants of this study were of the opinion that children are often left to their own devices as a result of parents' substance abuse and single parenthood. Again this is upheld by findings of the '100 schools project' in which principals prioritised parents health priorities as follows: Substance abuse, tobacco use, unhealthy diet, HIV/AIDS (De Villiers et al., unpublished). At this stage children's choices are dependent on the food purchases parents make, so parent education becomes important.

Glassauer et al. (2003) identified parents as key role players in the nutrition education of learners. In most studies reviewed, parent involvement was never recognized as a strong component or the easiest group to involve, but their involvement is deemed as important (Steckler et al., 2003; Reynolds et al., 2000; Draper, Kolbe-Alexander & Lambert, 2009 and Glassauer et al., 2003). Principals and educators in this study had great concern regarding the

socio-economic realities in these communities and felt that it would be a challenge to engage the communities and make them aware of the benefits of healthy living, when they are struggling to survive on a daily basis. The following findings verifies educators concerns: in the Pathways study , family events had an attendance rate of less than 50% (Steckler et al., 2003) and the High 5 project also did not report optimal parent involvement (Reynolds et al., 2000).

The realities of limited time and competing priorities like Naylor et al. (2006) stated, are the natural situation of schools. Also the socio-economic profiles of these communities are not likely to change soon; thus HealthKick and other interventions have to seriously consider these realities in their intervention planning. Chrisholm (2003:10), in her argument with critics who question the disparity between theory and practice concludes based on the Gramscian political view: “that the poorest deserve the best and the best is not always to be found in the immediate environment but requires learning about the new and unknown ways introduced by the school”. Schools are there to prepare children for the future.

### **5.3 The enablers and challenges in the process**

The four key enablers in the action planning process as recognized by participants were the recognition of the potential benefits this programme holds for learners, educators and the larger community; the facilitation received from the project team; the fact that the HealthKick curriculum complements their existing curriculum and the receipt of the resource toolkit.

The results of the process evaluation of the action planning process indicate overall satisfaction with the facilitation received. Similarly in the Action Schools BC! programme information derived from focus groups indicated that the hands-on guidance and school visits were useful and one of the key facilitators in the process (Naylor et al., 2006). In the Healthnutz programme educators also expressed their appreciation for the treatment and support they received from the project staff (Draper, Kolbe-Alexander & Lambert, 2009).

The lack of responses with regards to the educators’ workshop in the focus group discussions and interviews indicates that these workshops did not have the desired impact. This lack of impact is in contrast with the findings of the administrators of the Action Schools BC!

programme who reported that the training provided by master trainers, improved educators skills to utilize activities in their classrooms as well as their motivation to implement healthy activities in the classroom (Naylor et al., 2006). Educators mentioned that workshops/training assisted them in increasing their comfort with the programme; educators were of the opinion that they learned the reason behind why it is necessary for learners to learn about nutrition and physical activity in primary schools; also what to highlight in each activity or lesson and how to match the curriculum with other areas of the program (Naylor et al., 2006; Steckler et al., 2003). The lack of impact the workshops had on educators in the current study could be associated with the uncertainty of what was expected of them as participants and role players in the action planning process. HealthKick would have to re-evaluate how they make use of workshops and training, to not only provide nutrition and physical activity education and placing it into their curriculum but to further develop educators' skills and confidence to be an effective agent of change.

The findings of the current study suggest that educators and champions are of the opinion that the HealthKick curriculum fits into their learning outcomes and are complementary to their current curriculum. In the Pathways study it was also seen as a great benefit to be able to integrate the programmes curriculum with other subjects (Steckler et al., 2003). In a review of evaluations conducted on health promoting schools by Mukoma and Flisher (2004) it was found that it is possible to integrate health promotion into the school curriculum and policies successfully. Thus the idea of integrating programme curriculum into school curriculum is possible but to have it implemented on a national level by the Department of Education remains an area to be explored.

The resource toolkit was very well received and appreciated by all schools. The one misgiving around the toolkit was the fact that each school only received one toolkit and that is not practical as more than one educator will not be able to access the same resource at the same time. Also they felt that educators would have to familiarize themselves with the resources if they intend to use it; again one resource toolkit does not allow for this to happen. The educators in the study of Action Schools BC also felt that the resources provided by the programme were a key facilitator in the process, but the need for educators' familiarization with resources was also indentified by

the Action Schools BC! process evaluation as necessary (Naylor et al., 2006).

The other misgiving educators had was the fact that most resources were in English and most HealthKick schools are Afrikaans. Similarly Latiff (2000) recognized the need for resources to be translated into schools' indigenous languages. Kitao and Kitao (1997) are of the opinion that curriculum, resource materials, teaching methods, and assessment standards are supposed to be designed for learners and their specific requirements. The authors also state that it is the educators' responsibility to assess appropriateness of educational and resource materials (Kitao & Kitao, 1997). In the instance of this study findings educators recognised language as a barrier for their children and when considering their current workload it is not practical for them to translate materials in their limited planning time.

#### **5.4 The role of the principal and champion**

The other possible major enablers could be the roles of the principal and champion within the programme, should they be appropriately enabled and nurtured.

The principals have not played an active role in the action planning thus far. This was a decision made by the project team to eliminate the bias his/her involvement might have caused in the process, especially the self-assessment. The facilitators have now however concluded that this decision was incorrect. Facilitators now realize that the active involvement might be beneficial to the programme as leadership through example is a highly recognized concept. The principals during interviews indicated their willingness to get involved even though they have limited time. Inchley et al. (2006) found that programmes in which senior management takes the lead gives the programme status, even if they are not involved at the operational level, their involvement is deemed critical to successful implementation. Senior management is also able to entrench the health promoting message into the core of the school; also being able to delegate tasks to the staff in question as well as external organizations. Management can also benefit the programme by making resources available to it (Inchley, Muldoon & Currie, 2006). Fullan (1991), states that every key piece of research on advancement and school efficiency confirms that the principal has a powerful influence on the probability of change (Fullan & Stiegelbauer, 1991 in Lahiff,

2000). Some of the aspects of the role of the principal in health promotion have been identified by Lahiff (2000) as: promoting whole-staff communication; leading by example; implementing policy; sees health education as a priority in timetabling; selects suitable staff to deliver health education and is aware of the research which shows that personal and social programmes, as well as health promoting policies lead to happier learners and improved exam results. The HealthKick project team will have to explore ways of enabling such a leadership role by principals within the HealthKick programme.

Champions did not report much pertaining to their role as champion; only that it was sometimes a challenge to get the cooperation and support of the rest of the educators. The champion was thought to play a lead role in the action planning process. As mentioned previously champions were supposed to volunteer for this role but instead were placed in the role by the principal or were volunteered by colleagues. The facilitators recognized that champions play a critical role in the action planning process and that they should be invested in more with regards to training etc. as a motivated champion can facilitate and steer the action planning process more successfully. Inchley et al. (2006) confirms this perception when they state that the effectiveness of a 'project coordinator' (champion) as a driver for change is reliant on their commitment to the programme as well as their ability to express excitement to others. Blom-Hoffman (2008), describes the function of the champion as one who stops the programme from vanishing among competing priorities as well as to address implementation barriers as they arise. The author also asserts that a nutrition champion ought to be respected by school staff, know the school environment and ought to have good quality communication and coordination skills (Blom-Hoffman, 2008). Lahiff (2000) describes the programme coordinator's role as: initiator; instigator; 'a preparer of the way'; a resource person; one who is key in the emergence of a whole school policy and approach; coordinating meetings of the health education 'team'; and liaising with partners and community.

### **5.5 Positive impact the action planning afforded**

The action planning process nevertheless yielded some positive results. Participants at one school were very excited about a successful community event they held at their school. The event afforded the opportunity to get the message of healthy living, especially eating to a very disadvantaged parent community. They were also able to introduce economic ways of eating healthy by making use of in season produce for example fresh salads, which reportedly were well enjoyed. A few other small but significant successes was mentioned, which includes important concepts such as awareness and self-efficacy. Children are aware of the reasons why one should eat healthily; their purchases at the tuck-shop are healthier choices, facilitated by attempts to stock healthier items in the tuck-shop. The children are also bringing healthier lunches to school and they are also closely watching what the educators eat, which in turn encourages educators to eat healthier. Thus a potentially healthy cycle is emanating as a result of the HealthKick process, to an extent instilling a sense of purpose and pride in both educators and learners. In the study by Naylor et al. (2006), they expressed that there could be value in exploring the benefit of positive educator lifestyle change and improved staff solidarity further. The Healthnutz programme also reported that it created a space for educators to live a healthier lifestyle as they were conscious of the fact that they are role models for the learners (Draper, Kolbe-Alexander & Lambert, 2009).

### **5.6 Conclusion**

Although the action planning process did not work as well as it was envisioned it still had some positive outputs. It is important to remember that HealthKick is a pilot project with the objective to develop a sustainable project and for this to occur efficiently, lessons have to be learned in applied situations. The HEALTHY study's study group for example carried out a succession of pilot studies which informed the ultimate design of the study. The pilot studies were of great value and afforded necessary modification which was a shift from their original plan but to great improvement to their intervention (Schneider et al., 2009). Similarly this process evaluation afforded the HealthKick project team the opportunity to reflect informatively on their current action planning process and enabled them to modify/improve the process going forward.



## **CHAPTER 6**

### **CONCLUSION AND RECOMMENDATIONS**

#### **6.1 Introduction**

In this chapter conclusions are drawn and recommendations are made based on the findings of this study.

#### **6.2 Conclusions**

The aim of this study was to conduct a process evaluation of the action planning process, the HealthKick programme in disadvantaged primary school settings in the Western Cape. The study sought to develop an understanding of the action planning process and why some aspects might have been successful and others not.

The results of the study suggest that although the perceptions of the participants about the program were overwhelmingly positive, the action planning process did not take place as intended. While the participants felt that the goals of the programme were clear, it seems as if the principals, champions and educators did not fully grasp what was expected from them at the outset of the action planning process. Other factors that could have contributed to the action planning not taking place as intended were, workload, competing priorities and time constraints especially around time available for planning.

The educators saw the action planning as additional work and most were not even sure how much of the action planning process they had actually completed. Only two schools actually engaged in action planning and even these schools only saw the value of the action planning process after the action planning had been completed. There was also the view that the process was too broad and that it should be narrowed down or focused as educators are accustomed to a very prescriptive way of planning and teaching. Participation in the action planning process needs to be made clear from the outset in terms of time, commitment and other possible expectations. The limited time also impeded on the process and made educators somewhat resistant. Thus facilitators had a difficult time getting the necessary participants together in order

to start the proceedings. Often facilitators had to return to schools a few times for the same action planning session.

One of the biggest barriers to the successful planning of the action planning process was the poor socio-economic circumstances of the communities that surround the participating schools. Although participants recognised the potential benefits the programme held for the children, themselves and the larger community they were still sceptical and could not see how the many socio-economic barriers could be overcome. These socio-economic problems were also highlighted in the formative phase of the intervention by principals and this evaluation has now shown that educators' perceptions about the impact of these conditions could be a major barrier to planning for nutrition and physical activity related improvement in the school environment.

The results however also pointed to positive aspects in the action planning process such as the expectations that results of the action planning process will be beneficial to the learners, educators and the wider community. The HealthKick curriculum was also seen as complementary to the existing curriculum. Most participants felt that the facilitation received was adequate and the support and presence of the project team added to the positive experiences throughout the process. These positive experiences however did not have the desired effect in the completion of the action planning process by schools.

Participants made some suggestions to integrate the whole programme into the life orientation curriculum which would make it easier for their planning and also to save time. There was a call for more demonstration lessons, especially physical activity lessons as most observers to these lessons saw how much the children enjoyed it. The need for parent involvement in all aspects of the programme; planning and implementation, as well as parent education was stressed as children's food choices would be dependent on the food purchases and preparation of their parents. There was also a call for community involvement as a healthy lifestyle could benefit the whole community.

## **6.3 Recommendations**

### **Time Limitations**

Time limitations were identified as the biggest barrier in the action planning process. In their suggestions to improve the process, educators proposed that planning starts earlier than before, in order for them to integrate the HealthKick goals into their lesson plans at the beginning of the year. Perhaps the action planning should take place at the end of the school year so that action plans are ready for placement in the year planner.

Another possible resolution might be to integrate the action planning into the Western Cape Education Department's Quality Assurance Directorate's existing Whole School Evaluation (WCED online, 2007). This would save a great deal of time as schools would only have one assessment document to complete. Ideally schools should complete the whole school evaluation annually, among others: to evaluate effectiveness of the school; to strengthen level of support given; to provide feedback to achieve continuous school improvement and to identify aspects of excellence (WCED online, 2007).

### **Workload and Competing Priorities**

The issue of workload and competing priorities poses an integral threat to the action planning process. A potential answer to this is the suggestion from the participants and a number of authors who call for the integration of nutrition and health promotion curriculum into the normal academic curriculum (Perez-Rodrigo & Aranceta, 2001; Glassauer et al., 2003; Knai et al., 2006 and Inchley, Muldoon & Currie, 2006). Glassauer (2003) argues that it is important for the integration of nutrition education into the normal curriculum as it is not seen as important and is easily sidelined. Inchley et al. (2006) also states that it is of the utmost importance for new initiatives to be integrated into existing school practices to ensure sustainability. The notion of integrating the HealthKick curriculum in the normal curriculum is plausible but has to be implemented on a national level by the Department of Education and this remains an area to be explored. The project initially envisioned that the healthy behaviour curriculum would be integrated into the existing life orientation curriculum and as a result was placed into the life orientation learning outcomes. However an ambiguity exists about the change of curriculum in

2011 and the status of the life orientation within the curriculum is not clear, thus it would be best to fit the healthy behaviour outcomes across the academic curriculum. HealthKick would have to then perhaps reduce number of action planning zones to cover food and nutrition; physical activity; staff health and the physical environment only.

According to Blomhoff, Kelleher, Power and Leff (2004), including paraprofessionals as agents of behaviour change in under-resourced schools better enables schools' capacity for health promotion. Not only are workloads decreased and time saved but also paraprofessionals have the additional advantages of being able to interact with learners in structured and unstructured school context. They also usually live in the same neighborhoods as learners and they may have children or relatives attending where they work and thus have a stake in the overall wellness of the schools. Paraprofessionals might be existing volunteers who help at the feeding scheme or parents who assist with monitoring classes when educators are absent.

### **Training and Workshops**

Carroll et al. (2007) are of the opinion that facilitation strategies can be utilized to ensure and standardize implementation fidelity to make certain that the intervention is as uniform as possible; especially in multi-site interventions. This can be ensured by providing participants with uniform training and support. Approaches may incorporate the provision of manuals and guidelines, training and monitoring as well as feedback to participants delivering the intervention. The project team would now in the light of the lessons learned adapt manuals to be more suited for the limited time available. User-friendly time efficient manuals or guides might have enabled better training sessions as well. Workshops and training has been recognised in the literature as a key enabler with regards to intervention implementation (Carroll et al. 2007; Naylor et al., 2006; Steckler et al., 2003). HealthKick would have to re-evaluate how they make use of workshops and training, to not only provide nutrition and physical activity education and placing it into their curriculum for the action planning process but to further develop educators' skills and confidence to be effective agents of change.

### **Parent involvement**

In most studies reviewed, parent involvement was never recognized as a strong component or the easiest group to involve, but their involvement is deemed as important (Steckler et al., 2003; Reynolds et al., 2000; Draper, Kolbe-Alexander & Lambert, 2009 and Glassauer et al., 2003). Programmes have had moderate successes with regards to parent involvement (Steckler et al., 2003; Reynolds et al., 2000; Peters et al., 2009; Knai, Pomerleau, Lock and McKee 2005), further exploration need to be taken in order to maximize and sustain parent involvement. The European Network of Health Promoting Schools (ENHPS) also state that partnerships with families and communities are important, in addition they argue that members of the whole school community should have the opportunity to be involved in the decision making (ENHPS, undated). The HealthKick project team can perhaps explore the feasibility of including parents as part of the action planning team. Currently parents serve on the school governing body, which regulates policies around health and safety, tuck shop and fundraising events. The activities of the action planning process can be placed on the governing body's agenda for discussion and a representative of the body can become an active action planning team member who can serve as a liaison for parents. Parents could play an important role in suggesting bridges to overcome socio-economic barriers identified in this study.

### **Principal involvement**

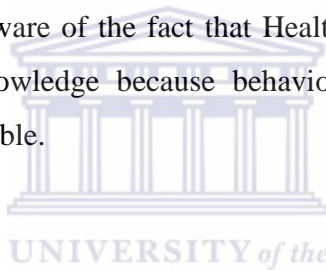
The HealthKick project team initially excluded the principal from the action planning process as they were of the opinion that he would bring bias to the process. In retrospect they have realized that this might have been a critical mistake as it hindered the process from moving forward, the principal's involvement might be beneficial to the action planning process as leadership through example is a highly recognized concept. As mentioned in the discussion, senior management affords status to the project (Inchley, Muldoon & Currie, 2006), even if they are not actively involved at the operational level.

### **The role of the champion**

The role of the champion or project coordinator as some authors call them are also key a enabler in the process of delivering a successful interventions in schools (Inchley, Muldoon & Currie, 2006; Lahiff, 2000; Blom-Hoffman, 2008). Lahiff (2000) describes the programme coordinator's role as: initiator; instigator; 'a preparer of the way'; a resource person; one who is key in the emergence of a whole school policy and approach; coordinating meetings of the health education 'team'; and liaising with partners and community. Champions should be invested in more with regards to training and modeling them to be motivated productive leaders in the process.

### **Socio-economic factors**

The barrier imposed by the socio-economic factors is a difficult matter to address. The aim of HealthKick is to prevent the onset of diabetes and associated diseases of lifestyle, and it would be important to make educators aware of the fact that HealthKick is not concentrating only on the immediate application of knowledge because behaviour change in their current socio-economic climate may not be possible.



### **Conclusion**

Even though the HealthKick's action planning process was not implemented as originally planned, the process has a lot of potential. It has enabled participating principals and educators to think about health, nutrition and physical activity, not just in the school environment but also with regard to personal health. The action planning process is a very useful tool and has already reaped some benefits internationally and in a few of the HealthKick schools. Modifying the tool to be more suitable to the time stricken, curriculum bound environment educators find themselves in; will see the goal of HealthKick: Kick-starting diabetes prevention through improved nutrition and physical activity in schools, realised. Pilot studies are of great value and it affords necessary modification which might be a shift from their original plan but for greater improvement to the intervention (Schneider et al., 2009). The HealthKick project team should learn from the lesson from this study to modify their action planning process to make it more effective and sustain the desired results.

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## Appendix 1: **Interview Schedule** (Champions and FGDs)

Today I would like for you to take me through your experience of the HealthKick planning process, from your introduction i.e. Briefing, Toolbox Introduction, Educators Workshop (Champions Workshop) and Action Planning Process, working through the zones, and forming your action plans.

Please tell me how you experienced the action planning process of the Healthkick programme.

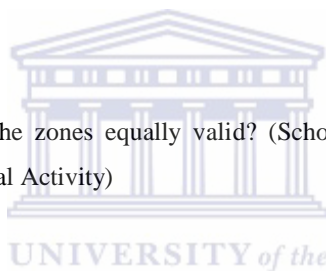
Questions should be covered by the main question:

Briefing...their experience, thoughts of the programme presented to them?

Toolbox Introduction

Teachers/champions Workshop

Working through the zones...Were all the zones equally valid? (School physical environment, Life orientation Curriculum, Food & Nutrition and Physical Activity)



The action planning...would you say in future the action planning should take a different format?

Tell me, what were the challenges/barriers you have experienced during this process.

What facilitated implementation?

How well do you think this process is working in your school?

Tell me, what do you think needs to be done for this programme to work (or to work even better) in your school in terms of resources etc.?

Questions should be covered by the main question:

Human Resources, time, etc.

How did you experience the facilitation of the process?

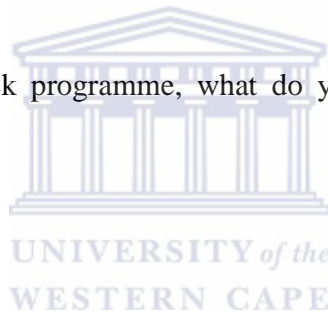
Questions should be covered by the main question:

Did the facilitator play an important role in the process?

What was your expectation of the facilitator's role and did the facilitator meet your expectations?

Tell me, how does the implementation process of the HealthKick programme compare to/differ from other projects you have had in your school.

If you think about the HealthKick programme, what do you think should change about the programme if any?



## Interview Schedule

### Principal

Your school has been part of the Healthkick programme for well over a year now, how would you describe your experience with the programme?

Perhaps explore how he feels about not being an active part of the action planning process. Has he noted any progress? Barriers/challenges?

How has the champion involved you in the programme so far?

How 'connected to' the programme or 'engaged with' the programme does the principal feel?

From what you have seen and heard from the educators and champions, how would you describe the way they feel about the programme?

What are their views with regard to the programme?

Do you share their fears/enthusiasm?

What changes have you noticed in educators' attitudes towards / perceptions of the programme?

What / who do you think brought about these changes?

How would you describe the way forward with regards to the programme?

Where would you like to see your school with regard to the programme in a year or two?

How would you say this programme differs from other programmes that have been involved in your school?



## **Interview Schedule (Afrikaans)**

### **(Champions and FGDs)**

Vandag will ek graag he dat u vir my deur u ervaring van die HealthKick beplanning proses moet neem, vanaf die introduction i.e. Briefing, Toolbox Introduction, Educators Workshop (Champions Workshop) and Action Planning Process, toe u-hulle deur die sones werk, en die vormering van u aksie planne.

Kan u asseblief vir my se hoe u die action planning proses ervaar het.

Questions should be covered by the main question:

Briefing...hulle ervaring van die briefing, hul eerste gedagtes oor die program toe dit aan hulle voorgestel word.

Toolbox Introduction

Teachers/Champions Workshops



Wat was die gevoel toe hulle deur die zones gewerk het...was al die sones van toepassing? Lewensorientering, Voeding, Fisiese Aktiwiteit,

Die action planning...sou u se dat in die toekoms die action planning in 'n verskillende formaat moet wees.

Se my, wat was die moeilikhede wat u-hulle ervaar het tydens die proses.

Wat sou u se is die suksesse wat u-hulle behaal het, en waaraan sou u-hulle dit toeken?

Hoe goed dink u die proses werk in u skool?

Se my, wat dink u moet gedoen word sodat hierdie program in u skool sal werk/suksesvol sal wees; in terme van hulpbronne etc.

Questions should be covered by the main question:

Menslike hulpbronne (Human Resources), tyd, etc.

Hoe het u die fasilitering gedurende die proses ervaar?

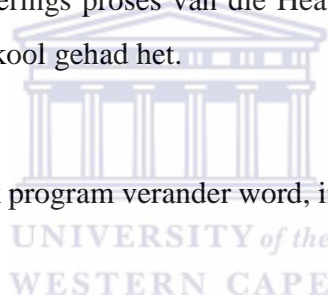
Questions should be covered by the main question:

Het die fasiliteerder 'n groot rol in die proses gespeel?

Was die fasiliteerder se teenwoordigheid te min of te veel, in u mening?

Se my, hoe verskil die implementerings proses van die HealthKick program met die van ander programme wat u al reeds by die skool gehad het.

Wat dink u moet in die HealthKick program verander word, indien enige-iets?



## **Interview Schedule**

### **Principal (Afrikaans)**

U skool is nou al baie meer as 'n jaar deel van die Healthkick program, hoe sou u, u ervaring met die program beskryf?

Hoe voel hy/sy oor die feit dat hy tot nou toe nie 'n aktiewe rol in die action planning gespeel het nie? Het h/sy al 'n verskil op gelet (i.v.m. program)? Enige moeilikhede?

Hoe het die champion tot dus ver u by die program betrek?

Hoe betrokke voel die prinsipaal ann die program?

Van wat u gehoor het van die champion en opvoeders, hoe sou u se voel hulle oor die program?

Wat is hulle menings oor die program?

Deel u hulle bedenkinge/opwinding?

Het u al enige veranderinge in die opvoeders se gesin/menmings oor die program op gelet? Wat dink u het hierdie verandering te mee gebring?

Hoe sou u die pad vorentoe beskou t.o.v. die program?

Waar sou u, u skool met betrekking tot die program wil sien in 'n jaar of twee?

Hoe verskil hierdie program van ander programme wat al by u skool betrokke was?

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Information sheet

**Process Evaluation of the HealthKick Action Planning Process in Disadvantaged Schools in the Western Cape**

Dear Principal/Champion/Educator

Your school is currently participating in the HealthKick Programme as a Co-implementation school.

I am a research intern from the Medical Research Council (MRC), Parow. I am conducting a study on the perceptions and experiences of principals, educators and champions of all participating Co-implementation schools in the HealthKick Programme. I would thus like to gain insight into your experiences and your ideas about improving this programme.

Why am I doing this study?

As you know this is a pilot study, we are endeavouring to find the best practical methods to successfully implement the programme at all interested schools in the future. To accomplish this we need to evaluate every aspect/step of the intervention. Therefore it is necessary to document the challenges, concerns and other issues that need to be addressed.

What would be expected of you?

If you are willing to participate:

You will be asked to participate in a focus group discussion for approximately 45 minutes to an hour

The champion and principal will participate in individual interviews of approximately 30-45 minutes.

These will take place after you have completed the action planning process.

The focus groups and interviews will be conducted in your language of preference i.e. English, Afrikaans. The focus groups and interviews will be audio-recorded to ensure that no information is lost. The information gained from focus groups and interviews will remain confidential, and your name and any identifying details will not be recorded on the transcription. No personal details or the schools name mentioned in the reporting of this particular part of the study. The information will be used strictly for research purposes.

There is no remuneration or immediate benefit for participating in this study. However, the information gathered will be of great benefit to the programme and your school.

Participation in this study is completely voluntary and you are able to withdraw from the study at any time you wish. If you agree to participate, I will request that you sign the attached Consent Form (see back of page) which confirms your voluntary participation in this study.

Any further questions?

If you have any questions or queries at a later point I would be happy to provide you with further information.

Thank you for your consideration of this request. If you are willing to participate, please sign the consent form.



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### CONSENT FORM

#### **Process Evaluation of the HealthKick Action Planning Process in Disadvantaged Schools in the Western Cape**



I, \_\_\_\_\_ (study participant), hereby agree to participate in the above study.

I have had the study explained to me by \_\_\_\_\_ (researcher) from the Medical Research Council and I understand what has been explained to me.

I agree that the information from the focus groups and interviews will only be used for research purposes.

I agree that the focus groups and interviews will be recorded and confirm that my name will not appear on the transcription of these recordings, or any other notes made during these focus groups, or in any documentation that results from this study.

I understand that I may withdraw my consent at any point during this research project.

Participant Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date:        /        /2009

Person who gained consent: \_\_\_\_\_

Signature: \_\_\_\_\_

Date:        /        /2009

Any questions and queries

Please contact:

Jillian Hill (Masters Student Researcher)

**Tel:** 021 938 0801

**Email:** [jillian.hill@mrc.ac.za](mailto:jillian.hill@mrc.ac.za)

or

Suraya Mohamed (Supervisor and Lecturer)

**Tel:** 021 959 2809

**Email:** [sumohamed@uwc.ac.za](mailto:sumohamed@uwc.ac.za)





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### Inligtingsbrief

#### **Process Evaluation of the HealthKick Action Planning Process in Disadvantaged Schools in the Western Cape**

Liewe Skoolhoof/Champion/Onderwyser

U skool is op die oomblik deel van die HealthKick Program as 'n ko-implementerings skool. Ek is 'n navorsingsintern by die Mediese Navorsingsraad (MNR) Parow. Ek doen 'n studie op die persepsies en die ondervindings van die skoolhoofde, onderwysers en champions wat deelneem aan die ko-implementering van die HealthKick program by hulle skole. Hierdeur sal ek insig kry in u ondervindings en ook u idees kry rondom die program se implementeringsproses en hoe om dit te verbeter.

Hoekom doen ek die studie?

Soos u weet is dit 'n loodsstudie en ons probeer om die beste moontlike metodes te gebruik om die program suksesvol te implementeer sodat dit in die toekoms moontlik ook by ander skole geïmplementeer kan word. Om dit te bereik moet ons elke aspek van die intervensie evalueer om sodoende alle probleme, bedenkinge maar ook suksesse te ondersoek .

Wat sal van u verwag word?



Indien u gewillig is om deel te neem:

Sal u gevra word om deel te neem aan 'n fokusgroep bespreking vir ongeveer 45 minute tot 'n uur.

Die champion en skoolhoof sal deel neem aan 'n individuele onderhoud van ongeveer 30-40 minute.

Hierdie onderhoude en fokusgroepe sal volg na u die aksie beplannings proses af gehandel het.

Die fokus groepe en individuele onderhoude sal in u verkose taal, Engels of Afrikaans plaasvind. Die fokusgroepe en onderhoude sal opgeneem word sodat geen inligting verlore gaan nie. Alle inligting van fokusgroepe en onderhoude sal konfidensieel gehou word en geen name of identifiseerbare detail sal op die transkripsie gesit word nie. Geen persoonlike inligting of skool name sal genoem word in verslae in die betrokke projek nie. Die inligting gaan streng vir navorsingsredes gebruik word.

Daar is geen betaling of onmiddellike voordeel om aan die studie deel te neem nie, alhoewel die inligting wat ons verkry tot voordeel van skool sal wees.

Deelname is heeltemal vrywillig en u kan ontrek van die studie wanneer al u ook al wil. As u instem om deel te neem vra ek dat u asseblief die aangehegde testemmingsvorm (sien agterblad) sal teken.

Enige verdere vrae?

As u enige verdere vrae het of navrae op 'n latere stadium sal ek bly wees om u van meer inligting te voorsien.

Baie dankie dat u hierdie versoek sal oorweeg en by voorbaat dankie vir u deelname.

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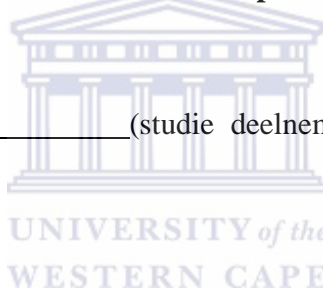
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Toestemmings Vorm

**Process Evaluation of the HealthKick Action Planning Process in Disadvantaged Schools in the Western Cape**

Ek, \_\_\_\_\_ (studie deelnemer), stem hiermee in om deel te neem aan die bogenoemde studie.



Die studie was aan my verduidelik deur \_\_\_\_\_ (navorser) van die Mediese Navorsings Raad en ek verstaan wat aan my verduidelik was.

Ek stem saam dat die inligting van die focus groepe en onderhoude sal vir navorsings redes gebruik word.

Ek stem saam dat die focus groepe en onderhoude sal opgeneem word en dat my naam sal nie op die transkripsies van die opnemings verskyn nie, of op enige notes wat tydens die focus groepe en onderhoude gemaak word nie, of op enige dokumentasie wat vanaf die studie kom sal verskyn nie.

Ek verstaan dat ek my toestemming terug kan trek tydens enige tyd gedurende die navorsings projek.

\_\_\_\_\_

Datum: / /2009

Handtekening van ondervraagde

\_\_\_\_\_

Datum: / /2009

Handtekening van ondervraer

Enige verdere vrae?

Kontak asseblief vir::

Jillian Hill (Masters Student Navorsers)

**Tel:** 021 938 0801

**Email:** [jillian.hill@mrc.ac.za](mailto:jillian.hill@mrc.ac.za)

of

Suraya Mohamed (Studie Leier & Dossent)

**Tel:** 021 959 2809

**Email:** [sumohamed@uwc.ac.za](mailto:sumohamed@uwc.ac.za)



## Code List

CODES-PRIMARY-DOCUMENTS-TABLE (CELL=Q-FREQ)

Report created by Super - 10/02/10 10:55:56 AM

"HU: [C:\Documents and Settings\jhill\My Documents\Scientific Software\ATLASTi\TextB...\Process Evaluation.hpr5]"

Code-Filter: All [85]

PD-Filter: All [12]

Quotation-Filter: All [291]

PRIMARY DOCS													
CODES	1	2	3	4	5	6	7	8	9	10	11	12	Totals
action planning - at	0	0	0	1	0	0	0	0	0	0	0	0	1
action planning - ca	0	0	0	0	0	0	0	0	0	0	2	0	2
action planning - co	0	0	0	0	0	1	0	0	0	0	0	0	1
action planning - di	0	0	0	0	0	0	0	1	2	0	0	0	3
action planning - in	0	0	0	3	0	0	0	0	0	0	0	0	3
action planning - ne	0	1	0	0	0	0	2	0	1	0	0	0	4
action planning - po	0	0	0	1	2	1	0	0	1	0	0	0	5
action planning - ti	0	1	0	0	0	1	0	0	0	0	0	0	2
action planning - wo	0	0	0	0	0	0	0	2	0	0	0	0	2
barrier - curriculum	0	0	0	1	0	0	0	0	0	2	0	0	3
barrier - don't live	0	0	0	0	0	1	1	0	0	0	0	0	2
barrier - food purch	0	0	0	0	1	0	0	0	1	0	0	0	2
barrier - might have	0	0	0	0	0	0	0	0	1	0	0	0	1
barrier - parents	0	0	0	0	0	0	0	0	0	0	1	1	2
barrier - resources	0	2	0	0	0	0	0	0	0	0	0	0	2
barrier - socio-econ	0	1	1	2	0	0	1	0	2	0	2	3	12
barrier - time	0	0	0	3	0	1	1	1	1	0	0	0	7
barrier - training	0	0	0	1	0	0	0	0	1	0	0	0	2
barrier - whole scho	0	0	0	0	1	0	0	0	0	0	0	1	2
barrier - workload	0	0	0	2	0	0	0	0	1	1	0	0	4
champion - difficult	1	0	0	0	0	0	2	0	0	0	0	0	3
comparison - approac	1	1	2	1	2	0	2	0	0	3	0	0	12
comparison - duratio	0	0	0	0	0	0	1	0	0	0	0	0	1
comparison - similar	0	0	0	0	0	0	0	0	0	1	0	0	1

comparison - none	0	0	0	0	0	1	0	0	0	0	0	0	1
comparison - scope	0	0	1	0	0	0	0	0	1	0	0	0	2
comparison - unique	0	0	0	0	0	0	0	0	0	0	0	1	1
enabler - class teac	0	0	0	0	1	0	0	0	0	0	0	0	1
enabler - hands on p	0	0	0	0	1	0	0	0	0	0	0	0	1
enabler - new schedu	0	0	0	0	1	0	0	0	0	0	0	0	1
enabler - outside co	0	0	0	0	0	0	1	0	0	1	0	0	2
experience - change	1	2	0	0	0	0	3	0	2	0	0	0	8
experience - curricu	1	1	0	0	0	0	0	0	0	0	0	0	2
experience - diabeti	0	0	1	0	0	0	0	0	0	0	0	0	1
experience - health	0	0	0	1	0	0	0	0	0	0	0	0	1
experience - lack of	0	0	0	1	0	0	0	0	0	0	0	0	1
experience - little	0	0	0	0	0	1	0	0	0	0	0	0	1
experience - not eno	0	0	2	0	1	0	0	0	0	0	0	0	3
experience - enabler	2	1	1	0	1	1	0	1	0	0	2	1	10
experience - right a	0	0	0	0	0	0	1	0	1	0	0	0	2
experience - socio-e	0	0	0	0	0	0	0	0	0	0	0	1	1
experience - workload	1	0	1	0	0	0	0	0	1	1	0	0	4
facilitation - adequ	4	2	0	2	2	0	2	0	1	0	0	0	13
facilitation - inadequ	0	1	0	0	0	0	0	0	0	4	0	0	5
feedback from champi	0	0	0	0	0	1	0	0	0	0	0	2	3
future action planni	0	0	0	0	0	0	1	0	1	0	0	0	2
future action planni	0	0	0	0	0	0	1	0	1	0	0	0	2
impact - expansion	0	1	1	0	2	0	0	0	0	1	0	1	6
impact - cooperation	0	0	1	0	0	0	0	2	0	0	0	0	3
impact - evaluate	1	0	0	0	1	0	0	1	0	0	0	0	3
impact - excitement	0	0	0	0	1	0	0	0	0	0	0	0	1
impact - fun walk	0	0	0	0	1	0	0	0	0	0	0	0	1
impact - guilt	0	0	0	0	0	0	0	0	0	1	0	0	1
impact - needs/sugge	2	0	3	2	1	0	3	3	5	1	0	1	21
impact - planning	1	0	0	0	2	0	0	0	1	0	3	0	7
impact - enabler	0	0	0	0	0	0	0	0	1	0	0	0	1
impact - results	0	0	0	0	0	1	0	0	0	0	0	0	1
impact - tuckshop	0	0	0	0	0	0	0	0	0	1	0	0	1
impact - visibility	0	0	0	0	0	1	0	0	0	0	0	0	1
perception - content	2	1	1	0	1	0	0	0	0	0	0	0	5
perception - extra w	1	1	0	0	0	0	0	0	0	0	1	0	3

perception - negativ	0	1	0	2	0	0	1	0	2	0	2	2	10
perception - positiv	0	2	1	0	2	2	1	6	0	1	4	3	22
resource toolkit - a	0	0	0	0	0	0	1	0	0	5	0	0	6
resource toolkit - c	1	0	0	0	1	0	0	0	0	0	0	0	2
resource toolkit - e	0	1	0	0	0	0	0	0	0	0	0	0	1
resource toolkit - f	0	0	0	1	0	0	0	0	0	0	1	0	2
resource toolkit - l	0	0	0	1	0	0	0	0	0	0	0	0	1
resource toolkit -	0	1	0	0	0	0	0	0	0	0	2	0	3
role - curriculum	0	0	0	0	0	0	0	0	0	0	0	1	1
role - give access	0	0	0	0	0	0	0	0	0	0	0	1	1
role - involvement	0	0	3	0	0	1	0	3	0	0	0	1	8
role - left out	0	0	0	0	0	0	0	1	0	0	0	0	1
role - resource tool	0	0	0	0	0	1	0	0	0	0	0	0	1
role - workload	0	0	0	0	0	1	0	0	0	0	0	0	1
school's own initiat	1	0	0	0	0	0	0	0	0	0	0	0	1
successes - behaviou	0	0	0	2	2	0	0	0	0	1	0	0	5
successes - cancer/d	0	0	0	0	0	0	3	0	3	0	0	0	6
successes - self-eff	0	0	0	0	1	0	0	0	0	0	0	0	1
successes - too earl	1	1	0	0	0	0	1	0	0	0	0	0	3
teachers workshop -	0	0	0	0	0	0	1	0	0	0	0	0	1
thanks!/gratitude	0	0	1	0	1	0	1	1	1	1	0	0	6
workshop	0	0	0	0	0	0	0	1	0	0	0	0	1
zones - curriculum	1	2	0	0	1	0	0	0	0	1	0	0	5
zones - not comprehe	0	1	0	0	0	0	0	0	0	0	0	0	1
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Totals	22	25	20	27	30	14	33	19	34	28	20	20	292