OUTCOME EVALUATION OF A HEALTH PROMOTING SCHOOL APPROACH INTERVENTION: AN IMPACT ANALYSIS OF MENTAL HEALTH OUTCOMES AMONG HIGH SCHOOL LEARNERS IN THE CAPRICORN DISTRICT, LIMPOPO PROVINCE.

By

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DEDICATION

I dedicate this thesis to my children Unathi, Thabisile and Madikabje. They give me such joy, hope and assurance that God is good all the time and that His mercies are new every morning.

DECLARATION

I declare that this thesis hereby submitted to the University of Limpopo for the Degree of PhD in Psychology has not been previously submitted by me for a degree in this or any other university and that it is my work in design and execution, and that all the material contained here has been duly acknowledged.

SIGNED AT _____________ ON THE __01__DAY OF OCTOBER 20 20

R C LANGA (MS)

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ABSTRACT

This thesis is an evaluation of a study that focused on the health promotion of learners in schools. The study evaluated the process of health promotion in the schools focusing on the school's compliance as health-promoting schools in line with the WHO principles, the intervention process that includes training of students in health promotion and assessing the impact of such intervention. The intervention was delivered by Life Orientation (LO) Educators over nine months. The thesis aimed to evaluate if learners who have been exposed to the health-promoting school programmes will exhibit more confidence in avoiding and refusing to indulge in mental health-related risky behaviours than those who were not exposed; and whether the WHO health-promoting school approach compliance can be modified to establish site-specific agenda regarding mental health.

Twenty schools in two circuits within Capricorn district in Limpopo province participated in the evaluation process using eighteen schools that took part in the whole school intervention project of LASH project. Data was collected for process evaluation and impact analysis of the intervention. Process evaluation used data collected from the interview reports of LO Educators who implemented the project at schools and thus evaluated the process of their experience with the project. The impact analysis was done using data collected from the participants at baseline and a follow-up after nine months using a self-administered questionnaire. The process evaluation findings showed that the degree of understanding of the expected implementation objectives was not standardised and was not done according to the initial plan as well as following the contextual needs. Factors that came out explicitly as hindering the desired effect included neglect of key methodological aspects meant to enhance and validate the experiential report by the Educators namely classroom observation and logbook reports; specialisation of the topics for the intervention and lack of training manuals specific for the task; lack of adequate capacity building for staff, the schools to take charge of the process and neglect of the needs to avoid challenges for contextualrelevance. However, it is worth noting that the introduction of the process was done under the systematic recommendation by WHO with the schools adhering to the basic principles for health promotion outlined by WHO. The impact analysis evaluation highlighted some negative and positive results ofthe study. Positive results

on the impact of the intervention elicited factors such as the development of learners' assertiveness, learners' utilisation of available policies in the school for their daily activities and change in risky behaviour. The gaps noted above were in the region of methodological aspects, capacity building, context-related challenges and recommendations were made in the areas of (i) enhancement of methodological gaps that were neglected in the main study; this included the utilisation of logbooks and classroom observation that were planned and did not materialise as well as more succinct validation of some items in the questionnaires that seemed to have created ambiguity in some responses ii) development of specific training manual for health promotion and not use of ad-hoc topics separately developed with limited capacity for comparability between schools iii) capacity building of staff to take full charge and act as role models for the learners and not feel compromised; iv) capacitation of the school management to assist with the daily logistics and enhancement for implementation especially at school level v) planning process that contextualise the needs of the schools involved. The project was ground-breaking work of whole school health promotion with promise in the behaviour changes of learners and their empowerment and aggressive outlook on the difficult school based challenges around substance abuse, violence and sexual behaviour. Such work could in future benefit from studies that are both theory and evidence-based which will use validated and contextualised realistic methods guided by the findings of pilot studies which was missing in this project.

CHAPTER 1

ORIENTATION OF THE STUDY

1.1 Introduction

The health of adolescents is an important component of public health in any country, and it has a significant impact on national development. World Health Organisation (WHO,1946) defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. According to this definition, it becomes clear that mental health becomes part of holistic health.

According to WHO, ill-health is generally caused by unhealthy environments, inadequate or inappropriate health services (WHO, 1946). Brook, Morojele, Brook and Rosen (2005) indicate that in the sub-Saharan Africa common health problems among adolescents include sexually transmitted infection (STIs), HIV/AIDS, parasitic diseases, malnutrition, injuries, dental health problems, and mental illness (WHO/AFRO), with the latter being associated with adolescents' use of alcohol, cannabis (marijuana) and cigarettes. Furthermore, Degenhardt and Wall (2006) state that there is a link between cannabis use and schizophrenia and between methamphetamine use and various psychiatric disorders (Yen & Chong 2006; Russell et al., 2008). This link in itself suggests that young people are at risk of suffering from mental illness.

According to the World Health Report by WHO (2002), 8.9% of global disease burdens attributed to psychoactive substance use. Tobacco and alcohol are responsible for a major part (8.1%) of the disease burden, with alcohol being the top risk factor for health in low mortality developing countries. Tobacco, alcohol and illicit drugs are responsible for 12.4% of all deaths worldwide (WHO,2002).

Mental health is as important as physical health to the overall well-being of individuals, societies and countries. Like many physical illnesses, mental and behavioural disorders are the result of a complex interaction between biological, psychological and social factors. For all individuals, mental, physical and social health is vital strands of life that are closely interwoven and deeply interdependent. As the understanding of this relationship grows, it becomes even more apparent that mental health is crucial to the overall well-being of individuals, societies and countries (WHO, 2001).

According to Prince et al. (2007) adolescents are at risk of developing ill-health. Therefore, mental health promotion becomes even more important to guard against the succumbing of adolescents to risky behaviours and equipping them with resilience when faced with such threats.

Health-promoting school approach is used as a point of departure for this project. According to WHO (1986), health-promoting school is defined as a school that constantly strengthens its capacity as a healthy setting for living, learning and working, and which:

1) fosters health and learning; 2) engages health and education officials, teachers, teachers' unions, learners , parents, health providers and community leaders in an effort to make the school a healthy place; 3)strives to provide a healthy environment, school health education, and school health services along with school/community projects and outreach, health promotion programmes for staff, nutrition and food safety programmes, opportunities for physical education and recreation, and programmes for counselling, social support and mental health promotion; 4) implements policies and practices that respect an individual's well-being and dignity, provide multiple opportunities for success, and acknowledges good efforts and intentions as well as personal achievements; 5) strives to improve the health of school personnel, families and community members as well as pupils

and 6) works with community leaders to help them understand how the community contributes to - or undermines - health and education (WHO,1986).
The potential effect this type of project might have on the mental health of in-school adolescent is not widely documented, and in South Africa, the studies that were conducted to evaluate Health Promoting School were not specifically for mental health and none was conducted in Africa as indicated by Mukoma and FLisher (2004); hence the scarcity of documentation about the practical application of the programme in the South African context. It is this lack of documentation that necessitate the need to evaluate the Health Promoting School Approach Intervention, particularly with identifying profiles for the sustainability of mental health promotion. Therefore, this study forms part of the broader study explained above in that it is going to evaluate the effect that the broader study had on the mental health of learners.

1.2. Background of the study

It is estimated that by the year 2020 mental health problems will become the greatest burden of disability in the developed world (Murray & Lopez, 1996). According to the WHO (2001) many of today's and tomorrow's leading causes of death, disease and disability (cardiovascular disease, cancer, chronic lung diseases, depression, violence, substance abuse, injuries, nutritional deficiencies, and HIV/AIDS/STI infections) can be significantly reduced by preventing: 1) tobacco use, 2) behaviour that results in injury and violence 3) alcohol and substance use 4) dietary and hygienic practices that cause disease 5) Sedentary lifestyle, and 6) sexual behaviour that causes unintended pregnancy and disease.

The transition from adolescence to healthy adulthood which in this case includes a healthy mind is dependent on the environment in which young people live, as well as the family and community structure that they are exposed to. However, their lives are being compromised by disease, depression, violence and substance use. South Africa is one of the countries with a large young population group that

is vulnerable to the health problems mentioned above, where a high number of people are living with HIV and AIDS and the majority of new cases occur in young people 15 to 24 years old and that it has a rising prevalence of substance use, violence and road-related accidents (Parryet al., 2004; Wild, Flisher, Bhana & Lombard, 2004).

In a study of mental health among 15 - 19-year-old youth in five cities globally, female adolescents from Johannesburg reported the highest levels of depression and post-traumatic stress symptoms (44.6% and 67.0%, respectively) (Chenget al., 2014).
In the Limpopo Province of South Africa, secondary school learners in urban areas start using any substance at the age of 16 or less (Peltzer Cherian & Cherian 1999). The most used substance in Limpopo among adolescents is cannabis (Madu & Matla, 2003) and later moved to nyaope which is becoming a major problem in the province and many other parts of South Africa. When compared to other age groups, adolescents are likely to engage in experiences and behaviour that may impact negatively on a person's life course and mental health (Richter, 2006).

Across the globe, adolescents living in impoverished areas are vulnerable to widespread exposure to substance abuse and violence in the home, school and neighbourhood, whereas exposure to violence increases the probability of youth involvement in violence (Van der Merwe & Dawes, 2007). According to Petersen, Swart, Bhana and Flisher (2010), there is an association between the risk behaviour that the adolescents engage in and them dropping out of school, especially the youth living in impoverished, marginalized areas of South Africa (Wegner, Flisher, Muller, & Lombard 2006).

Mental health promotion among adolescents in South Africa has been dealt with as part of the national life-skill programme which was introduced in 1995 and implemented in 2005. In reviewing such programmes, Mukoma and Flisher (2004)

found that this type of programme has a positive impact on knowledge, attitudes and communication. However, their impact on actual behaviour change is rather limited. A mental health promotion programme implemented under a shadow of a fixed approach may not work in other contexts if distinctive barriers to its practicality are not taken into consideration. A tailor-made approach to suit a specific context and that will take into accounts the unique situation that a particular setting may find itself may be effective since it will be taking into account the elements that may put the programme under threat both for implementation and sustainability (Mukoma & Flisher, 2004).

High quality, systematic rigorous evaluation and ongoing monitoring procedures are essential to successful intervention programming. Special attention needs to be paid to the evaluation of programmes using the best research design available. The future development of mental health promotion needs to be based on sound knowledge and evidence base and this demands that appropriate evaluation framework and research methods are applied which are capable of reflecting the complexity and creativity of contemporary practice (Mukoma & Flisher, 2004).

Attempts to evaluate its effectiveness have been made by several researchers. Steward-Brown (2006) produced a report "What is the evidence on school health promotion in improving health or preventing deseaces? where he reviewed articles which covered a whole lot of topics including mental health, prevention of substance use, promotion of healthy eating and physical activities and found that no studies have researched initiatives that adopted all the component of the HPS approach and that it is not always the case that programmes will be effective but that programmes to promote some aspects of health are more effective than those that promote other aspects.

Mukoma and Flisher (2004) in their review did not find any evaluation of health-promoting the school in Africa which was also the case with Deschense, Martin and Hill (2003) in their review of literature where they concluded that evaluation

results are still few and inconclusive as to how to operationalize the global nature of the HPS approach.

According to Waggie, Gordan & Brijla (2004), many educators do not initiate or sustain the concept of HPS. It is viewed as an additional task by which they are not assessed and which is the duty of the Department of Health and Social welfare. In any health programme, a key element of success has to do with achieving optimal contact with the defined target population including but not limited to program reach, acceptability and integrity.

The outcome evaluation will therefore measure the effects or the benefits that can be attributed to the programme implemented to the end-users. As much as the process answers the how part of the evaluation this part answers the what part. What happens to the learners or participants after they have received the intervention? What could be pointed out as a piece of evidence to show whether the intervention worked or did not work?

This is to say that the health behaviour associated with mental health will be improved and participants will among other things, as an example, report to be having a high level of confidence in refusing indulgence in risky health behaviours as compared to before they were exposed to the intervention.

It can almost be challenging to evaluate the outcome of a programme about a particular aspect without evaluating the process undertaken to lead to such. Therefore, process evaluation comes to play as a pivotal component for associating the outcome with an intervention conducted. In other words, it can assist in terms of identifying factors that could facilitate or hinder the process. It will also determine whether the programme was implemented as intended. This will also assist the researchers to put into context findings of the study by Branscum, Sharma, Wang, Wilson, and Rojas-Guyler (2013) which is often a time not taken into consideration when programmes are evaluated.

Research has found that schools need to use a whole school approach to promote mental health effectively (Weare & Markham, 2005). furthermore, schools are potentially one of the most effective agencies for promoting health, including mental health (Weare, 2000). In their review of a universal approach to mental health promotion in school Wells, Barlow and Stewart-Brown (2003) found that the effectiveness of school-based programmes on mental health was from programmes that used a whole school approach and were implemented on a long term basis. It needs to be considered that its effectiveness concerning mental health has not yet been established in South Africa (Mukoma & Flisher 2004).

Given this background, it becomes important to evaluate mental health promotion interventions' sustaining factors so that the interventions are not implemented homogenously without putting them into context, but be informed by their practicality and effectiveness. Therefore, this study attempts to respond to that need by evaluating both the process and outcome of a health-promoting school approach intervention (LASH) among learners, by looking at its effectiveness concerning mental health and tendencies associated with it. The current study is part of a broad project called LASH whose aim was to design and implement an intervention project for health promotion in South Africa and Tanzania.

1.2.1. Description of the main study

To understand the context of the current study it becomes necessary to describe the main project to give meaning to the current study. The main study was a collaborative project between South Africa (Limpopo province) and Arusha province in Tanzania and thus came to be called Limpopo Arusha School Health (LASH) project.

- **The LASH Project**

The intervention process that is being evaluated in the current study was developed and implemented as part of the broader study of the LASH project, whose aim was to design and implement a comprehensive intervention programme to promote the health of in-school adolescents in Tanzania and South Africa (Limpopo Province). Each local team conducted a situation analysis study to determine their local needs for the intervention design. The intervention aimed at using a health-promoting school approach in conducting an intervention and policies targeting WHO identified behavioural categories, which are prioritized according to their level of seriousness per school. The project involved three phases viz. the intervention development; planning of the intervention and implementation of the intervention.

Phase 1 : **Intervention development**

In Limpopo Province, the intervention was developed and implemented. It was delivered by educators who are teaching Life Orientation in the government schools. These educators work with learners between 14 and 18 years of age. The development of the programme was based on a thorough analysis of health-related determinants and of modifiable factors at the individual level and within the family, school and local community environment. The WHO health-promoting school approach was taken as a point of departure for developing the intervention.

The Intervention Mapping (IM) procedure applied by Bartholomew, Parcel, Kok and Gottlieb (2001) was applied for intervention development. This is the stepwise approach to ensure systematic evidence-based and theory-driven development and implementation of health promotion interventions. It provides guidelines with regards to the selection of specified intervention goals, choice of intervention strategies and the development of intervention tools. It also prepares the adoption, implementation and evaluation of the intervention programme making it an important tool for being able to bring out the relevant context for the development,

planning and evaluation of a programme (Bartholomew, Parcel, Kok & Gottlieb, 2001). For an example, kok, Schaalma, Ruiter, Empelen and Brug (1994) and Orlandi, Landers, Weston, and Haley (1990) explain one of the important principles of IM as being able to bridge the gap between programme development and evaluation on one hand, and planning of diffusion & adoption of the programme on the other.

Phase 2 : The intervention plan

The outcome of the IM process was, (1) situation analysis (2) formation of expert panel, (3) training of LO educator in preparation of conducting the intervention, (4) strategies to be used during implementation, (5) Logbook for both the LO educators and LASH staff, (6) an inventory for health-promoting school-related services conducted and a place in schools and (7) topic guide that was to be followed by the LO educators as an intervention. These topics were in line with the LO curriculum which is compulsory for all learners in all government schools up to grade 12.

LO curriculum addressed six areas that are seen as key for producing a well-rounded learner: (1) Health Promotion; (2) Social Development; (3) Personal Development; (4) Physical development and Movement; (5) and the World of Work. This period is allocated two hours per week per class. As a result, learners are exposed to the subject content for 8 hours a month. The aim of this subject is in line with what the Health Promoting School aims to achieve which is to produce learners that being guided and prepared to respond to life's responsibilities and opportunities by equipping them to interact optimally on a physical, psychological, cognitive, motor, moral, spiritual, cultural and socio-economic level. (Department of Education, National curriculum statement 2011). The areas that were of interest to the HPS programme were those of health promotion.

The LO educators were at liberty to utilise whatever strategy seem relevant to execute a particular topic. They were to deploy conducive methods suitable for age and appropriateness of the environment.

The educators were each given a logbook to record the activities that took place during implementation and to take note of deviation and or reason for such. The purpose of this logbook was to serve as a tool for process evaluation. It would help to identify site-specific implementation process and practicality of implementing the programme in different context given the complexity of schools in terms of resources allocation and availability.

Phase 3 : Implementation

The programme was implemented by trained LO educators over nine months. The LO educators were chosen on the basis that they were already implementing a programme that covered these topics. It was not intended by the LASH programme to replace the LO lesson but rather to put more emphasis on topics that formed part of the HPS. One of the strategies that were to be employed was the use of an expert panel who agreed to be part of the programme at respective schools. These panels were to be consulted during the facilitation of modules related to their scope of work. The programme was implemented over nine months with the intervention schools, whereas the control school continued with their usual LO curriculum as expected by the department of education. The control school were allowed to continue with any arrangement they had for additional intervention including health promotion related projects. The LASH programme focused more on the area that is related to health promotion. The implementation took place during the L O periods. This means that it did not require extra time or arrangement outside school hours for implementation.

1.3 Contexualising the current study

The current study is the evaluation of the main study described above. It utilized data from the processes done in the main study as secondary data. This included school profiling, the baseline survey for general learner behavioural and health profiling, description and implementation of an intervention process to evaluate the quality of the intervention, its sustainability and how the process of its implementation can be used for the future in the schools.

Even though whole school approach seems likely to be effective and its success has been documented by Rivers et al., (2000), currently there is, however, little evidence which reliably links a whole school approach to improvements in mental health or other outcomes (Lister-Sharp, Chapman, Stewart-Brown, & Sowden, 1999). Without overlooking the fact that enormous potential of the school as a setting for mental health promotion has been endorsed in recent years and that it has been reported that schools can and should help prevent suicide and enable children and adolescents to develop sound and positive mental health (WHO, 2001). Systematic reviews have shown that not all interventions are effective and that promoting young peoples' mental health through the school system is a challenging business (Harden et al., 2001).

It is important to note that these reviews were mainly conducted in either United State of America (US) or United Kingdom (UK) and that such evaluation of effectiveness has not been conducted in Africa, hence the scarcity of documentation about the practicality of Health Promoting School in the South African context (Mukoma & FLisher, 2004). This study, therefore, responds to this need for documenting the effectiveness of a health-promoting school approach to mental health in Africa.

The health of adolescents is an important component of public health in any country, and it has a significant impact on national development. World Health

Organisation (WHO, 1946) defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. According to this definition, it becomes clear that mental health becomes part of holistic health.

Therefore, this study forms part of the broader study explained above in that it is going to evaluate the effect that the broader study had on the mental health of learners. The participants for this study will be sampled from the ones in the main study.

1.4 The Problem Statement

WHO, in collaboration with the World Bank, has estimated that by the year 2020 mental health problems will become the greatest burden of disability in the developed world (Murray & Lopez, 1996). There are still misconceptions about what mental health is and what kind of effort is necessary to promote mental health. It, therefore, becomes clear that there is a need to develop, implement and carefully evaluate the effectiveness of health promotion with the emphasis being put on mental health.

Evaluation becomes important not only for assessing the effectiveness of the programmes but also to give direction for the implementation of new programmes, and the cost-effectiveness of such programmes (Coleman & Ford, 1996). According to Mukoma etal. (2009) it is also for designing future interventions and planning for larger-scale dissemination of school-based programmes. This is so because in South Africa there are very few trained health promotion specialists either capable or in the position to inform politician and opinion leaders about the relationship between health and social determinants, and the evidence of the effectiveness of health promotion actions (Onya, 2007).

In an attempt to establish the current situation, a review of studies designed to evaluate health-promoting school initiatives was conducted by Mukoma and Flisher, (2004) and the available data point to the potential of these initiatives in terms of influencing various domains of health for the school community through successfully changing the school curriculum and policies.

Even though both published and unpublished reports were searched, the authors were able to identify only nine studies, none of which had been conducted in Africa, hence the scarcity of health-promoting school initiatives in African settings, especially about mental health. Furthermore, evaluation data indicating how this initiative is perceived by learners, school personnel, families and other community members in Africa are lacking. Equally lacking, as a result, is the potential impact these programmes might have on the health of learners and others. This lack of documentation represents a critical barrier to larger dissemination and improved practice across the 32 African countries currently trying to implement this initiative.

1.5. Research Questions

- To what extend do the schools have capacity to promote a safe environment and developing healthy public policy with subsequent improvement of learners' confidence and avoidance of risky behaviours?
- Does the intervention match up to the standards set out by WHO with regards to programme reach, integrity and accessibility?
- What is the impact of the intervention programme on the learners' mental health?

1.6 Aim of the study

The study aimed to conduct process and outcome evaluation of a health-promoting school approach (LASH) intervention with regards to mental health among high school learners in the Capricorn district in Limpopo Province.

1.7. Objectives of the study

The objectives of the study were:

- To assess the schools' adherence to WHO key areas of becoming health-promoting schools by demonstrating the capacity to promote a safe environment and developing healthy public policy with subsequent improvement of learners' confidence and avoidance of risky behaviours.
- To evaluate the LASH intervention programme within the context of programme reach, integrity and accessibility as well as the process evaluation of the programme implementation and the gaps associated with the challenges.
- To conduct an impact analysis of the intervention programme on the learners' mental health

1.8. Hypotheses

This study tested the following hypotheses:

- Schools that were exposed to the LASH program will exhibit changes in the WHO areas of improvement of promoting a safe environment; developing healthy public policy
- Learners who have been exposed to the health-promoting school programmes will exhibit more confidence in avoiding and refusing indulgence in mental -relatedrelated risky behaviours than those who were not exposed.
- Learners partaking in health-promoting-promoting school intervention programme will report a decrease in their indulgence in risky behaviours and show a change in mental health compared to before being trained.

1.9 Significance of the study

In South Africa, a White Paper on the transformation of the health system in the country presented in 1997, specifically outlined the role of health promotion in the improvement of health for all South Africans. The Policy Guidelines for Youth and Adolescents Health particularly aims to promote healthy development for all young people. Health-promoting school activities have been implemented in developing countries, but their experiences have not been fully shared (Yoshimura et al., 2009). Therefore, this study will contribute to documenting:

- The enabling factors and distinctive barriers associated with the implementation of the health-promoting school intervention.
- Its impact on mental health and improving the learners' confidence level on avoiding being involved in risky behaviours.
- Things to consider for future evaluation of such type of programmes is to contextualize the health-promoting school intervention model to suit the rural South African context.
- Its implications for policy and development of cross-curricular collaboration approach to the health of a high school learner, since health promotion in schools is not just about encouraging children and young people to eat well and to exercise; it encompasses a much broader holistic approach which includes promoting the physical, social, spiritual, mental and emotional well-being of both staff and learners (www.1scotland.org.uk.healthpromoting schools/index.asp.)
- The progression of the monitoring and evaluation tool design that can be used in evaluating school-based health promotion interventions.

1.10 Chapter summary

The chapter introduced the main elements of the study as an evaluation study of the effect of health Promotion school project (HPS) in South Africa. This was done by giving the background of the study and explaining the implementation of the LASH intervention which the study aims to evaluate. The aim, objectives and the hypotheses for the study were outlined as well as the significance of the study. The study aimed to evaluate the of HPS (LASH) intervention, by assessing the implementation process and the effect the intervention had on the mental health of the learners. There are six other chapters in this thesis: Literature review; theoretical framework; methodology; findings divided into two sections; discussion of the findings; conclusion, limitations, recommendations from the study and future research. The following chapter will focus on the review of literature according to the aim of the study.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

In this chapter review of literature is presented to ensure the understanding of the concept of health promotion. In particular, focus is more on the evaluation of similar studies from other countries with emphasis put on the findings of the evaluations to establish whether health-promoting school approach is effective in promoting mental health and the behaviours associated with it as well as its universality in implementation.

Children and youth account for over 50% of the South African population. The majority of these children and youth are from disadvantaged backgrounds and the majority of these children fall under the category of children with special needs. They grow up in poverty, have been subjected to physical, emotional, and/or sexual abuse, have experienced or witnessed various forms of violence in their families and communities; and some are addicted to alcohol and habit-forming drugs. Such children are at risk of various mental health problems. Examples of such problems are anxiety states; attention deficit hyperactive disorders; post-traumatic stress disorders; behavioural and antisocial disorders; and depression that may result in suicide (Tshotsho, accessed 2011/11/14)

According to Tshotsho (2011), one of the key priority areas identified in the intervention framework of the national health policy guidelines for improved mental health in South Africa is the introduction of Life Skills Education for children and adolescents which is critical to such issues as substance-abuse prevention, teenage pregnancy, HIV/AIDS prevention, violence reduction, and child abuse. The development of such skills is crucial to the promotion of both physical and mental well- being.

2.2 HEALTH PROMOTING SCHOOL APPROACH

2.2.1 WHAT IS A HEALTH PROMOTING SCHOOL?

A health-promoting school is one that constantly strengthens its capacity as a healthy setting for living, learning and working. A health-promoting school according to WHO (WHO, 2011):

- Fosters health and learning with all the measures at its disposal.
- Engages health and education officials, teachers, teachers' unions, students, parents, health providers and community leaders in efforts to make the school a healthy place.
- Strives to provide a healthy environment, school health education, and school health services along with school/community projects and outreach, health promotion programmes for staff, nutrition and food safety programmes, opportunities for physical education and recreation, and programmes for counselling, social support and mental health promotion.
- Implements policies and practices that respect an individual's well being and dignity, provide multiple opportunities for success and acknowledge good efforts and intentions as well as personal achievements.
- Strives to improve the health of school personnel, families and community members as well as pupils; and works with community leaders to help them understand how the community contributes to or undermines, health and education.

A health-promoting school would foster health with all the measures at its disposal; engage health and education officials, teachers, teachers' unions, learners, parents, health providers and community leaders in efforts to make the school a healthy place as well as striving to provide a healthy environment, implement policies and practices that respect an individual's well-being, improve the health of school personnel, families and community members as well as pupils.

The HPS concept provides the basis for the spreading of health ideas and practices from the school to the community. The Health Promoting School, networks and links up with other schools in this process and may become a model for other schools. A sense of ownership of self and the school is established and self-respect is reinforced and as a result, the health status of the learners, educators, community and the environment is enhanced (KZN Department of Health, 2001).

The health-promoting approach calls for a significant change in the manner in which schools and their staff run their school health. This may mean changing from the normal way of teaching health education in a classroom to a more comprehensive, incorporated construct of health-promoting activities that will dwell on the learners' attitudes, behaviour and their environment.

Health-promoting schools focus on:

- Caring for oneself and others
- Making healthy decisions and taking control over life's circumstances
- Creating conditions that are conducive to health (through policies, services, physical/social conditions)
- Building capacities for peace, shelter, education, food, income, a stable ecosystem, equity, social justice, sustainable development.
- Preventing leading causes of death, disease and disability: helminths, tobacco use, HIV/AIDS/STDs, sedentary lifestyle, drugs and alcohol, violence and injuries, unhealthy nutrition.
- Influencing health-related behaviours: knowledge, beliefs, skills, attitudes, values, support (WHO,2011).

2.2.2 Where does the health promoting schools approach come from?

The health-promoting schools approach was initiated by the World Health Organization (WHO). It came about from the WHO initiative for health promotion as described in the Ottawa Charter for Health Promotion (WHO,1986). The health-promoting schools approach uses the principles and five action strategies of the Ottawa Charter to the school setting.

2.2.3 Rationale for health promoting schools

The schools have enormous potential as a setting for health promotion. They provide a valuable site for community-based education. This is where the integration of services is made possible and viable (Waggie, Gordon & Brijlal, 2004).

Most schools experience a wide range of health problems. Some of these problems lie within the school itself. Others are problems of the surrounding community, which impact on the school environment and the health of its learners and staff. Efforts to address these problems often fail and result in discouragement.

The HPS concept provides the basis for the spreading of health ideas and practices from the school to the community. The Health Promoting School, networks and links up with other schools in this process and may become a role model for other schools. A sense of ownership of self and the school is established and self-respect is reinforced and as a result, the health status of the learners, educators, community and the environment is enhanced (KZN Department of Health, 2001).

2.2.4 Aims of the health promoting schools

The health-promoting school aims at achieving healthy lifestyles for the total school population by developing supportive environments conducive to the promotion of health. It offers the opportunities for and requires commitments to, the provision of a safe and health-enhancing social and physical environment [Parsons (1997), cited in (Deschesnes, Martin & Hill, 2003)].

The health-promoting needs to be flexible and be tailored according to the context of the setting. In other words, no content can be implemented the same way in different contexts, Darlington (2018).

According to Turunen, Sormunen, Jourdan, von Seleen and Buijs (2017), one of the reasons could be because the achievement that the health promotion programmes aim to attain are multi-level and complex, and that the most of the time these get revealed on interventions that are longer which incorporate multifaceted interaction between the audience and their living environments.

The health promotion approach has the potential of improving the social and well-being of young people provided they are implemented over a longer period (Barry, Clarke, Dowling, 2017)

2.3.1. Health Promotion in other Parts of the world

In Europe there is a European health promoting school network which was launched in 1993. The Department of Education in England has since launched the Healthy Schools Rating Scheme, whereby schools are encouraged to participate in order to see how well they are doing in response to health matters. It is however acknowledged that the monitoring of the programme has been minimal without sufficient follow-up activities on the programme which was already well integrated with health department of the country, (Cheater, 2019).

In Africa the Health Promoting School approach is embraced by about 32 countries. Even though this is the case, it is still believed that the continent as a whole still need strong political action, broad participation and sustained advocacy for the initiative to meet its desired outcomes (Macnab, Stewart, & Gagnon, F. (2014). This served as a motivation for the study that is being evaluated by the current study to look at the impact of the intervention programme of school health promotion approach for Africa with indepth focus on the regional evaluations including South Africa and Limpopo as one of the rural provinces for a start.

2.3.2. Health promotion in South Africa

Health promotion first entered the South African health system around 17 years ago. At that time old-style health education and family planning advisers and others were deployed into new health promotion services. The result of this deployment was that many people entered this new service without any formal training in health promotion and without even a clear picture of what health promotion could offer South Africa and how it differed to its predecessor, health education.

To some extent, this confusion has continued. For example, there are still very few training opportunities for South Africans in health promotion, although there is a recent national initiative through the Department of Health to establish a programme of health promotion training in tertiary institutions in South Africa. However, the slow development of training opportunity has led to a capacity gap in health promotion in South Africa today. Few people in the health service are adequately qualified to provide leadership in health promotion.

The national policy for health promotion practice in South Africa is also based on the principles and approach of the 1986 Ottawa Charter for health promotion. The health-promoting schools project is a good example of a programme of health action outside the health sector. However, this does not mean that the health sector does not have a critical role to play in health promotion.

Health Promotion is a Directorate located within the Social Sector Cluster (SSC) within Primary Health Care (PHC), District and Development operations which falls under the Deputy Director-General for Health Service Delivery in the National Department of Health (DoH) (Onya, 2007). The first significant piece of a new policy for health promotion in South Africa appeared in the African National Congress (ANC) health policy document, health care services including reproductive health care. At the moment, health promotion service delivery is the responsibility of the national, provincial and local governments with provincial and local governments mainly implementing and the National Health Promotion Directorate offering support (Onya, 2007).

The principles of an integrated, holistic and co-ordinated approach, quality assurance, capacity building, utilization of existing resources, ownership and sustainability, equity and redress were proposed as a guide to developing health-promoting school/sites in South Africa (Health Promotion Task-Team, 2000).

The health status of the people in South Africa must be considered within a historical, social and economic framework. Poverty, unemployment, poor social and physical conditions, such as lack of safe water and sanitation have impacted on the health status of the country. When South Africa gained independence in 1994 a large proportion of the population was seriously disadvantaged through grossly inadequate access to health services and health-related information. Child and adolescent health was a major concern in South Africa (Reddy & Tobias, 1994).

Most schoolchildren between 5 and 19 years of age exhibited unacceptable levels of mortality, morbidity, and risk-taking behaviours, most of which is preventable (Reddy & Tobias 1994). Many of these problems persist into adulthood and result in a range of chronic lifestyle diseases and increased health care and welfare expenditure (Flisher & Reddy, 1995)

To address these problems, pre-requisites for health such as nutrition, water and sanitation, healthy childhood development, child protection and social welfare must be addressed (Lazarus & Reddy 1996).

South Africa confirmed around 2006 that schools in all nine provinces were identifying themselves as health promoting schools, but it was realized that there was lack specific scientific monitoring and evaluation tool acclimatized to the HPS concept. The growth of the concept led to the development of various instruments among which was a questionnaire by Struthers, Wegner, de Koker, Lerebo and Blignaut (2017) for the validity and reliability of the South African health promoting schools monitoring. The aim of which was to be able to assess the opinions of students about their school being health promoting. This was regarded as important to inform inform modification, strength and deviations in the health promotion process according to context.

2.4. Mental health in South Africa

More and more, research demonstrates that mental health has a profound impact on a person's overall health. A recent review of studies designed to evaluate health-promoting school initiatives concluded that available data points to the potential of the health-promoting school in terms of influencing various domains of health for the school community through successfully changing the school curriculum and policies (Mukoma & Flisher, 2004). In South Africa, there are very few trained health promotion specialists either capable or in the position to inform politician and leaders about the relationship between health and social determinants, and the evidence of the effectiveness of health promotion action (Onya, 2007).

Despite efforts at improving management and prevention of non-communicable diseases, awareness campaigns often do not reach their targeted audiences, particularly in a rural area, while routine screening for risk factors is seldom achieved due to lack of skills and training among health workers. This has led the National Department of Health to consider health promotion as a priority area in its strategic plan, hence programmes such as:
(a) The Collaborative HIV/AIDS and Adolescent Mental Health Project (CHAMP).
(b) The Mental Health Information Centre of South Africa (MHIC).
(c) A Perinatal Mental Health Project: A women's mental health programme in Cape Town, South Africa. The programme is aiming at identifying women at risk or currently suffering from mental distress.

2.5 Sustainability elements in mental health programmes

According to Petersen et al., (2010) to achieve sustainable development and a consequent reduction in levels of poverty, a multi-sectoral response to development incorporating pro-poor economic policies in low-to-middle-income countries is required. This should include the promotion of mental health through promoting positive mental health outcome within the context of risk. Apart from increasing positive mental health, mental health promotion has an important role to play about mental disorder, in that positive mental health is a strong protective factor against mental disorder (WHO, 2004). In this positive sense, mental health is the foundation for well-being and effective functioning for an individual and a community.

As a programme progresses to more widespread implementation it becomes critical to identify what factors increase the potential for sustainability of effective interventions. There is a need to consider the organisational structures and policies that are necessary to support long-term maintenance and sustainability of quality programmes. According to Jane-Llopis (2005) factors to be taken into consideration are organisational capacity, quality training, funding, stability, commitment, and resources.

2.6 Threats to the sustainability of mental health promotion in schools

2.6.1 Unpredictable and non-linearity of programmes

According to WHO (2006), health-promoting schools can be messy. For an example planned activities often do not happen, and schools that are involved in a programme tend towards not being able to start the initiative at the same time and eventually different types of interventions may be implemented due to the circumstances surrounding each school. Some interventions are sometimes forgotten as schools struggle to achieve another target. It is therefore suggested by WHO (2006) that there is a need to understand why this messiness occurs and how it impacts on the programme.

Given the suggestions mentioned above, it becomes necessary that factors that can hinder or complicate the success of a mental health promotion need to be taken in

consideration and a strategy to deal with them need to be developed so that when developing a model for mental health promotion it be such that it suit the local context for a better understanding of those complexities and unpredicted outcomes while the intended and anticipated outcome is achieved.

2.6.2 Violence in schools

Violence in schools across South Africa has become common and is likely to impact negatively on children in several ways. Experience and exposure to violence in any environment at a young age increase the risk of later victimization as well as engaging in anti-social behaviour later in life.

The recently completed National School Violence Study (NSVS) undertaken by the Centre for Justice and Crime Prevention (CJCP) has established the exact extend of violence within South African school. In total, 15.3% of learners in primary and secondary school have been victims of some form of violence while at school, or immediately outside the school gates. Assault, sexual assault, rape or sexual harassment and robberies are all form violence that has been identified by learners of all ages, both boys and girls, as occurring within their school.

According to Reddy et al. (2003) bullying is a common phenomenon among school-going children in South Africa in that more than 50% of all boys and girls had experienced violence in the form of physical fighting. Limpopo province showed the highest prevalence of learners who had been assaulted by their boyfriends/girlfriends this was also the case with those that have been assaulted their boyfriends/girlfriends compared to other provinces. Most of these are found in grade 9. It is also important to note that in the Youth Risk Behaviour Survey (YRBS) Limpopo Province had the second-highest prevalence of gang membership and the highest of coercive sex and intimate partner violence. As part of injury/violence, another common problem among young people than old people is suicide. From the age of 15 suicides rise sharply and peak between the ages of 25 and 29 years (Reddy et al., 2003).

In addition to this Burton (2008) says it is more difficult to quantify forms of violence such as bullying or teasing, which are commonly associated with school environment. He

concluded that these experiences on violence highlight the need for a developmental approach to, and a more developmental understanding of, school safety, rather than focusing on individual aspects of the school or environment, it is therefore suggested that a 'whole school' approach be taken into consideration when dealing with violence in schools.

The impact of exposure to violence at a young age is well documented (Richter, Matthews, Kagura & Nonterah, 2018) pointing to television viewing habits as long-term predictors of child agreesion as wellas interpersonal violence leading to arrest and conviction later in life.

Deaths resulting from school violence are only part of the problem. Many young people experience nonfatal injuries. Some of these injuries are relatively minor and include cuts, bruises, and broken bones. Other injuries, like gunshot wounds and head trauma, are more serious and can lead to permanent disability.

Not all injuries are visible. Exposure to youth violence and school violence can lead to a wide array of negative health behaviours and outcomes, including alcohol; drug use; suicide; depression; anxiety; fear and many other psychological problems that can result from school violence.

2.6.3 Poverty

There are several obstacles, deficits and threats to health inherent in poverty. The poor are often exposed to dangerous environments, have stressful, unrewarding and depersonalising work, lack the necessities and amenities of life and because they are not part of the mainstream of society, are isolated from information and support.
Poverty is associated with many long-term problems, such as poor health and increased mortality; school failure, crime and substance misuse (Drever & Bunting, 1997).
Violence can be triggered by poverty in that poverty provides the breeding-ground for violence at home and in the school. Children were caught up in a vicious circle of pro- and reactive violence and socialized to accept violence as an instrument of empowerment (Burnnet, 1998). Across the globe, adolescents living in impoverished areas are vulnerable to widespread exposure to substance abuse and violence in the home, school

and neighbourhood, whereas exposure to violence increases the probability of youth involvement in violence (Van der Merwe & Dawes, 2007). According to (Townsend et al. in Petersen et al., 2010), there is an association between the risk behaviour that the adolescents engage in and them dropping out of school, especially the youth living in impoverished, marginalized areas of South Africa (Wegner et al., 2006).

Murali & Oyebode (2004) found a relationship between poverty and psychiatric disorders (Langner & Michael, 1963), suicide (Crawford & Prince, 1999), alcohol abuse (Harrison & Gardiner, 1999), and personality disorders (Lynam et al., 2000).

2.6.4 Substance abuse

Substance abuse is of major concern in South Africa. The use of substances is associated with serious social problems like crime, violence, accidents, risky sexual behaviour, scholastic problems, mental health and physical health problems. International research has also found the relationship between cannabis use and schizophrenia and between methamphetamine use and various psychiatric disorders (Yen & Chong, 2006).

In the National Youth Risk Behaviour Survey (NYRBS) conducted in South African high schools in 2003, 1 in 2 learners reported having had some drink (at least one drink of alcohol) in their lifetime. Their age of initiation of alcohol use was 13 years (Reddy et al., 2003). The Limpopo province is rated low (17.5%) when compared to the national average (23.0%) (Reddy et al., 2003). According to Mpofu, Bility, Flisher, Onya, & Lombard, (2005), teenagers in rural communities have higher levels of substance abuse compared to those in urban areas. It has also been found that alcohol use was a significant factor in different types of homicide in South Africa.

In Limpopo Province, South Africa, secondary school learners in urban areas start using any substance at the age of 16 or less Peltzer (1999) and the most used substance among them is marijuana (Madu & Malta, 2003). When compared to

other age groups, adolescents are likely to engage in experiences and behaviour that may impact negatively on a person's life course and mental health (Richter, 2006).

Over and above substance use being associated with psychiatric disorders it is linked with multiple factors which may put young people at a risk. According to Morojele, (2001); Brook, Morojele, Brook, & Rosen, (2005); Snyder, Milici, Slater, Sun, & Strizhakova, (2006); Parry (2004); Ziervogel, Morojele, Van de Riet, Parry, & Robertson, (1997-1998) and Morojele, London, Olorunju, Matjila, Davids, Kirstie, Rendall-Mkosi, (2009) such risk factors include the following:

- Societal/community factors

The easier it is for young people to access drugs the more likely they will be to use them and they would also be encouraged to use by the portrayal of drinking and drug use in films and advertisements.

- School and academic factors

It has been found that low academic aspiration and poor performance at school is related to adolescents' use of alcohol.

- Parental/family drug taking

Young people whose parents and caregivers use alcohol and other drugs are more inclined than are those who do not experience drug taking in their homes to also use them and that adolescents who are exposed to such behaviours are more likely to model it and to consider it acceptable

- Parental/family environment,

The amount and quality of the time that parent spends with their adolescent children are linked to those children's use of alcohol and other drugs.

- Peers/friends

The more alcohol and other drug users there are in the young person's circle of friends the more likely he or she is to use such substances. Sometimes peer pressure seems to lead to drug use, whereby young people are encouraged by their friends to use drugs.

- Individual factors

Young people who tend to engage in rebellious and deviant behaviour tend to also be prone to using drugs. Having a positive attitude towards drug use means that the young person views the behaviour favourably and he/she expects positive outcomes to outweigh the negative outcomes of the behaviour.

This becomes a key challenge for mental health and substance abuse control. Now the question is what could be done to control these challenges. It is very obvious that mental health is threatened by many factors and that when one is not mentally stable one can end up engaging in risky behaviours which may in turn cause challenges to one's mental health. It becomes evident that to deal with these challenges a holistic approach is needed. And this according to the Department of Health (2004) includes stronger leadership and better coordination of mental health programmes within the DoH in general, and better collaboration and integration of efforts with other government departments, in particular the Departments of Education, SA Police Services, Social Development, and Justice.

Therefore, structured ways of helping are necessary. The programmes addressing mental health issues need to be proactive rather than reactive. So far programme developers have been reacting to the situation presented to them and such programmes have not been targeting mental health holistically, they have been either targeting one element that contributes to the mental ill-health and neglecting other contributing factors, for an example substance abuse reduction programme may be facilitated not taking in consideration the coping skills and attitude of learners towards their socio-economic status which may lead to the programme to be in vain.

2.7 The complexity in implementing the health promoting schools

According to Darlington, Violon, & Jourdan, (2016), health-promoting school intervention needs to be flexible and be tailored according to the context of the setting. In other words, no content can be implemented the same way in a different context. Turunen et al., (2017) argue that the achievement that the health promotion programmes aim to attain are multi-level and complex and that the most of the time get revealed on interventions that are longer which incorporate multifaceted interaction between the audience and their living environments.

2.8 Evaluation process

2.8.1 The key issues in the development, implementation and evaluation of the HPS

According to Deschesnes et al., (2003), the key conditions needed to further the implementation of a comprehensive school health approach include; a negotiated planning and coordination to support comprehensive, integrated nature of the approach, inter-sectoral action to actualize the partnership between school, family and community, political and financial support from decision-makers as leverage for adequate implementation of a comprehensive approach and evaluation to develop effective interventions further.

According to Lee, St Leger, & Cheng, (2007) schools need to clearly understand the partnership with communities. That community partnership means working with the community to maximize the opportunities to promote school health rather than perceiving it as meaning resource acquisition such as the engagement of speakers for health talks or procurement of health resource kits.
Parry-Langdon Bloor, Audrey, & Holiday, (2003) state that schools need to realize that health-promoting initiatives should benefit the school community as well as

the education system as a whole. There is a need to acknowledge that multiple factors affect health and this may be addressed by measuring the impact of an intervention on inequalities in health as well as evaluating the process of engaging the community as partners in setting the health agenda.

Mohammadi., Nutbeam, Rowling, Khavarpour, (2010) here are some aspects of programme implementation that need to be taken into consideration and be put in place. These include; understanding of the complexity of schools and their functioning as a complex adaptive system, acknowledgement of the diversity between schools, adequate flow of information and experiences about health-promoting schools between schools and between schools and health sectors, effective interactions between schools and the health sector and between schools and parents regarding health, adequate feedback loop about school's performance on health-promoting schools, adequate rules to support schools to become health promoting schools and adequate credit attribution mechanism for health in schools. When these aspects are not properly done they can turn to be barriers (Mohammadi et al., 2010).

2.8.2 Various Evaluation Principles

The evaluation process includes important steps to be considered to be able to decide on the compliance to set standards. Various authors (Lochman, 2004; Dadds, Barrett 2001) have highlighted numerous aspects that need to be satisfied in an evaluation process to conclude on the effectiveness or non-effectiveness of implementation of interventions.

The necessary principles that can make an intervention for a targeted audience to work and thus also be used to evaluate implemented programmes include: the theoretical basis underpinning the programme, clarification of the goals and objectives, Programme provider training and support; Evaluation and high-quality research; Infrastructural support from management; Programme fidelity versus

reinvention; Transferability to different countries and cultures; programme reach; programme acceptability and programme integrity (Barry & colleagues, 2005; by Jane-Llopis & Barry, (2005))

Nutbeam (1998) echoes the same tone as above in that he puts across the conditions for success. Various elements can contribute to the success or failure of the programme and they have been published in different articles and summarized by Nutbeam (1998) as follows:

- Programme reach***:*** This would in the evaluation answer the question of whether the program reached all of the target population as in any health programme key elements of success have to do with achieving optimal contact with the defined target population.

- Programme acceptability: Refers to when the programme has reached its targeted population and does not mean it would be accepted by the said target. The acceptability of the programme may be measured by the extent to which people feel involved in the programme.
- Programme integrity**:** This answers the question “was the programme implemented as planned”? interventions which have been evaluated and determined as effective by a group of highly motivated researchers working with equally motivated volunteers are not automatically well-received, executed and sustained when translated into a real-life setting.

2.8.3 Evaluation of the impact of health-promoting school programme on specific outcomes.

It is of paramount importance to find out what other researchers have established concerning the evaluation of this kind of programmes especially that it encompasses a lot of aspects and that it can be tailor-made to a specific site needs. This establishment will assist in checking whether the anticipated

challenges and / gaps found in this current studies have been identified previously and if so were there any recommendations made for bridging. It is not the intention of this study to identify more gaps but rather to check if such identified gaps can serve as contributing factors to the non-effectiveness of the programme.

Through a search of the literature, (Mukoma & FLisher, 2004; Turunen et al., 2017) the following were highlighted as being key for the future of program intervention. Therefore, found together with the recommendations. This included diversity, methodological challenges, implementers capacity building, a prerequisite for location, level of readiness for the program and buy-in by participants,
cut line of duration and intensity of programmes, previous intervention programs to match

* Diversity

Health-promoting programme needs to be institutionalized as the programme becomes integrated into practices and procedures. This needs to be done acknowledging the diversity between schools. The duration and intensity of the programme need to be taken into consideration and agreed upon. Even though HPS programme is known to be a continuous and open-ended effort, for outcome evaluation timelines need to be set and performance indicators need to be clearly outlined. Even though HPS programme is known to be a continuous and open-ended effort, for outcome evaluation timelines need to be set and performance indicators need to be clearly outlined. Previous successful interventions within their context may be used as a resource of reference and guiding outlines. Especially when one meet challenges that are not familiar one may need to check what others have done to overcome such and tailor-make it to their site-specific context

- Methodological challenges

Prommier, Guével, & Jourdan, (2011) suggest the use of realistic evaluation approach by using Mixed Methods(MM) in evaluating Health Promoting Schools. This will call for participation of all stakeholders involved as suggested by Mukoma et al (2004) since it aims to: (a) Understand the mechanism through which HP interventions produces change (b) Understand the contextual conditions necessary to trigger these mechanisms and (c) Develop outcome pattern predictions according to the context and mechanism triggered. In other words, the idea of realistic evaluation is to determine which individuals, subgroups and location might benefit most readily from the programme and which social and cultural resources are necessary to sustain the changes. See Pawson & Tilley (1997) and Merzel (2003) for a detailed explanation of Mixed Methods and Realistic evaluation respectfully).

- Capacity building for implementers

There is a need for building specific capacity for each of the six stages of programme implementation. According to Gugglburger, & Dür W. (2011). Capacity building in and for health promoting schools: results from a qualitative study. *Health Policy. 2011 Jun;101(1)*:37-43. (2011) those stages include exploration & adoption of the programme; programme installation; initial implementation; full operation; innovation when changes occur and sustainability of programme implementation. For an example these can be realized by establishing visionary and effective leadership and management; developing structures that ensure the capacity for collaboration and coordination of health programmes and services; having extensive internal and external support; development and allocation of adequate resources both fiscal and human; supportive policies and procedures (according to Hoyle 2008; Waggie 2004 & Jourdan 2016). That is when all the role players are capacitated according to each of the six stages it means they will know what is required of them, in terms of the

output measures that shall have been in place which will in turn yield a positive process of programme implementation.

- Level of readiness for the program and buy-in

Researchers need not rush into an intervention stage without making sure that the primary beneficiaries are 100% on board and that they are well capacitated at each stage of the programme (Gugglburger, 2011). This may be accomplished by making use of the down-top approach whereby implementers make sure that they understand the context from the beneficiary's point of view and to avoid imposing the intervention (Prommier et al., 2010). One of the findings was about the new theory for health-promoting schools (Markham, Larmer, Ravitz,., Buck Institute for Education., T. (2003). et al., 2003). This new theory stresses the involvement of pupil in decision making in the management of their learning by encouraging them to be committed to the school by promoting cultural congruency between the school and the wider community. Schools need to clearly understand the partnership with communities. That community partnership means working with the community to maximize the opportunities to promote school health rather than perceiving it as meaning resource acquisition such as the engagement of speakers for health talks or procurement of health resource kits (Lee et al., 2007). It is not enough to let the government and other stakeholders be aware of the programme but also to let them understand how this programme will benefit them as a whole system

Process evaluation should not only take place during the implementation stage. It must also be incorporated at an early stage so that it would be easily determined whether the idea has been fully developed and sold and that the schools concerned have ownership of the programme. As a results performance measures need to be put in place for measuring the level of understanding and readiness by the schools from within.

Clear definition of roles for different stakeholders need to be defined and boundaries need to be set for minimization of confusion, duplication of duties and easy monitoring and evaluation purposes.

- Duration and intensity of programmes

Indicators may differ between schools (Mukoma et al., 2004) but the principle should be the same. According to Mukoma et al. (2004), programmes may fail not because it was not well implemented, but because the time invested in exploration and adoption stage of the programme was not enough for the schools to feel ownership of the programme and also to seek extensive internal and external support.

- Factors contributing to satisfaction of work prerequisites

Some prerequisites need to be satisfied for the HPS to be well implemented. This includes accommodation, equipment, teacher development, the project to be implemented with all the required objectives, amount of time needed and timelines indicated to allow monitoring of the process and anticipated deviations.

It is also important to note that schools performed well in those areas that already have guidelines from the education authority but less in the areas where they had to first start by drafting the guidelines themselves. In other words, when the project complements what is there already it becomes easier to notice its acceptability and its anticipated impact. (Busch, De Leew, Zuithoff, Van Yperen, Schrijvers, 2013; Inchley, 2007; Stewart- Brown, 2006). It, therefore, becomes clear that a comprehensive co-ordinated cross-curricular programmes through-out the school career are more important especially for those that appear to be susceptible to being alienated, detached or estranged.

2.9 Chapter summary

This chapter reviewed the literature in the context of evaluating HPS approach to address mental health-related issues among learners. A detailed background of what HPS approach is was given. The review included what is done globally and locally in the processes of health promotion and its evaluation. Factors that hindered or facilitated the intervention were identified as well as the review of methods used to evaluate this kind of studies. The chapter thus paved way for the following chapter which addressed the theoretical framework for the study.

CHAPTER 3

THEORETICAL FRAMEWORK

3.1 Introduction

This chapter will address the theoretical perspectives relevant to the evaluation process as well as the concepts within the study on health promotion. The perspectives will be covered alongside the main framework within which the study is conceptualised.

3.2 The theoretical perspectives

The theoretical conceptualization for this study is presented through the use of various theoretical models including the Health Belief Model (HBM) that can be used to guide health promotion and disease prevention programs as well as the Context, Process, Outcome model (CPO) for organizational health interventions (OHIs) and RE-AIM. HBM is used to explain and predict individual changes in health behaviours and it is one of the most widely used models for understanding health behaviours. The theories helped in the process evaluation and judging the effectiveness of health-promoting school approach intervention in the public mental health service delivery systems in schools. It focussed on the analysis of mental health outcomes among high school outcome learners in the Capricorn district if it resulted in the positive or negative mental health outcomes. It also evaluated how well the health promoting school approach intervention was implemented and the kind of mental health issues addressed.

The following discussions are based on the Health Belief Model (HBM), Reach, effectiveness, adoption, implementation, and maintenance (RE-AIM), Social Marketing theory and Context, Process, and Outcome model (CPO) for organizational health interventions (OHIs) as the theoretical background guiding the study.

3.2.1 The Health Belief Model (HBM)

The Health Belief Model (HBM) is one of the most widely used frameworks for trying to understand health behaviour. Furthermore, HBM may be used as an organising conceptualisation for explaining and predicting acceptance of health and medical care recommendations by Janz & Becker, as cited in Schomer & Wadlow, (1996). It was developed to predict individual responses and utilize screening and other of preventive health services. According to Thopson and Chait (2012), the HBM is a value-expectancy theory where behaviour is dependent on the subjective value placed on the outcome and the expectation that an action will lead to that outcome. In the context of health-related behaviours, the valued outcome is typically the improvement of health or avoidance of poor health; the expectation is the individual's belief that a health action can increase the likelihood of the outcome. HBM is based on the domains of perceived susceptibility (to disease), perceived severity, perceived threat, perceived barriers, perceived benefits, cues to action, and health action (Thopson & Chait, 2012).

The model has been used successfully for many decades to promote health behaviours such as seat belt use and the use of health screening and it is based on the premise that people are most likely to take health-related action if they feel that by doing so they can avoid a negative health condition (Thopson & Chait, 2012).

The model asserts that to plan a successful educational intervention, the individual or group's perceived susceptibility (e.g., to osteoporosis), perceived severity of the condition and its consequences, perceived benefits in taking certain actions to reduce risk, perceived barriers (e.g., costs of the advised action), and cues to action (strategies for activating the "readiness" to undertake health actions) are required (Thompson & Chait (2012; Janz & Becker, as cited in Schomer et al., 1996).

According to this model, the response and utilization of disease prevention programmes will be predicated on an individual's perceived seriousness of the disease or severity of the disease. It also includes knowledge of health risks. Since this model requires the perceived seriousness of the disease, it means that the individual will have received the information about the disease from a particular source, and his/her level of understanding may be influenced by how he/she perceives the credibility of that given source, for him/her to be concerned about the seriousness of the disease.

3.2.1 Reach, effectiveness, adoption, implementation, and maintenance (RE-AIM)

The reach, effectiveness, adoption, implementation, and maintenance (RE-AIM) framework was developed to improve the balanced reporting of internal and external validities of behavioural interventions (Holtrop, Rabin, & Glasgow, 2018); Ganchimeg, Ota, Morisaki, Laopaiboon, Lumbiganon, Zhang, et al. 2014). This transparent and consistent reporting may lead to a better understanding of the complexity WHO (2011) and potential public health impact of behavioural interventions (Holtrop et al.,; Ganchimeg, Ota, Morisaki, Laopaiboon, Lumbiganon, Zhang, et al., 2014). Reach assesses the number, proportion, and characteristics of participants when compared to the target audience. Effectiveness assesses whether the targeted behavioural outcome was achieved and the mental state of learners or other important outcomes. Adoption assesses delivery staff and setting variables (e.g., staff/setting characteristics and intervention adoption rate). Implementation assesses intervention fidelity and resources (i.e., cost and time). The maintenance dimension assesses both individual-level behaviour change and organizational/setting-level intervention sustainability (Holtrop et al., 2018).

Accurate reporting of these dimensions enhances replication and generalizability of interventions (Holtrop et al., 2018). Notably, RE-AIM includes a hyphen to differentiate the individual-level factors of reach and effectiveness from the organizational-level factors of adoption and implementation (Hodgkinson, Beers,

Southammakosane & Lewin, 2014). Maintenance is captured in both individual and organizational levels. Lastly, the constitutive definition of adoption includes both staff- and setting-level indicators.

According to Adekunle, Arowojolu, Adedimeji, Roberts 2000; Abdul-Rahman, Marrone & Johansson, 2011) RE-AIM framework has been used to in settings such as schools and communities (Chandra-Mouli, Camacho & Michaud, 2013). Furthermore, RE-AIM has been used for the planning, implementation, and evaluation of various health behaviour interventions programmes such as diabetes self-management Krugu, Mevissen, Prinsen, Ruiter, 2016; Kann, McManus, Harris, Shanklin, Flint, Queen, Lowry Richard, Chyen, Whittle, Thornton, Lim, Bradford, Yamakawa, Leon, Brener & Ethier, 2018) such as weight loss interventions and smoking cessation programs (Zhao, Song, Ren, Wang, Wang, Liu, et al. 2012). In this study RE-AIM included was used to determine the effectiveness of the health promotion schooling interventions, focus on the mental health outcomes. Exploratory aims included determining the degree to which educators intervened to improve mental health outcomes related to each dimension.

3.2.3 Social Marketing theory

This theory is based on the idea that all marketing is an exchange. If you want people to change their behaviour, you have to offer them something, be it security, information, an image, or a feeling of belonging. The theory of social marketing addresses important factors such as understanding behaviour and addresses questions such as who is your audience and who you want your audience to be. It also asks what action might affect a certain behaviour, and what perceptions guide that action. It is only after considering these aspects that an intervention may be developed (Hanlon, Lane & Romano, 2000). The social marketing theory becomes very important when developing a health promotion intervention programme

because it gives one the background of the audience dealt with, including their current behaviour and factors that precipitate those behaviours.

According to Parker, Dalrymple and Durden (1998), social marketing relates to the idea of using conventional commercial marketing techniques to achieve social benefits. In South Africa, social marketing techniques are applied to the promotion of *Lovers Plus* condoms, for example. Parker et al., (1998) further indicate that social marketing techniques have achieved considerable success worldwide, promoting condoms, contraceptives and other health products and effectively reaching millions of people who would not otherwise have had access to these products.

3.2.4 The Context, Process, and Outcome (CPO) Model

The Context, Process, and Outcome model (CPO) by Fridrich, Jenny and Bauer (2015) for organizational health interventions (OHIs) being one of the models that are used for the evaluation of complex interventions which encompass design and development of health service interventions (Bradley, Wiles, Kinmont, Mant & Gantley, 1999; Fridrich, Jenny & Bauer, 2015; Lehman, Brauchli & Bauer, 2019).

The CPO evaluation model assumes that changes in outcomes happen continuously as a result of the change process induced by the continuous implementation process; therefore, the CPO model depicts evaluation of proximate, intermediate, and distal outcomes ((Fridrich, Jenny & Bauer, 2015). Thus, outcome evaluation should be considered not only as an important intervention element where results of the change process are fed back into the organisational system at the end of the intervention but also as continuous observation and assessment of change results accompanying the entire implementation and change process, for example, by continuously measuring proximal outcomes to show successful growth in these variables. In this regard, change in proximate outcomes might already be visible after a project information

event (preparation phase) or after a particular intervention element, such as a stress management workshop (action cycle phase). Thus, collection and reflection of outcome data are also parts of an intervention and can influence the change process (Inauen, Jenny, & Bauer, 2012).

Fridrich, Gregor, Jenny, Georg and Bauer (2014) stated that the CPO model has a grid of phases and levels applied to these categories and subcategories. Phases refer to temporal distinctions within the implementation process and its discrete context (preparation, action cycle, and appropriation), the levels refer to hierarchical aspects of the context and the intended intervention outcomes, spanning from the individual to the organisation. The following description starts with this overlaying grid of phases and levels and then proceeds to the categories and subcategories of context, process, and outcome (Fridrich, Gregor, Jenny, Georg & Bauer, 2014).

- **Intervention Phases and Levels**

- **The Intervention Phases**

Organisational Health Interventions (OHIs) usually consist of several elements such as participatory workshops, survey feedback, and information events which are planned intervention elements are comprised within overall intervention structure. Furthermore, intervention planning and evaluation concepts usually distinguish between three and five intervention phases which share the notion that an analysis is needed before actions can be planned and implemented (Nielsen & Abildgaard; 2013, Inauen, Jenny, & Bauer, 2012).

- **The Intervention Levels**

The CPO evaluation model distinguishes the levels of individuals/leaders and groups/organisation (Nielsen, Stage, Abildgaard, & Brauer, 2013). Thus, outcome evaluation should be conducted in consideration of these levels to make

differentiated statements concerning the effectiveness of an intervention. This differentiation is also important for the evaluation of the intervention context, where different levels can be of importance during different phases.

3.2.5 The Main Categories and Subcategories of the Model

CPO model has three main categories viz, context, process and outcome. The categories will be described hereunder concerning the current study.

* **Context**

According to Kompier and Kristensen (2000) interventions always took place in context, and that this context is not under the control of scientists. According to van Berkel, Boot, Proper, Bongers, and van der Beek (2013), context had been used for understanding the causes of success and failure of interventions and as a process indicator. Context can be used in outcome evaluation of interventions and can reveal if the intervention was effective or ineffective in the team.

Context is sometimes treated as an unspecific setting parameter that concerns environmental and situational aspects and limit its conceptualization to its facilitating and hindering functions (Nielsen & Randall, 2013; van Berkel, Boot, Proper, Bongers, & van der Beek, 2013). Furthermore, the context of an intervention is often considered as an undesired, uncontrollable, and unmanageable constraint that could be neither predicted nor controlled. In this study, the importance of the context is attached to the school profiles that were used to contextualise the evaluation process for the study. The profile outlined the needed WHO adherence aspects that included the schools' capacity to provide a safe environment, having in place policies that guide them in their functioning.

*   **Process**

The process includes both the implementation processes and the intended and unintended process of change triggered in institutions with the management in the leadership towards facilitation of change in outcomes.

- Implementation Process

The CPO evaluation model defines the implementation process as the time-limited enactment of all steps and elements of the original intervention plan. The intervention elements can be arranged in parallel (e.g., if they address different target groups) or in sequential order (e.g., if they build on each other).

There is a range of intervention architectures for this, which usually incorporate a set of general implementation principles to be followed during the process. These include the preparation phase which is about the successful building of a strong coalition of project leaders, defining goals, and raising awareness and commitment are evaluated. During the action cycle phase, it is evaluated if the sequence and linkage of the intervention elements are implemented as planned. In the appropriation phase, it is evaluated whether and how the further development, maintenance, and sustainability of the intervention effects are ensured.

- Change Process

According to Fridrich, Jenny and Bauer (2015) the CPO evaluation model defines the change process as all intended and unintended individual and collective dynamics triggered by the implementation process, leading to alterations in the organisation and its members. Thus, the change process potentially involves all levels of the intervention context from the individual to the organisation and their environments which include, for example, individual and organisational learning, social processes, taking over others' perspectives, the realisation of jointly

developed action plans for improving work (mental outcome), organisational structure, and strategy (Fridrich, Jenny & Bauer, 2015).

- **Outcomes**

Outcome evaluation focuses on what effects an intervention has had (Goetzel & Ozminkowski, 2000). The CPO evaluation model defines outcomes as all results of the change process that are measurable and at the same time meant for the organisation, its members, researchers, and other stakeholders. The CPO model uses the proximate outcomes, intermediate outcomes, and distal outcomes to evaluate the outcome. These categories are based on a trichotomy of outcomes commonly used in the public health community. As all outcomes manifest in the intervention context, proximate, intermediate, and distal outcomes can be further observed on all levels of individuals, leaders, groups, and the organization (Julian, Jones & Deyo1995; Mark & Henry, 2013).

- Proximate outcomes, often called immediate, initial or short-term outcomes or first-level targets, refer to individual skills and collective capacities needed for the change process (i.e., as part of the discrete context) as well as quick-wins in the form of minor but instant structural changes. As such, they can be classified as results of the change process that immediately arise.

- Intermediate outcomes, often called medium-term outcomes or second-level targets, comprise, of changes in job demands and resources concerning factual (job-related) processes such as workload or time pressure and social (people-related) processes such as leadership behaviour or social support (Jenny & Bauer, 2013). As such, we can define them as results of the change process concerning factual (job-related) and social (people-related) processes.

- Distal outcomes refer to the distal objectives of the interventions such as improved individual health and increased organisational performance, which often depend on a change in the intermediate outcomes. These outcomes are often labelled as the overall objectives/goals or, simply, impacts, and we, thus, define them as higher-level results of the change process that evolve over time.

3.3 Theoretical framework of the study

The Context, Process, and Outcome model (CPO) by Fridrich, Jenny and Bauer (2015) for organizational health interventions (OHIs) was used as the theoretical framework guiding this study. The rationale for the choice of CPO model as a framework is that it is one of the models that are used for the evaluation of complex interventions which encompass design and development of health service interventions (Bradley, Wiles, Kinmont, Mant & Gantley, 1999; Fridrich, Jenny & Bauer, 2015; Lehman, Brauchli & Bauer, 2019).

Complex interventions as it is in this study that involved secondary data from the main study and process evaluation done for the evaluation process allow utilization of triangulated use of intervention methods to validate the outcomes (Bradley et al., 1999).

According to Fridrich, Jenny & Bauer, (2015) CPO model differentiates between the three categories context, process, and outcome evaluation of organisational health interventions and is thus labelled CPO evaluation model (see Figure 1).

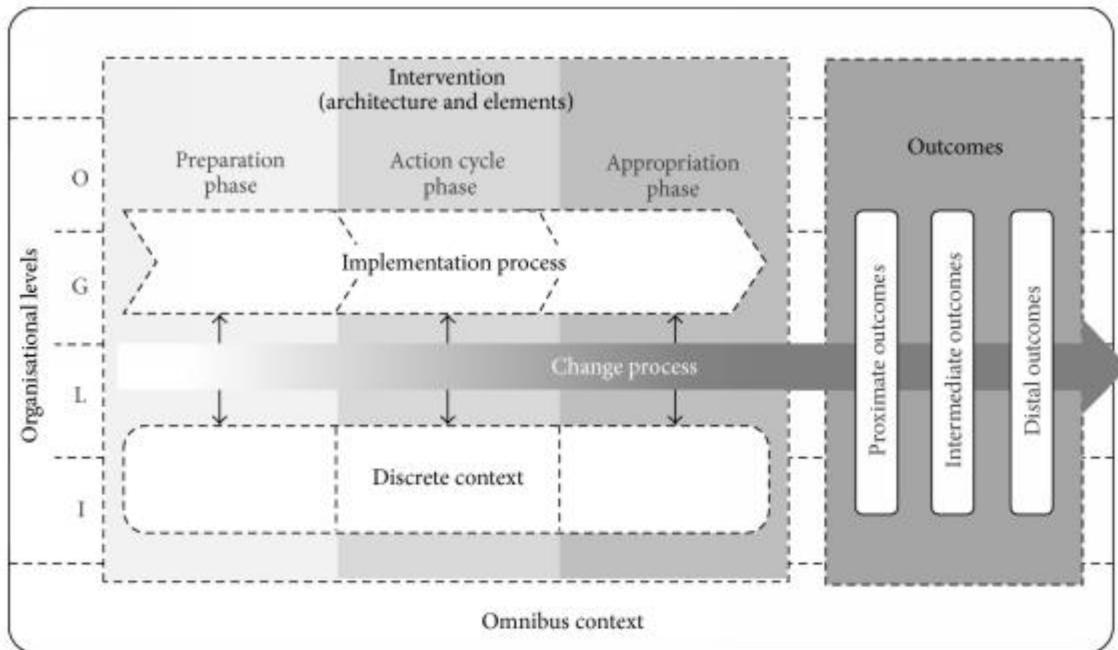

Figure 1: The context, process, and outcome (CPO) evaluation model.

Figure: The context, process, and outcome (CPO) evaluation model. O: organisation; G: group; L: leader; I: individual.

Context is seen as the underlying frame within an organisational health intervention is implemented, change occurs, and outcomes emerge. Regarding the category of process, two subcategories are differentiated: the implementation process as the time-limited enactment of all steps and elements of the original intervention plan and the triggered change process as all the intended and unintended and observable and no observable mechanisms of alteration in the intervention context (Fridrich, Gregor, Jenny, Georg & Bauer, 2014). This leads to outcomes, defined as all results of the change process observable and measurable in the intervention context. According to the phase of the change process, alterations of proximate, intermediate, and long-term outcomes can be distinguished.

CPO evaluation model is divided into three intervention phases: the preparation phase, the action cycle phase, and the appropriation phase discussed below.

• The first phase, the preparation phase comprises all activities needed to fit the intervention to the specific context and to obtain the commitment of the organisation for the following phases. This includes, for example, presentations and workshops with decision-makers, a qualitative analysis of the intervention context, the planning of the intervention architecture (who is involved, when, and how in the OHI), the establishment of a steering group, and project leader.

• The second phase is referred to as the action cycle phase that comprises of all activities needed to trigger a change process that will improve organisational health on a broad scale. It encompasses subphases analysis, action planning, enactment, and monitoring. Analysis, for example, an organisation-wide stress assessment, is considered part of the action cycle phase as it not only serves to generate information but also is an active intervention element since its mere implementation might trigger small changes, such as increased awareness, readiness for change, or sensibility for stressful issues (Inauen, Jenny, & Bauer, 2012). It should be noted that we use the term enactment to replace the commonly used term implementation, as the activities in the preparation phase and the final appropriation phase should also be considered as part of the implementation process (Nielsen & Abildgaard, 2013; Inauen, Jenny, & Bauer, 2012; Goldenhar, LaMontagne, Katz, Heaney, & Landsbergis, 2001).

• The third phase (appropriation phase) comprises of all activities needed to ensure the continuation, advancement, and diffusion of the change process triggered by the previous two phases. This phrase refers to the period when intervention implementers and researchers usually have left the organisation. At that time, capacities for self-optimization have been built up and the organisation and its members have to take over the responsibility for the continuation of the triggered

change processes in the form of continued, repeated action cycles and optimisation processes (Fridrich, Jenny & Bauer, 2015).

Regarding the timeline of change, the CPO evaluation model is based on the assumption that the implementation and change processes in OHIs are initiated with the beginning of the preparation phase. During the action cycle phase and the appropriation phase, the change process gains drive and develops its intended dynamics.

Evaluation of the change process can help to reveal what changes were triggered on which level by the implementation process and thus help to better understand the mechanisms of change. Evaluating whether, how, and to which extent these mechanisms have evolved, for example, whether and how intervention effects at the individual level have diffused throughout an entire team, might help to make the change process more visible (Fridrich, Jenny & Bauer, 2015).

3.4 Definition of concepts

3.4.1 Health Promotion

O'Donnell (2009) defines Health Promotion as the art and science of helping people discover the synergies between their core passions and optimal health, enhancing their motivation to strive for optimal health, and supporting them in changing their lifestyle to move toward a state of optimal health. The same definition will be used in the current study.

3.4.2. Mental Health

Mental health is defined as a state of well-being in which every individual realizes his or her potential, can cope with the normal stresses of life, can work productively and fruitfully, and can contribute to her/his community (WHO, 1996).

3.4.3. Health Promoting School ad Approach

A health-promoting school as defined by (WHO, 2012) is a school that constantly strengthens its capacity as a healthy setting for living, learning and working. The health-promoting school aims at achieving healthy lifestyles for the total school population by developing supportive environments conducive to the promotion of health. It offers opportunities for and requires commitments to, the provision of a safe and health-enhancing social and physical environment (Parsons,1997, cited in Deschenes, Martin & Hill, 2003).

A health-promoting school would foster health and learn with all the measures at its disposal; engage health and education officials, teachers, teachers' unions, learners, parents, health providers and community leaders in efforts to make the school a healthy place as well as striving to provide a healthy environment to implement policies and practices that respect an individual's well-being and improve the health of school personnel, families and community members as well as pupils.

The HPS concept provides the basis for the spreading of health ideas and practices from the school to the community. The Health Promoting School, networks and links up with other schools in this process and may become a model for other schools. A sense of ownership of self and the school is established and self-respect is reinforced and as a result, the health status of the learners, educators, community and the environment is enhanced (KZN Department of Health, 2001).

The health-promoting call for a significant change in the manner in which schools and their staff run their school health. This may mean changing from the normal way of teaching health education in a classroom to a more comprehensive, incorporated construct of health-promoting activities that will dwell on the learners' attitudes, behaviour and their environment.

The chapter outlined the theoretical perspectives relevant to the study as well as outlining the theoretical framework guiding the study. The next chapter covered the methodology for the study.

3.5 Chapter summary

The health promoting call for a significant change in the manner in which schools and their staff run their school health. This may mean changing from the normal way of teaching health education in a classroom to a more comprehensive, incorporated construct of health promoting activities that will dwell on the learners' attitudes, behaviour and their environment.

The chapter outlined the theoretical perspectives relevant for the study as well as outlining the theoretical framework guiding the study. The next chapter covered the methodology for the study.

CHAPTER 4

METHODOLOGY

4.1 Introduction

In this chapter the research design and methodology used in this study are described. This study was an outcome evaluation aiming at evaluating the impact of a health-promoting school approach intervention on mental health outcome among high school learners in the Capricorn District, Limpopo Province.

4.2 Study design

This study was conducted using the triangulation of methods within the sequential mixed-method approach. Data were thus triangulated from different sources using secondary data from the main-study and applying quantitative and qualitative methods within the ABAB experimental design.

Secondary data was sought on the background of the schools and the intervention process using LASH intervention from the main study and intervention impact with process and outcome evaluation data from the current study using ABAB experimental design approach and qualitative approach using interviews, records on class observations and logbooks.

The ABAB experimental design is used in intervention research where the targeted group for intervention is exposed to treatment/intervention (B) following baseline assessment(A) and a followup assessment (B). Such a design provides the within-subject control process wherein the group is assessed at the baseline and following treatment/intervention the impact of the treatment is measured as a followup. Embedded in this would be process and outcome evaluation by measuring the impact of the intervention program on the learners' perceptions of

their school following treatment and the process evaluation done by teacher interviews of the experience of the process.

4.3 Study Setting

This study was carried out in the Capricorn district of the Limpopo Province, which was purposefully selected from the five districts of the province (**Figure 1**). The district has four local municipalities namely: Blouberg; Molemole; Polokwane; Lepelle-Nkumpi. Two local municipalities (i.e. Polokwane for urban and Lepelle-Nkumpi for rural) were randomly selected for the study, and schools within the two selected municipalities were clustered according to their circuits – of which two circuits per municipality were selected for the study.

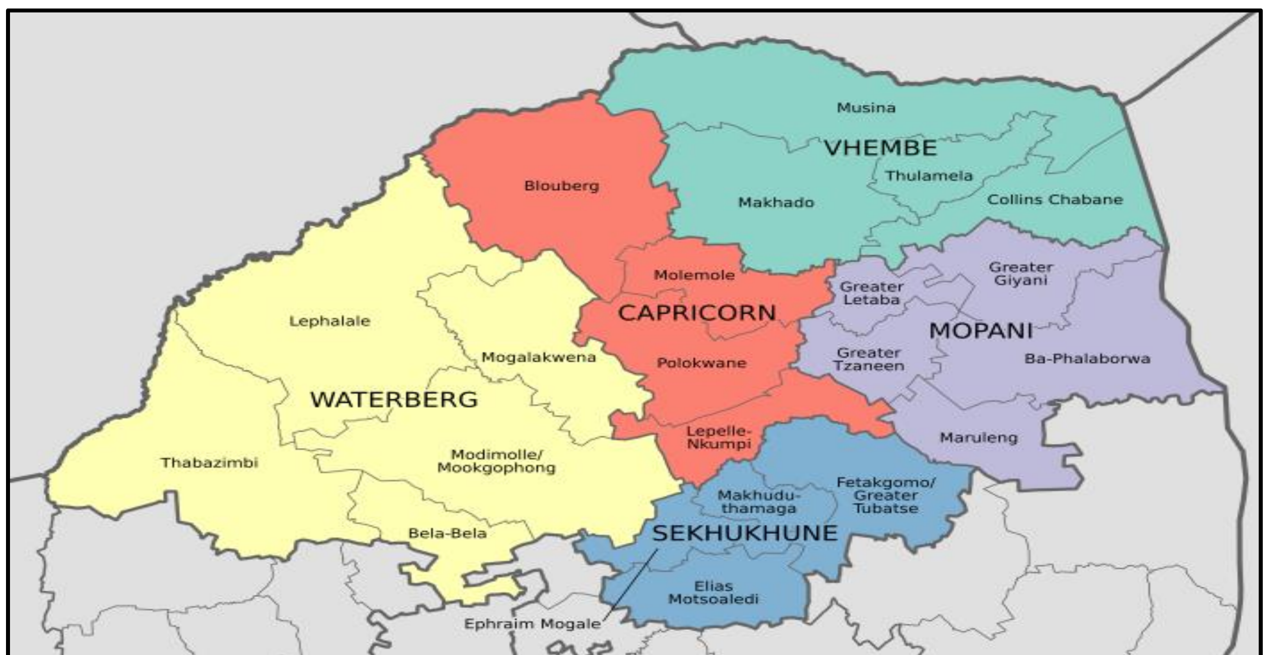

Figure 2: Map of Limpopo Province

Polokwane municipality has only two urban school circuits (i.e. Pietersburg and Seshego) with 24 urban high schools (Pietersburg and Seshego), whereas Lepelle-Nkumpi municipality has eight school circuits. Two circuits away from each other were purposefully selected for the avoidance of contamination of information (Sepitsi and Moletlane).

4.4 Study population

The study population was learners aged 15 and 16 attending public schools in the Limpopo province of South Africa. This age group has been chosen because it is seen as vulnerable in terms of experimentation and onset of risk behavioural patterns.

4.5 Inclusion and Exclusion criteria

All grade 12 learners were excluded in this study as they might not be available for follow-up data because they only have one year to be in school.

4.6 Sampling technique and Sample size

In Polokwane municipality, both circuits were selected for the study of which five schools with the highest number of learner's enrolment in each circuit two circuits were selected for the study. In Lepelle-Nkumpi municipality, two of the eight school circuits were randomly selected and five schools with the highest number of learner's enrolment within the two selected circuits were included in the study.

Based on the population size of 15 310 learners in the twenty selected schools, with a sampling error of 5% and non-response rate of 20%, a minimum sample size of 649 learners was required for this study. The sample size was calculated according to Yamane (1967:886) formula below. This formula was chosen because the total number of learners in each school is known.

$$n = \frac{N}{1 + N(e)^2}$$

Where
n is the sample size
N is the population size
e is the sampling error (5%)

The calculated sample size was distributed proportionally to the size of the learners in each school that were legible for participation (see Table 1).

Table 1. Sample Size per school

		No. of Learners	Sample Size
1	Pietersburg	1405	64
2	Pietersburg	1276	59
3	Pietersburg	1120	51
4	Seshego	1118	51
5	Seshego	1117	51
6	Pietersburg	1102	51
7	Pietersburg	1023	47
8	Pietersburg	884	41
9	Seshego	630	29
10	Seshego	385	18
11	Moletlane	810	39
12	Moletlane	819	31
13	Sepitsi	719	27
14	Sepitsi	650	24
15	Moletlane	689	26
16	Moletlane	633	24
17	Moletlane	470	18
18	Sepitsi	460	18
	Total	**15310**	**649**

Table 2: Number of learners enrolled per selected school per municipality

No of schools	Polokwane Municipality		Lepelle-Nkumpi Municipality	
	School	Enrollment	School	Enrollment
1	Pietersburg	1405	Sepitsi	719
2	Pietersburg	1276	Sepitsi	650
3	Pietersburg	1120	Sepitsi	460
4	Seshego	1118	Sepitsi	426
5	Seshego	1117	Sepitsi	412
6	Pietersburg	1102	Moletlane	819
7	Pietersburg	1023	Moletlane	810
8	Pietersburg	884	Moletlane	689
9	Seshego	630	Moletlane	633
10	Seshego	385	Moletlane	470

The learners in the intervention group from the main-study were 654 in total number after attrition. These were all considered in the current study based on the minimum number required as shown above.

For phase two of the study, for each of the participating schools in the municipality, there was an Educator for training. Out of the twenty schools, eighteen Educators could be reached for interviews. The two educators that could not be interviewed were no longer teaching at their respective schools.

4.7 Procedure

The evaluation process in this study was carried out in three stages. The first overall phase was the evaluation of the intervention process aimed at assessing the effects of the Health Promoting School Programme (HPS) on mental health among learners in the Capricorn district of the Limpopo Province. The second stage was process evaluation using face-to-face interviews with educator's (i.e. coordinators of the HPS during the intervention) to report on their evaluation of the training with a plan to study the logbook reports and the class observation report. The third stage was outcome evaluation to assess the impact of the intervention using questionnaires

4.7.1. Intervention Phase

The evaluation of the process included secondary data from the main-study. This included the process of teaching during intervention where the teachers kept a logbook and observations made during the teaching. The evaluation was conducted through interview of the teachers on the process in the current study. Evaluation is divided into two parts for ease of presentation: process evaluation and outcome evaluation.

***Process evaluation**

Process evaluation was done by interviewing the Educators on their experiences of the intervention process and to look at the records in the Logbooks done by the Educators as well as the study of the reports for class observation.

The process evaluation aimed to:

- To assess whether the intervention was implemented as planned.
- To assess the programme reach; accessibility and integrity
- To identify factors that might have enabled or hindered the implementation of the intervention programme

*** Outcome evaluation**

The outcome evaluation aimed to assess the effectiveness or impact of the intervention on the behaviours related to mental health ie general perception about their health, alcohol and drug use, sexual behaviour, violence, attitude towards life, social support and confidence in dealing with pressure. The evaluation was done through questionnaire administration to the learners at baseline before the intervention and at follow-up after the intervention.

4.8. Instruments

4.8.1 Quantitative Data Collection

Three instruments that were used for a quantitative phase in the main study to provide the secondary data for baseline information in the current study included: (1) learner questionnaire (2) Health promotion logbook. For the current study, the instrument used for learners were the same as the ones used for learner assessments at baseline by the main study. This was for purposes of comparing data post-intervention with the baseline information to detect a possible effect of the intervention. School compliance data was obtained as secondary data from the main study that used school-level questionnaire. All the questionnaires are attached as Appendices A-D.

***The learner questionnaire**

The areas that were covered in the learner questionnaire are: (a) learners' biographic information including their socioeconomic status, (b) three areas that the study is being hypothesized upon (learners' awareness of mental issues, demonstration of coping tendencies concerning indulging in risky behaviours and decrease in learners' indulgence in risky behaviours (see appendix A). The questionnaire was based on the existing survey instruments tested and applied in a similar setting, including the Global School-based student survey which was in turn modified to suit the local context (GSHS, WHO, Kugler, Komro, Stigler, Mnyika, Masatu, Aastrom, & Klepp, 2007; Mukoma et al., 2009). For mental health question, the Satisfaction with life scale by Diener, Emmons, Larsen and Griffin (1985) and depression self-rating scale Komor (1999) was used.

*** Health-promoting logbook**

This log book is in the form of a diary where educators were asked to record information related to the project. It could be what they taught in class or what they did in the garden or any other activity related to health-promoting school concept. Educators were also encouraged to record the challenges that they came across during implementation and the facilitating factors that they could have picked and enhanced the implementation.

4.8.2 Qualitative data collection

Process evaluation was done using structured Interviews conducted on Educators. The sample questions were based on the following:

- Educators' perceptions about the intervention programme about whether they think the intervention worked as planned
- Acceptability of the programme by the teachers
- The perceived benefit of the programme Knowledge about the LASH project
- Implementation views

- Implementation strategies employed
- Factors that could have enabled or hindered the implementation of the intervention.

4.9 Data collection procedure

4.9.1 Data collection protocol

A protocol was developed to maintain order and uniformity in collecting data from all the participants and at all locations. The same protocols were followed in both the main study and the current study. Field workers that administered the baseline data collection were used again during follow-up data collection. They were selected based on their level of experience with data collection procedures and knowledge of research methodologies as they were honours students. They were trained in the processes of the protocol that dealt with specification from 'how field workers introduced themselves' to 'how they left the school and the groups at the end of each interaction with participants'. The questionnaire was administered to the participants following the researcher's explanation of the instruction on how to complete it.

Before completing the questionnaire learners were given consent forms, which on signing was followed by an authorization form which explained that the participation was voluntary and that learners can refuse participation or withdraw from the survey at any given point without having to explain and that they would not be penalised for that.

To link the data each learner was given an envelope with one questionnaire, a piece of paper, and a small envelope. The questionnaires were already numbered. Learners were to transfer the number they see on the questionnaire to the piece of paper, on the other side of the paper they were to write their names and school name. After they would put that piece of paper and put it in the small envelope,

seal it and hand it back to the Fieldworkers before starting with filling in of the questionnaires. The field workers were the only people who would open the envelope on the day of follow up and transfer the number onto paper on the follow-up questionnaire for linkage purposes. This would not be shared with anyone else.

Contact numbers of the research office of the University of Limpopo were made available for any clarity seeking and consultation about the process of data collection.

a) Administration of the questionnaire

Questionnaire administration was done per school at one sitting and it was usually during periods that were considered free or after school hours especially for schools that had the targeted audience spread across the grades. It was administered by two trained field workers per school with the supervision of the researcher. Learners were assembled at a convenient place within the school premises and also at a convenient time to avoid tempering with the school programme and also to avoid learners missing lessons of other subjects.

b) Logbook

Each school through the programme coordinator (L O educator) was requested to submit a logbook of events related to the implementation of the programme. The programme initiators were also requested to submit the logbooks of correspondence and interaction with the school regarding the implementation of the programme at large.

c) Clarity and consultation

After completion of the questionnaire and submission, the research team would stay behind for a while to accommodate those who might have had questions or issues they wanted to discuss in private. The role of the researchers was outlined clearly and that they were not to perform any duties or assume any responsibility

beyond their scope of practice as researchers and data collecting at that time. It was further explained to the participants that should any matter arise it was to be handled with sensitivity and referred to appropriate personnel.

4.9.2 Qualitative data collection procedure

***Structured interviews**

The schools were informed ahead of time for securing the appointment with L O educator for interviews. The time was dependent on the availability of educators and the time that was conducive for them. These interviews were conducted in the current study after the intervention process has been concluded from the main study. The objective was to get the overall overview of the impression the intervention made on the school especially the primary beneficiaries who are in this case the learners. The interviews were conducted with health-promoting school coordinators/L O educators at each intervention school.

4.10. Data analysis

4.10.1 Quantitative data

The data was captured using SPSS version 22.0. and was analysed using STATA version 10.0 (StataCorp LP, College Station, TX, USA). This was done for secondary data from the main study and data in the current study. Data were analysed using statistical programme STATA version 10.0 (StataCorp LP, College Station, TX, USA). Comparisons were performed using student t-test and chi-square tests for continuous and categorical data, respectively. A p-value ≤ 0.05 was considered statistically significant (Yamane, 1967).

4.10.2 Qualitative data

The analysis of the interviews was deductive, in that the themes were pre-generated as guided by the framework for implementation of an HPS intervention programme. The arguments were from a particular view to generating generalization. The purpose was to check conformity or challenges with regard the key implementation components: Leadership and management; preparing and planning for school development; policy and institutional anchoring; student participation; professional development and learning; relational and organizational support; partnership and networking; quality assurance and sustainability.

4.11 Ethical considerations

This study is part of the broader study entitled: A comprehensive school-and health system-based approach to adolescent health promotion in South Africa and Tanzania. The broader study has since obtained permission from the Medunsa-Research Ethics Committee (MREC) and the Limpopo Department of Education. For the present study, the researcher sought further approval from Turfloop Research Ethics committee (TREC) of the University of Limpopo through the School of Social Sciences and the Faculty of Humanities research committees for the recognition of this present study as an independent doctoral study.

4.11.1 Informed consent

The participants were given sufficient information that included the following items: the research procedure, the purpose, risks and anticipated benefits, alternative procedures and they would be informed very clearly that their participation is voluntary.

The informed consent was written in lay language to avoid any technical misunderstanding. Permission was sought from parents or School Governing Body for schools that shall give responsibility to SGB for granting permission.

4.11.2 Confidentiality and anonymity.

The participants were assured confidentiality and anonymity about their responses not being linked to any name by either mentioning or implication. Questionnaires were numbered and analysed using numbers. The record of the names with the allocated numbers was used in case there is a need to have more information from the respondent. Such a record with numbers alongside the respondent's name is kept separate from the questionnaires and safe under lock for the period of the study and will be destroyed after the study.

4.11.3 Protection from harm

Participants were informed that they are free not to answer any question they feel uncomfortable answering and that participation is voluntary. Participants were also told that they can stop at any time should they feel they do not want to continue with the study.

4.11.4 Provision of care

Participants who got distressed were promised debriefing Participants showing distress resulting from their participation in the study were referred to a Clinical psychologists or any other appropriate health professional at the Pietersburg/Mankweng hospital complex for assistance.

4.12 Chapter Summary

This chapter presented a detailed research design and methodologies that were employed in the current study. The chapter covered the study design, methodology covering the sampling, data collection procedure, planned process for data analysis and ethical considerations. The following chapter (chapter 5) presents the findings of the study.

CHAPTER 5

PRESENTATION AND INTERPRETATION OF THE RESULTS FOR THE INTERVENTION

5.1 Introduction

This chapter focused on the results of the intervention phase of the study. The findings are presented according to the objectives and the hypotheses laid down in the study. The data is presented in the sequential form so that it relates to the research questions that have been studied and tested. The sections covered include the demographic information of the participants, the analysis of responses on the questionnaires that were used in the main study as secondary data and the followup questionnaire in the current study as per objectives in the study.

5.2 Demographic information of learners

A total of 654 learners participated in the study and completed both baseline and follow-up data. **Table 3** presents the demographic characteristics of the learners who participated in this study. Nearly two thirds (63%) of learners were in the age group 15-16 years of age and most (79.8%) were in Grade 9. The majority (96.6%) of the participants was African and 43.1 said they leave with both parents. Slightly more than half (52.1%) leave in rural areas and only 47.9% in urban areas. Eighty-seven per cent said they have a television set at home.

Table 3: Demographic profile of the study participants, (n=654)

	No	**%**
Age		
11-12	17	2.6
13-14	219	33.5
15-16	412	63.0
17+	3	0.5
Unknown	3	0.5
Gender		0.0
1	297	45.4
2	348	53.2
unspecified	9	1.4
Race		0.0
African	632	96.6
Indian	4	0.6
Coloured	1	0.2
Unspecified	17	2.6
Live with		
Mother	228	34.9
Father	21	3.2
Both	282	43.1
Neither	112	17.1
Unspecified	11	1.7
Location		
Urban	313	47.9
Rural	341	52.1
Grade		
7	1	0.2
8	51	7.8
9	522	79.8
10	64	9.8
11	1	0.2
Unspecified	15	2.3
Have Television		
Yes	568	86.9
No	76	11.6
Unspecified	10	1.5

5.3 Findings on the schools compliance to the who principles for school health promotion

5.3.1 Promotion of Safe Environments

Table 4.1 shows the effect of Health Promotion Programmes (HPP) on promoting a safe environment. There was a significant decline in the mean score for "*I feel safe at school*" (2.1±1.3 versus 2.0±1.1, p<0.05) and "*My school care if leaners are hungry at school*" (2.9±1.5 versus 2.6±1.4, p<0.05). No significant change was observed concerning "*My school expects learners to be respectful to each other*", "*My school expects that educators are respectful to learners "," If I was sick or needed help my educators would help me", "Girls are treated the same as boys ", and "My school cares about my sexual health".*

Table 4.1: Effect of HPS on promoting safe environments

	Baseline	Follow-up	p-values
I feel safe at school	2.1(1.3)	2.0(1.1)	0.028
My school expects learners to be respectful to each other	1.8(1.0)	1.8(1.0)	0.887
My school expects that educators are respectful to learners	2.1(1.2)	2.0(1.1)	0.096
My school care if learners are hungry at school	2.9(1.5)	2.6(1.4)	<0.001
If I was sick or needed help my educators would help me	1.8(1.0)	1.8(1.1)	0.608
Girls are treated the same as boys	2.4(1.2)	2.5(1.2)	0.467
My school cares about my sexual health	2.6(1.3)	2.6(1.3)	1.000

5.3.2 Developing Healthy Public Policy

A significant increase is noted in the mean score after the intervention about the items: "*I have the freedom to express my meanings and opinions at school"* (1.9±1.1 vs 2.1±2.4, p<0.05), "*learners at my school are involved in planning health education programs for youth"* (2.4±1.4 vs 2.9±1.3, p<0.05) and "*I'm*

encouraged by my school to take part in meetings/help plan youth health activities" (2.4±1.3 vs 2.5±1.3, p<0.05). This shows an inclination towards the development of healthy public policies. However, The results revealed a significant decline in the mean score for "*My school discourages learners from using tobacco*" (2.2±1.5 vs 1.9±1.3,p<.05) and "*My school discourages learners from drinking alcohol*" (2.0±1.4 vs 1.8±1.2, p<0.05). The finding could have implications for probable lack of adequate validation of the questions seeing the pattern of the expressions on the items above about improvement on the health policies by the schools.

Table 4.2: Effect of HPS on developing Healthy Public Policy

	Baseline	**Follow-up**	**p-values**
I have the freedom to express my meanings and opinions at school.	1.9(1.1)	2.1(2.4)	0.0230
My school is concerned about my health and well-being.	2.9(1.4)	2.9(1.3)	0.8941
Learners at my school are involved in planning health education programs for youth.	2.4(1.2)	2.7(1.3)	0.0002
I'm encouraged by my school to take part in meetings/help plan youth health activities.	2.4(1.3)	2.5(1.3)	0.0327
My school discourages learners from using tobacco	2.2(1.5)	1.9(1.3)	0.0002
My school discourages learners from drinking alcohol	2.0(1.4)	1.8(1.2)	0.0048
My school discourages learners from using drugs	1.9(1.2)	1.8(1.2)	0.2068
I have chances to play and be active while I am at school	2.2(1.3)	2.2(1.1)	0.5654

5.4. Findings on the impact analysis of the program implementation

The impact of the intervention was analysed through analysis of the leaners questionnaire on various issues including confidence, mental health issues, substance abuse, sexual behaviour. The following are findingsconcerning the skills learners need to make sound decisions that might influence their engagement in behaviours impacting on their mental health.

5.4.1 Impact on learners' confidence

The effect of HPP on learners' confidence is shown in **Table 5.1** There was a significant increase in the mean score for "*say no to drink alcohol"* (3.0±1.3 vs 3.2±1.2, $p<0.05$); "*if offered cigarette"* (3.2±1.2 vs 3.4±1.1, $p<0.05$); "*offered marijuana*" (3.1±1.2 vs 3.4±1.1, $p<0.05$); "*avoid a physical fight*" (3.0±1.2 vs 3.2±1.1, $p<0.05$); "*use a condom when having sex"* (3.2±1.2 vs 3.5±1.0,$p<0.05$); "*avoid eating too many sweets"* (2.6±1.2 vs 2.8±1.1, $p<0.05$) and "*avoid eating too many fried foods*" (2.5±1.2 vs 2.7±1.1, $p<0.05$). This indicates that there is some development of assertiveness among the learners.

Table 5.1: Effect of HPS on learner's confidence

	Baseline	Follow-up	p-value
How confident are you:			
Say no to drink alcohol	3.0(1.3)	3.2(1.2)	<0.001
Say no if offered cigarette	3.2(1.2)	3.4(1.1)	<0.001
Say no if offered marijuana	3.1(1.2)	3.4(1.1)	<0.001
Could avoid physical fight	3.0(1.2)	3.2(1.1)	<0.001
Use condom when having sex	3.2(1.2)	3.5(1.0)	<0.001
Say no to have sex against your will	3.2(1.1)	3.3(1.1)	0.1098
Ask person bothering you to stop	3.2(1.1)	3.3(1.0)	0.0950
Get healthy physical activity	3.0(1.1)	3.1(1.0)	0.1113
Healthy amount of fruit/vegetables	3.1(1.1)	3.1(0.9)	1.0000
Avoid eating too many sweets	2.6(1.2)	2.8(1.1)	0.0024
Avoid eating too many fried foods	2.5(1.2)	2.7(1.1)	0.0026

Learners significantly improved in almost all items related to health behaviours: say no to drink alcohol; say no if offered marijuana; should avoid a physical fight; use a condom when having sex; avoid eating too many sweets and avoid eating too many fried foods. The responses to these items indicate that participants developed assertiveness in refusing to be tempted to take alcohol, smoke and indulge in violence and sexual behaviour.

5.4.2 Impact on learners' mental health

Table 5.2 illustrates the effect of HPP on learner's mental health. The mean score on "*taught about handling stress"* significantly decreased (1.7±0.7 vs 1.6±0.7, p<0.05) after the intervention, while for "*feeling sad without a reason"* increased significantly (2.6±1.1 vs 2.8±1.2, p<0.05). There was no significant change in the mean score for "*feeling about life in general", "general feeling about self", "feeling of hopelessness", "feel life is not worth living" and "taught on how to deal with mental issues"* after the intervention. The learners' knowledge increased about the impact of feeling sad without a reason but decreased in handling stress and no change about feelings of hopelessness and general feeling about self. The items indicate the need for a revisit of the questions validation as there is a discrepancy in what would be expected of a person who understands what sadness without a reason implies while not understanding the handling of stress.

The following reflects the learners' attitude towards life in general and how they feel about life after the intervention.

Table 5.2: Effect of HPS on learners' mental health

	Baseline	Follow-up	p-value
Taught about handling stress	1.7(0.7)	1.6(0.7)	<0.001
Feeling about life in general	1.7(0.7)	1.7(0.8)	0.5101
General feeling about self	1.8(0.8)	1.9(0.9)	0.2840
Feeling sad without a reason	2.6(1.1)	2.8(1.2)	0.0043
Feeling of hopelessness	2.9(1.2)	2.9(1.2)	1.0000
Feel life is not worth living	3.5(1.3)	3.6(1.4)	0.6939
Taught on how to deal with mental issues	1.7(0.7)	1.7(0.7)	0.4279

5.4.3 Impact on learners' mental health: indulgence in risky behaviours

The effect of HP on risky behaviour is presented in **Table 5.3**. There was a significant drop in the mean score for had >1 girl/boy at the same time (1.5±0.5 vs 1.3±0.5,p<0.05); had vaginal sexual intercourse (1.8±0.4 vs 1.6±0.5, p<0.05);

however, the mean score for used condom during sexual intercourse (1.4±0.7 vs 1.6±0.6, $p<0.05$); use any method of birth control (1.5±0.9 vs 1.8±0.9,$p<0.05$) and several people had sexual intercourse (1.5±1.2 vs 2.2±1.7,$p<0.05$) significantly increased after the intervention.

The mean score for testing alcohol significantly decrease (1.7±0.5 vs 1.4±0.5, $p<0.05$), 1.2±0.5 vs 1.3±0.7, $p<0.05$) while the number of drink per day (1.6±1.4 vs 2.2±1.9, $p<0.05$); several friend drink alcohol (1.5±0.8 vs 1.7±0.9, $p<0.05$); number of times used dagga/cocaine (1.0±0.3 vs 1.1±0.5, $p<0.05$) and number of friends used dagga/cocaine (1.2±0.5 vs 1.3±0.7, $p<0.05$) significantly increase.

The mean score for significantly declined for seriously injured (1.5±0.9 vs 1.3±0.9, $p<0.05$) and carry weapon (1.2±0.6 vs 1.1±0.5, $p<0.05$).

Table 5.3: Effect of HPS on risky behaviour

	Baseline	Follow-up	p-value
Sexual Behaviour			
Had >1 girl/boy at same time	1.5(0.5)	1.3(0.5)	<0.001
Had vaginal sexual intercourse	1.8(0.4)	1.6(0.5)	<0.001
Had oral sex	1.9(0.3)	1.9(0.3)	1.000
Had anal sex	1.9(0.2)	1.9(0.2)	1.000
Used condom sexual intercourse	1.4(0.7)	1.6(0.6)	<0.001
Use any method of birth control	1.5(0.9)	1.8(0.9)	<0.001
No. of people had sexual intercourse	1.5(1.2)	2.2(1.7)	<0.001
Alcohol/Drug Use:			
Tasted alcohol	1.7(0.5)	1.4(0.5)	<0.001
No. of days have one drink	1.4(0.9)	1.3(0.8)	0.060
No. of drink per day	1.6(1.4)	2.2(1.9)	0.001
No. of friend drink alcohol	1.5(0.8)	1.7(0.9)	<0.001
Try to use dagga or cocaine	1.9(0.2)	1.9(0.3)	1.000
No. of times used dagga/cocaine	1.0(0.3)	1.1(0.5)	<0.001
No. of friend used dagga/cocaine	1.2(0.5)	1.3(0.7)	0.004
Violent behaviour:			
Physically attached	1.4(1.0)	1.3(0.9)	0.0643
Physical fight	1.4(0.9)	1.4(0.9)	1.0000
Seriously injured	1.5(0.9)	1.3(0.9)	<0.001
Bullied	1.5(1.1)	1.4(0.9)	0.081
Carry weapon	1.2(0.6)	1.1(0.5)	0.002

The environment was found to be adequate for health promotion with the schools adequately built with safety measures in place and allowing appropriate utilization of amenities as the resources are available as well as having several policies available to guide the running of the school and thus allowing health promotion to be possible.

The process of the implementation was found to be fair although a few aspects were not in place. The processes that involve the taught program were somehow not in a place like a classroom observation and the use of logbooks. The programme was based on available LO topics and not utilizing completely innovations for the topics which could have clouded the findings for both groups.

The results above indicate that the programme yielded results showing that the learners who were exposed to the programme showed a significant increase in assertiveness and confidence. Though they are still lacking in understanding issues around stress and feelings of sadness. There was also an impact shown for behaviour change that showed a decrease in sexual behaviour, violent behaviour and alcohol abuse. This is an important factor since it relates to the aspects of mental health.

The current chapter outlined the findings on the three aspects viz the selected schools in the projects' compliance on the WHO principles for HPS, the evaluation of the implementation process and the impact analysis of the intervention program on the learners. The next chapter will be a discussion on the findings as well as the recommendations, limitations and future research possibilities.

5.5 Chapter summary

In this chapter, the results from the outcome evaluation have been presented. According to the evaluation process as outlined, elements of compliance by schools to be health-promoting schools by WHO were adhered to. The contextual

background and implementation process data as identified in this chapter assisted in contextualizing the results of the study. This gives a highlight in weather the non-effects were due to implementation strategies or missing components in the intervention as a whole. The following chapter (chapter 6) discusses the findings for the implementation process which addresses in detail the evaluation process.

CHAPTER 6
FINDINGS ON THE PROCESS EVALUATION FOR THE IMPLEMENTATION PHASE

6.1 Introduction

This chapter focused on the process evaluation to position the evaluation of the intervention for analysis of its success as a process since the effectiveness is bound to factors of the credibility of the implementers, the process and the assessment techniques utilized.

6.2 Process Evaluation

Process evaluation was done through a structured interview of the educators and planned to do a study of the report on the logbooks and classroom observation. The interviews were deductive and subjective in nature. This is because these results rely entirely on the views of the L O educator who implemented the programme. They were not quantified for statistical weight.

6.2.1 Findings from the Interview of the LO Educators

The main objectives of the interviews were to get an insight into the experience the educators had about the implementation of the intervention. More specifically their perceived benefits or effectiveness of the intervention on the primary recipients (learners) and the school environment at large. These interviews were conducted at the end of the intervention to get an overall picture and assessment of the whole implementation by educators.

Three main questions were asked to assess the process: 1) Can you share with us the experience you had about the implementation of the LASH HPS intervention programme? 2) What would you say are the enabling factors that contributed to

the smooth implementation and what would say were the hindering factors? 3) What is your general view ofthis kind of programmes?

The themes that emerged in their responses are categorized according to the questions.

What is your experience concerning the implementation of the LASH HPS intervention programme?

The Educators started by outlining the intervention process that they followed by describing the situation and all the challenges they experienced. Their description of the programme-outline highlighted their view of the way they perceived the programme-plan.

The themes that emerged in the initial description of their experience were the following:

1) Lack of thorough demarcation of the programme with the existing programme in the schools on learning orientation.
All the Educators indicated that they implemented the intervention during the L O periods as a result learners just knew it as L O and there was no extra effort put on teaching the lessons.

The Educators attestation:

> *'We just taught the learners like it was time for LO period. As such, the learners were not aware that this was a new programme as they just thought it was LO'*

2) Topics overlap in the intervention and LO programmes

The Educators indicated that there was hardly much differentiation between what they normally teach during LO classes and the new programme.

The Educators attestation:

> ‘*We covered all the topic since those were normally topics that formed part of the LO’*

3) Challenges with the teaching in the intervention programme

The Educators acknowledged some challenges that they came across. Those challenges are highlighted in the following themes:

a) Lack of support from initiators and managers

Most Educators felt that even though the programme appeared to have been well received in their school, there seems like not enough support was provided to run the programme optimally.

One of the Educators’ attestation:

> *‘At face value, it appeared the programme was accepted by the school since during the interaction with the schools during the introduction of the programme the schools gave it a go-ahead through their management team and school governing bodies, but now we are on our own, the initiators are gone with no support for us or the school management for that matter’.*

Another Attestation:

> *‘When the educators and the SGB agreed to the programme they didn’t understand the magnitude of the programme’*

Some educators indicated that they were most of the time lacking support and resources.

'This has made the implementation process not to run as smooth as we had anticipated.

This lack of support was categorized by:

- **Non- visibility by the programme initiators**

According to the L O educators, this was necessary as it was going to reinforce the seriousness of the programme.

'There was no visibility of the university as a result we ended up dragging our feet and forgot some of the objectives we pledged… no wonder even learners did not take it seriously' [male teacher]

Most educators felt like there was no continued support by the initiators of the programme. According to most of them:

'There is a lack of support from both school managers and project managers.'

- **Lack of parental support**

One teacher indicated that she thinks they addressed non-urgent topics as she believed they should have started with addressing the attitude of the learners towards health and education and also to include the parents or community at large.

Attestation:

'I think these learners are not taking any intervention seriously since their guardians do not encourage them. They allow them to do whatever they want especially during weekends when they go to the taverns...' [male teacher]

- **No interest was shown by the school managers**

According to the findings, one educator indicated it did not matter how many times he tried to explain the concept to the principal but still he did not give it support and encouragement.

Attestation:

> *'One major challenge, especially with our case, is that within that period of implementation we had six principals and every time the new one comes it's a new concept to him/her, as a result, were forever starting afresh'* [male teacher]

There was no transparency across the whole school ad the information resided in the involved Educators and the other Educators were in the dark.
Educators who were not coordinators would say during school visits for the interviews where the interviewer had to call the teacher who was no longer working at that school to give feedback and participate in the interview. This was the case in one school where the coordinator had left the school and gone to another and they did not remember who else was in the project.

Educator attestation:

> '*I remember something like that but am not sure of what took place'*.

b) Neglecting ground rules for local context

The Educators indicated that class observation was not done because the unions were not invited as it is the practice when class observations are made in the school.

Attestation:

'Class observation is a no go area if the observer is not accompanied by a union member. These observations can get you kicked out of work, so you need your representatives present when it is done'.

What would you say are the enabling factors that contributed to the smooth implementation and what would say were the hindering factors?

a. Insufficient Educator capacity and esteem building

Stress management kept on recurring as a subject of challenge. The educators indicated that they lacked coping strategies and that this is one area that is seldom discussed at school level since it does not fall within their scope of everyday address.

Attestation:

'the whole process required our ability to do things. It has always been a challenge to do new things at this school because we are not shown properly, you just guess and learn on your own.'

Attestation:

'The work in the school is not allocated equally, so we who knowknow LO we have to help like we are the school counsellors as well, and the whole thing gives us extra stress and we are not shown how to help ourselves'

Educators indicated that there were no teaching strategies and equipment for teaching other topics which appeared either challenging or needed more exposure by the educators around the subject

'We as educators also have stress and we may not know how to handle it what more if I am expected to teach it in a proper way that will help learners to deal with it'.

'We thought that this was a research project only used for the collection of data and publication of articles.'

b) No clear cut demarcation between LASH intervention and LO

All the educators/programme coordinators understood the plan to be implemented during life Orientation periods. As a result, learners could not differentiate between the programme and their normal Life Orientation period which is normally not taken seriously by most learners.

The manager that is being referred to here are the school principals.

Attestation:

'*This programme was just like any other programme and because learners could not see the difference between the program and L O they just took it too ordinary and they did not put any effort to be part of it.'*

c) Cost implications and Affordability for the programme

Another factor that was coming up especially when talking about resources was that of schools being a non-school fee-paying school and that most of them rely on the budget prescribed by the department of education.

Attestation:

'The budget constraints means that we may not go beyond the prescribed amount per activity and most of the things needed learners to be exposed to certain things such as technology and we don't have that'.

d) Limited resources for innovative and motivating teaching methods

The educators indicated that they used the traditional methods of teaching in almost all the topics which included teaching standing in front and giving instructions with minimal use of role-plays and discussions except as an activity from the LO.

Only one school indicated that they now call health professionals to come to address some of the topics and this is what was gained from the LASH programme.

- **Unmotivated students**

One of the common reason stated by educators was that learners lack the motivation to study and they are often left alone at home so there are no elderly people who guide them in terms of school work and its importance.

Attestation:

> *'These learners lack motivation and I think it is because they seem not to be having role models in their communities, there are those that are educated and doing well but they only a hand full and often time not accessible'* [female educator]

- **Institutional intervention**

The following paraphrased statement indicates the frustration faced by educators with regard to the schooling system of progressing learners. Though this was not part of the anticipated item to be deduced from the finding it is worth noting as it may have implications for the level of seriousness of learners about their school work.

'If we want to be fair, our education system is not doing justice to our children, this thing of them wanting our children to pass with 30% and even giving them free 20% at random is killing them. I am sitting with learners who are not a true reflection of the grades that they are in because they have been condoned through progression and as a result, they are affecting our pass rate and we have to account for their failure hence I am saying the problem may not even be the topics that you want us to discuss but intervening for individual attention. We are stranded we don't know what to do with the learners that seem not to be fitting in in the school system because they don't want to be stigmatized like others who have gone to special schools' [female teacher].

e) **Not well-articulated mandate for a panel of experts**

During the training, it was emphasized that cross-curricula methods should be employed especially in a situation where educators felt lack of esteem in delivering a particular content. This was one of the reasons for the formation of the expert panel which was a multidisciplinary team for each school.

From the interviews, it was clear that not all educators included other disciplines in the implementation of the intervention sessions.

'We initially believed the LO educators are the ones relevant but it seems it would have been even better if it was facilitated from outside since leaners are too used to them and as such do not take them seriously.'

'Traditional way of teaching seems to be posing another hindering factor as these learners are vibrant and exposed to technology unlike us during our schooling…' [male teacher]

What is your general view with regard this kind of programmes?

- **Misuderstanding about the objective the programme.**

Some thought that this was just another research project, whereby people just come to the schools to collect data for their own publication. The following statement shows that there were still some whom did not fully understand what the intervention was all about.

> *'We thought that this was a research project only used for the collection of data and publication of articles.'*

> *'We initially believed the LO educators are the ones relevant but it seems it would have been even better if it was facilitated from outside since leaners are too used to them and as such do not take them seriously.'*

- **Potential of introducing learners to technology**

They indicated the potential for the programme to introduce learners to technology, due to lack of resurces they could not deploy such mechanism.

most of the things needed learners to be exposed to certain things such as technology and we don't have that'.

6.3. Classroom observations

The main objective of this aspect of the process was to get a familiarity with how educators were facilitating the intervention and the process especially in imparting knowledge in the classroom. Different aspects were to be observed during this process: a) site-specific underlying factors, b) facilitation strategies and c) resources both human and material.

An educator at the first school that was going to be observed asked if their teachers' union representative was aware that they were going to be observed. As this was never discussed during teacher training and since no union representative formed part of the expert panel, it was then decided after that discussion that no observation in the classroom was going to be made. The rationale being that it would have meant that the project staff should go through the process of acquiring permission from all the unions representing teachers, which might mean a new procedure altogether.

6.4 Chapter summary

This chapter shas presented findings from the process evaluation. The deductive method has been used whereby the themes have been pre-identified and established according to adherence to WHO. Things that were found prominently lacking according to the assessment of programme reach and accessibility were visibility of the programme initiator for validation of the programme. Concerning enabling and hindering factors, the insufficient targeted capacity was also prominent together with lack of resource and support. The following chapter (chapter 7) discuses the findings from both process and outcome evaluation which will subsequently lead to the implications and recommendations that will be discussed in chapter 8.

CHAPTER 7
DISCUSSION OF THE FINDINGS

7.1 Introduction

In this chapter, the findings on the outcome and process evaluation are discussed. The discussion is positioned according to the context of the literature on the effectiveness of the HPS programme on promoting mental health among young people. Implications of the results are discussed followed by the drawing of conclusions based on the findings and guided by what other researchers have said in similar findings.

This study aimed to evaluate the effectiveness of the LASH intervention, a health promoting school programme with regard to the mental health of the learners. The objectives of which were (i) to determine the impact of health-promoting school project on learners' mental health in general, risk behaviours that may harm learners' mental health, (ii)To determine the extent to which the health-promoting school project is helping learners improve their skills such as confidence in avoiding risky behaviours (iii) To assess the outcome associated with the level of implementation of key areas (promote safe environments, developing healthy public policy [including policies that discourages learners from drinking alcohol and smoking, policies that encourage learners to participate in sport and be involved in school and community projects); promoting community action, developing personal skills and re-orienting the health service) of health by promotion as established by WHO for the effectiveness of the health promotion projects.

Process evaluation aimed at evaluating the implementation process conducted using secondary data from the main study on the profile of schools to check for the quality of the context for credibility as health promotion institutions and use of the structured interview with the coordinators of the programmes (Life Orientation educators). The main objective for the interviews was to assess the perceived

benefits of the intervention by the educators and to find out if there were any challenges that the educators came across and how those were dealt with. All this information was gathered to assess the credibility of the schools to provide an appropriate context for health promotion as well as the educators' capability in the application of the intervention process.

7.2 Discussion of the findings on the study

The findings were outlined in the following stages: a) Findings on the schools' adherence to the criteria set by WHO to qualify as HPS; b) Findings with regards to the implementation process (process evaluation) c) Findings with regards to impact analysis (outcome analysis following the intervention).

7.2.1 Discussion of the findings on the schools' adherence to the criteria set by who to qualify as HPS

The findings are in line with WHO principles for adequacy in health promotion. These principles include; promoting a safe environment, safety measures and policies. The objective about the evaluation for the compliance of the schools to the WHO requirements for HPS requires adherence of the schools to have the capacity to promote a safe environment, provision of safety measures in the school and having policies in place. The findings on the evaluation for these aspects are summarized hereunder:

a) Promoting a safe environment

For a HPS to be conducive the environment both physical and climate should be conducive and be accessible and friendly to the learners. As a result, the learners to need to be able to interact with their environment and feel safe in it. The profiles for the schools in the secondary data showed that schools had a basic save

environment in place. This includes having amenities, armed response, buildings being well done and fenced to provide security to the learners.

The context seems safe to the learners based on buildings and the environment. The context in which safety is determined in this report does not include interactive processes on the campuses which sometimes could be the basis for lack of safety as there are numerous reports of violence in the school premises. For example, participants indicated that they do not feel safe at school. The possible interactive problems of violence in schools may be what the students focussed on when questioned about their feeling of safety in the school. This finding is not unique to this study as it concurs with the recommendation by Burton (2008) that understanding of school safety needs to be approached holistically rather than focusing on the individual aspect. In this case, learners might have had a different understanding of what safety means because of daily happenings on campuses hence the discrepancy in findings.

Furthermore, with regards to environmental safety, various items were included in the questionnaire to establish satisfaction by learners about their safety and feeling happy with the feeding and general safety.

The schools provided buildings and security safety and other items that indicate compliance to safety and caring depended on the school's qualification to be provided with such scheme or activity from the relevant government department. The schools were thus evaluated to be providing a safe environment on the aspects they have control over and also got out of its way to provide using its budget. This includes buildings, provision of toilets, fence and armed response structures etc.

b) Developing Healthy Public Policy

Another WHO principle for compliance in health promotion includes the development of policies in the schools that are involved in health promotion. In the evaluation process, secondary data from the main study indicated that several schools complied in the evaluation since they have various policies in place. The policies include the school's position in various things about school governance about the learning environment, the learners and teachers and how they are disciplined and educated as well as provision of guiding rules for the environment of learner education. Such policies are important for the credibility of health promoting schools. This is supported by Moon et al. (1998) who indicated that facilitation of effective school health-promoting behaviour is done by promoting the role played by young people in all decision making processes relating to health in school. This is the case because the policies that are developed should provide guidelines on how to manage and relate to the youth during their schooling lives.

The current study yielded positive results towards the aspect of developing healthy public policy. Learners through the existing policies in the schools indicated their ability to show independence as highlighted in the following: a) I have the freedom to express my own opinion at school; b) learners at my school are involved in planning health education programmes for youth; c) I am encouraged by my school to take part in meetings and help plan youth activities were addressed as part of the intervention development stage. Such responses to the questionnaire indicate that the existing policies are being applied and the learners are well aware of their rights and are also utilising the policies. The negative responses also indicate further that the policies are available and also in line with guiding health promotion. This is indicated in the responses to the following items: My school discourages learners from using tobacco, My school discourages learners from drinking, My school discourages learners from using drugs and I have chances to play and be active while I am at school. These items are such that the effect can be quantified

and visible. Learners might have interpreted their non-visibility as evidence of not being there.

7.2.2 Discussion on the findings concerning impact analysis of intervention on the learners

a) Development of Assertiveness

It was hypothesised that participants who took part in the intervention would show an increase in their level of confidence about personal skills. Some significant increase in the number of learners who indicated that they developed the confidence to can say say 'no' when offered substances and that they both could avoid physical fights, indicate assertiveness of the learners following the intervention.

According to Steward-Brown et al., (2006) children who are exposed to the warm environment have a reduced risk of numerous physical and mental health disorders including depression and associated health risk behaviours.

b) Development of confidence, self-concept and identity

Participants were asked about: (a) general feeling about life, (b) general feeling about self, (c) whether they feel sad without a reason, (d) feeling of hopelessness and that life is not worth living. The positive response to the item 'feel sad without a reason' and no change but still not a drop in other items, indicates that participants' general feeling about life has not changed after the intervention which could have been due to them indicating that they were not taught about how to handle stress. According to Pfeifer and Berkman (2018), these elements are very key for youth development concerning self-concept and identity in the developmental tasks for adolescence.

Torsheim & Wold (2001) states that the experience of stress and lack of well-being in adolescents is linked to schools and that it also poses a risk to health in society and this could be due to the imbalance found between the demands put on a person and the inner-outer resources available to meet these demands (Lazarus, 1999). What this implies is that when learners lack resilience and capacity and do not have resources and support to handle what they are confronted with at school they get stressed.

c) Developing learner's skills in reducing indulgence in risky behaviours

Certain behaviours can be done as a result of unhealthy mental state for an example sexual behaviour; alcohol and drug; and violent behaviour. In this study, there was an impact shown for behaviour change that showed a decrease in sexual behaviour, violent behaviour and alcohol abuse. The intervention effect was detected in almost all the items about sexual behaviour related to mental health; as well as a decrease in the number of times learners tasted alcohol during follow up as compared to baseline.

Although this is the case it worth noting that the findings from this study also confirms the findings by several types of research such as Brook et al. (2005); Snyder et al., (2006); Parry et al., (2004); Brook et al., (2005); Ziervogel (1997-1998) and Morojele et al., (2009) that the more alcohol and other drug users there are in the young person's circle of friends the more likely he or she is to use such substances. As it has been detected in this study that the mean score for the number of friends using substance and them using substance have significantly increased.

This does not correspond well with them indicating that they are confident they could say no when offered alcohol, cigarette and marijuana. What this could mean is that there is a difference between being pressured to do something and voluntarily dong it by observing others.

Steward-Brown (2006) says programmes that promote some aspects of health are more effective than those that promote other aspects. This could be one reason this study finds a significant reduction in violent behaviour about seriously injured and carrying weapons to the school, unlike substance use.

7.2.3 Discussion of findings with regards to the implementation process

The themes that emanated from the interviews showed that there were some prerequisites for better implementation that were omitted or neglected either by coordinators or managers. Those are such as a) lack of support, neglecting ground rules for local context, unavailability of logbooks, insufficient targeted capacity building, visibility of programme initiators, a) lack of support by managers, c) neglecting ground rules for local context, unavailability of logbooks for communication processes and interaction, lack of an innovative method of teaching, d) insufficient targeted capacity, e) affordability, f) parental involvement, and g) neglecting ground rules for local context.

The above discussion concurs with findings from research by several authors who have indicated that intervention programmes for health promotion should be done with proper planning that will include capacitated implementors, resources, clear manuals and management powers in place and properly validated methodologies.

- **Lack of support**

According to the findings from the process evaluation there seemed to be lack of support from both programme initiators and school managers:
According to the findings from the process evaluation, one factor that contributed to it not to run smoothly was the invisibility of programme initiators. This has left the implementer to feel deserted and contributed to the programme not to be valued by learners and other important role-players within the school.

This may also be interpreted as a lack of support from programme initiators. The findings are not unique to study. Other researchers found that the anticipated support from researchers was not as high as anticipated (Darlington, et al., 2018).

The interpretation thereof is that the programme implementers (in this case L O educators) should during intervention planning state their expectation from the programme concerning things that they think will enhance their implementation capabilities.

This lack of support suggests that the programme was not as accessible as it was supposed to be though it reached the targeted audience. The implications, is that this one important aspect set as a prerequisite for adherence was not fully met. That the programme is established and agreed upon does not automatically translate to it being accessible, except that guidelines for such were established and well-articulated.

- **Neglecting ground rules for local context**

This study found that some key role players were omitted during the process of implementation especially the teachers'unions. Since this type of study is based the on-site-specific context is very important to identify and acknowledge the influential role that stakeholders tthey may not be necessarily explicitly listed in the WHO requirement be included in the site they deem important. These findings are in line with Preiser, Struthers, Mohamed, Cameron, & Lawrence, (2014), that the part played by external stakeholders is that of negotiating partnership and lay conditions that are advantageous for those implementing the programme even when it is not easy.

What this may mean is that as much as the HPS is transferable each site is unique and the context for such should be documented for the facilitation of smooth implementation. In other words, in the South, it would not be easy to an extent of

being impossible to smoothly run the programmes that will include school community without involving the teachers' unions.

- **Insufficient targeted capacity and esteem**

This study revealed that one of the hindering factors to the smooth implementation of the programme was an insufficient targeted capacity for the programme implementors. This has to lead them not managing to execute some topics (i.e. stress management) according to the initial plan. This is not surprising since in their review DeCorby et al. (2018) found that capacity–building is effective in enhancing skill, self-efficacy, change in policies, behaviour change and perception of system-level capacity at an individual level. Like Gugglburger (2011) indicated that capacity building is needed for each of these stages: exploration & adoption of the programme; programme installation; initial implementation; full operation; innovation when changes occur and sustainability of programme implementation.

What this may mean is that when the implementers feel capacitated they gain confidence in executing some duties and may be able to suggest some changes or modification in policies that had a potential of hindering the process of implementation.

- **No clear cut between LASH intervention and LO**

It was not easy for both learners and educators to differentiate the intervention from the normal L O period. This might have caused them not to be able to identify with the programme. In other words, learners might have missed the purpose of the intervention, especially since there was no tracking of progress. L O period isis normally not taken seriously by the students (van Deventer 2009).

These findings suggest that the need that was identified during the initial phase of the programme was not addressed as planned. This was serious neglect of a primary goal of the HPS.

- **Limited resources for innovative and motivating teaching methods**

The educators indicated that they used the traditional methods of teaching in almost all the topics which included teaching standing in the front and giving instructions with minimal use of role-plays and discussions except as an activity from the LO.

Only one school indicated that they now call health professionals to come to address some of the topics and this was attributed to the LASH programme.

Another important factor that was coming up especially when talking about resources was that of schools being a non- fee-paying schools and that most of them rely on the budget prescribed by the department of education. They may not go beyond the prescribed amount per activity. They believe most of the things needed learners to be exposed to certain things such as technology.

- **Unmotivated students**

The educators in the intervention schools believed that learners are generally not motivated due to them not have role models that they can look up to in their communities. This could be due to a lack of partnership between communities and schools. They do not see community members taking interest in their school matters.

"These learners lack motivation and I think it is because they seem not to be having role models in their communities, there are those that are educated and doing well but they only a hand full and often time not accessible" [female educator]

- **Non-clear understanding of the implementation of policies by department**

The following paraphrased statement indicates the frustration faced by educators about the schooling system of progressing learners. Though this was not part of the anticipated item to be deduced from the finding it is worth noting as it may have implications for the level of seriousness of learners about their school work.

[*If we want to be fair our education system is not doing justice to our children, this thing of them wanting our children to pass with 30% and even giving them free 20% at random is killing them. I am sitting with learners who are not a true reflection of the grades that they are in because they have been condoned through progression and as a result, they are affecting our pass rate and we have to account for their failure hence I am saying the problem may not even be the topics that you want us to discuss but intervening for individual attention. We are stranded we don't know what to do with the learners that seem not to be fitting in in the school system because they don't want to be stigmatized like others who have gone to special schools*] [female teacher].

This finding implies policy development and understanding. It suggests that the educators seem not to understand the rationale behind what they suggest is taking place currently. This may dampen the morale of the teachers especially if the students also know that this is the case. Since it is assumed that every programme brought to school is related to assisting them to pass and progress to the next grade or level. Policies and changes need to be clarified so that the educators have a clear understanding of why they are implemented.

This implies that during the initial phase the issue of policies that may facilitate the implementation of HPS intervention was not thoroughly discussed. This could be one reason there was no modification on any of the policies during the

implementation of the programme. It could be educators treat policies as a matter of compliance rather than facilitation.

- **Not well-articulated mandate for an expert panel**

During training, it was emphasized that cross-curricula methods should be employed especially in a situation where educators felt lack of esteem in delivering a particular content. This was one of the reasons for the formation of an expert panel which was a multidisciplinary team for each school.

From the interviews, it was clear that not all educators included other disciplines in the implementation of the intervention sessions through a partnership was formed with a team of an expert during the initial phase of the programme. The panel was formed given their area of expertise that could be used in the programme.

'We initially believed the LO educators are the ones relevant but it seems it would have been even better if it was facilitated from outside since leaners are too used to them and as such do not take them seriously.'

- **Classroom observations**

The main objective of this aspect of the process was to get a familiarity with how educators were facilitating the intervention and the process especially in imparting knowledge in the classroom. Different aspects were to be observed during this process: a) site-specific underlying factors, b) facilitation strategies and c) resources both human and material.

An educator at the first school that was going to be observed asked if their teachers' union rep was aware of the fact that they were going to be observed. As this was never discussed during teacher training and since no union reps formed part of the expert panel it was then decided after that discussion that no

observation in the classroom was going to be made. The rationale being that it would have meant that the project staff should go the process of acquiring permission from all the unions representing teachers which might mean a new procedure altogether. Therefore, in this aspect, the following aspect is seriously noted.

7.3 Chapter summary

This chapter discussed the findings ofthe study. The findings were matched with what other researchers found previously. The implications of this study about the set principles of HPS implementation process were also discussed. In the following chapter (Chapter 8) the conclusion, limitations of the study and recommendations for future research are made.

CHAPTER 8
CONCLUSION LIMITATIONS AND RECOMMENDATIONS FOR FUTURE RESEARCH

8.1 Introduction

The current chapter will address the conclusion reached and how these can be placed within the theoretical framework for the study, the limitations and recommendations for future research

8.2 Conclusion

The current study, which was to evaluate the intervention program from the main-study of LASH, included schools in Capricorn that were involved with the intervention program for health promotion. The objectives of the study were to assess the schools' adherence to WHO key areas of becoming health promoting schools by demonstrating the capacity to promote a safe environment and developing healthy public policy with subsequent improvement of learners' confidence and avoidance of risky behaviours, to evaluate LASH intervention programme within the context of programme reach, integrity and accessibility as well as the process evaluation of the programme implementation and the gaps associated with the challenges, as well as to conduct the impact analysis of the intervention programme on the learners' mental health.

The findings indicated an overall positive impact on the intervention. The aspects that were investigated included evaluating compliance of the schools for health promotion in line with the WHO principles of a safe environment, safety measures and availability of policies. The schools in the study were found to be compliant. The evaluation of the aspects around the school's compliance was done by the learners to indicate how they experienced the schools. There was an indication of experience of independence due to availability of policies; feelings of safety in the

environment were responded to with ambivalence and that was thought to be as a result of schools being compliant for safety in the buildings but interactive active compliance was still a challenge with experiences of bullying and violence high in the schools.

The learners also indicated experiences of growth in assertiveness, knowledge of stress management and change in indulgence in various behaviours including sexual behaviour, alcohol consumption and violence.

The process for the implementation of the intervention was found to have been credible in some areas with challenges noted in some areas. The program was successful in that some positive changes were noted in the learners viz assertiveness, understanding of stress, self-identity as well as a change in behaviour.

8.2.1 Conclusion on the study within the CPO theoretical framework

The context within CPO for this project is the planning phase which included the use of secondary data from profiling of schools in the main study to locate the level of compliance for the participating schools. This also included the use of baseline data for the learners from the main study and the current study, this section included planning for the implementation of the intervention by introducing HPS to the participating schools, doing workshops and training of L.O educators who were to implement the programme at the schools.

The implementation phase was planned to involve teaching process, the evaluation of progress using logbooks and observation of the process. The teaching of the learners was the only aspect covered and the observation and evaluation were neglected in the implementation phase. These were highlighted as challenges in the study.

The impact analysis was done as part of the observation of the change process during the intervention as well as post-intervention. This was done by using the followup questionnaires for the learners. The change process in this study was carried out through the intervention programme addressing needs related to the lives of students as identified in the situation analysis and need an assessment done in the main study and as seen by the schools to be necessary.

Following the CPO framework for this study, the context, which is the school environment was found to be compliant with the WHO principles that are highlighted in the study to be needed to foster learning for health promotion. It was also found that there is need to enhance the intervention program (process implementation) with all its necessary aspects to produce the envisaged results around outcomes enlisted for the program that includes mental health outcomes viz assertiveness, containment of stress, knowledge of stress stimuli and change in engagement in risky behaviour including violence, sexual behaviour and substance abuse.

The process evaluation also indicated that there were gaps in the intervention phase which could jeopardise the intervention programme in the future. These had to do with the methodologies, capacity building and aspects related to proper planning of the project.

The change process involved the checking of gaps in obtaining outcomes following an impact analysis of the intervention. Recommendations made for the filling of the gaps were monitored through progress evaluation of suggested repeat intervention and checking on elements recorded to have been missing through the utilization of portfolios and process observation in teaching.

The outcomes were obtained from the analysis of the impact of the intervention with proximate and intermediate outcomes identified. Further impact analysis for the change process in this study, is recommended to be done within the post-

intervention process; wherein progress evaluation should be done to monitor the inclusion of highlighted missing elements in the form of producing portfolios to show the new outcomes. Such distal outcomes as defined in this model will further make the outcomes sustainable as they will be providing positive throughput for individuals and community to benefit.

Figure 3 below suggest the flow of evaluation of implementation process.

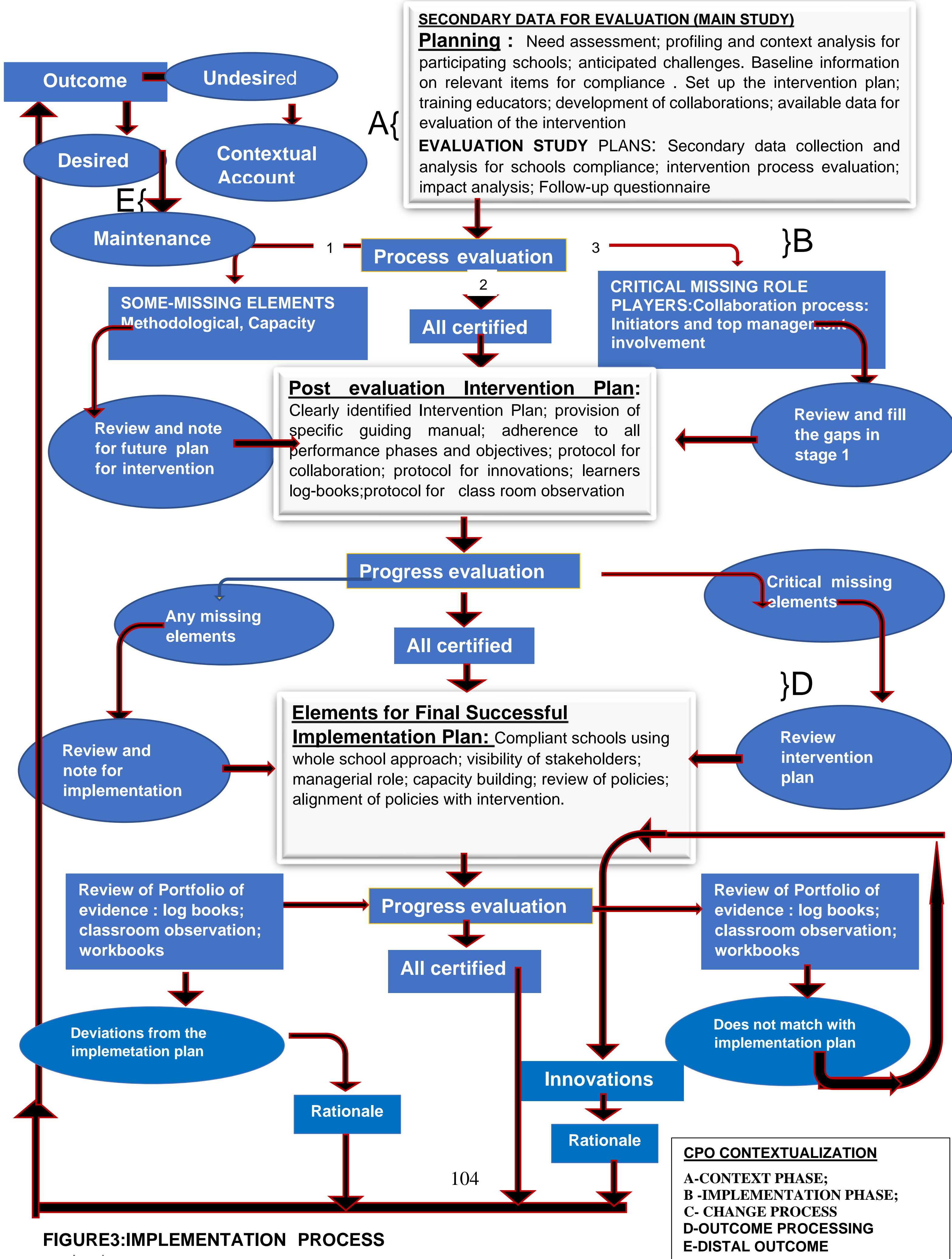

FIGURE3:IMPLEMENTATION PROCESS

The additions on the CPO existing model will be to add: 1) the school compliance aspects on safe environment and safety measures as part of the contextualised planning for the intervention highlighting the gaps in the planning process. 2) The implementation process to include perfecting of highlighted gaps around the development of training manual with clear objectives indicating the units to be taught, different innovative delivery modes; onsite capturing of assessment of the knowledge change and management (logbooks) and onsite observation and immediate feedback on the teaching process. 3) Progress evaluation within the continued change process to include monitoring process and highlight need for portfolios and further development of relevant outcomes for the benefit to the individuals and the communities, and thus making the program become a sustainable process for the schools.

8.3 Limitations of the study

The following gaps were identified:

8.3.1 Methodological gaps

- Logbooks were indicated as a requirement to record the training process and progress for individual learners. These were not available in the implementation process. Future intervention work could include the use of a logbook to enhance the research on the assessment of learners in the intervention process.
- Classroom observation that was indicated in the proposal was not done. The future program could benefit from bringing into the intervention observation aspects to enhance the evaluation of the impact of the program in question.
- Limited validation of some sections of the questionnaire which seemed ambiguous and also elicited less clear responses

8.3.2 Capacity Development

- Lack of adequate capacity development, support and training for implementors for the capacity to carry the program to the end. The future intervention could benefit from including more training sessions for the implementors who in this study seemed to feel lost sometimes and needed the support of the project leaders or to have the project leaders providing more power to the schools to help manage the program in their absence.

8.3.3 Planning

- Lack of full buy-in by educators and non-adherence to their belief in unions during their work on their campuses.
- Lack of specific and distinct program manual for training. The training was democratically developed guided by ad-hoc and informal development of a training manual which was developed according to the local needs in the different schools as it befitted the individual educators. Development of a specific manual can be beneficial in future work in this area.

8.4 Recommendations

Recommendations are made within the evaluation framework of planning, programme reach and integrity covering the implementation process and impact analysis of the program intervention outcomes as well as compliance to the principles of WHO on environment safety and availability of public policy in the health promoting schools.

The gaps above need to be addressed and the following are recommended:

8.4.1 Planning Phase

- Need to invest enough time in this phase for the adequate planning process and reaching all the relevant stakeholders for proper buy-in and subsequent participation and provision of resources and support
- Need to ensure buy-in by top management for continued support Evidence of buying in and commitment**:** There is a need to establish a level of commitment from the relevant and key role players. In other words, it should be documented as to how much commitment are they pledging and the resources they can bring along. These resources could be inhuman or material resources or even knowledge-related resources. Lack of evidence to support the involvement of expert panel member even after the formation of such warrants this recommendation. This is so because the formation of such was to come to play to matters or topics that needed their expertise.
- Need to address anticipated barriers such as unhealthy relations**:** The introduction phase should be treated as an initial implementation phase. This will give the direction of the programme concerning the commitment and the pledged support that the implementers will require at a later stage when delivering the actual programme.

8.4.2 Methodology

- Tighter methodology: Planning of intervention phase as well as reporting of impact needed utilisation of questionnaires with validated items to avoid ambiguity. Some responses like ‘I do not feel safe at my school’ as well as ‘my school does not allow smoking’ items seemed not to be in line with the observed increase in the positive impact of the program on the students which could have been answered with something in mind.

8.4.3 *Resources*

- Inventory of resources: This is a very critical phase of the programme. It is during this phase that preceding phases are neglected and no longer taken into consideration. This phase needs to be carefully considered and it will either endorse or deviate from what was agreed upon. The following recommendation is made in this regard:

  > There must be a clear availability of resources for each aspect of implementation. Those resources should be matched with activities. Innovative ways of handling issues that were not anticipated should be encouraged and recorded.

8.4.4 *Capacity building*

- Capacity and training of programme implementers; The programme implementers need to be trained according to the topics to be addressed. This will assist them in gaining confidence in facilitating those topics and also on how to involve other stakeholders should the topic seem beyond their scope or capacity.
- Clear demarcation from L O period: The programme needs to be launched as an individual programme that takes advantage of the L O stage setting. Schools concerns and the participants need to recognize it as such. It is recommended that it should have a portfolio of evidence of participation in a form of skills gained. This is so because L O does not form part of the outcome evaluation at schools. Except for evaluation questionnaires, there are limited ways of finding whether the intervention is beneficial or not.

8.4.5 *Intervention Phase*

- Guiding manual**:** The intervention topics and strategies should be clearly articulated with performance objectives and the desired learning outcomes.

The outcomes should be in line with the theory guiding the intervention. It should also be in line with the needs identified.

- Need for the clear demarcation of the intervention program from the normal LO program followed in the schools. This could have been upgraded with clear innovations in the delivery methods to be able to make a clearer impact on those trained.
- Stand-alone intervention**:** As much as the school should not be overburdened with programmes and can benefit from those that are consonant with their curriculum, the intervention should address specific issues as identified in the situational analysis and need assessment. The topics should not be overshadowed by the L O topics. Should it appear that they are the same topic, the main aim for including them should be made known and popular to both the beneficiaries and implementers.
- School-specific: Even though the process of doing the intervention is somewhat standardized the school must align the intervention to their context. This will help them to teach or capacitate the leaners that are in front of them rather than the ideal ones.
- Interrelated topics: Issues of mental health are interrelated and they should be addressed as such. Specific issues related to mental health need to be identified so that the intervention should target such for effectiveness.

8.4.6 *Process evaluation*

- The recommendation for this phase is about process and outcome. Lack of logbook from the implementers as initially proposed and unavailability of information from classroom observation calls for the following recommendations: As a result, the following are very important during the process evaluation:
- Need for a clear follow-up on the use of logbooks for the training process as it was in the initial proposal but was not fully implemented in the main-study and thus could not be used to follow-up on the process of intervention.

Implementers' Logbook: This will assist in that it will identify the strength and the challenges that the implementers meet during the implementation. When reviewed by both implementers and initiators it will assist with strategizing or enhancing what is in place and working. It will point out to the resources that might have been missed during the inventory and also to the underlying factors that may have been subtle during need assessment. It is an element that should not be overlooked

- Classroom observation: The purpose of observation is not to judge whether the implementers are doing the write but to have an understanding of what they are going through. This goes both for the implementers and participants. This will assist about the modification and enhancement of the strategies. Need for the clear follow-up on the classroom observation which was not done as planned. This was said to be due to the resistance by the LO educators which could be since because the formal program was not launched to be differentiated from the normal LO so that the implementation should not be done in line with the usual practices in the school (for visit to the classrooms done with unions)

- Need for the involvement of teachers' union**:** The situation analysis should not only be conducted only as part of proposal formulation but it should be rigorously conducted to inform the entry point at school level and to address issues anticipated as per the finding of such. Issues such as unhealthy relationships are not far-fetched and can be anticipated in any organization despite the setting.
- Student representation:

Students need to have a sense of ownership and take responsibility for their intentions as much as their expectations. If this is not emphasized they will take it an ordinary programme like it has alluded and they may not understand the need for it. This will also assist incapacitating the students that are in front of you rather than dealing with the ideal in mind. In other words, the strategies will not be imposed but rather a true reflection of the needs of the students.

8.5 Recommendations for future research

The future research could be developed to improve on the intervention process with more focus on the gaps highlighted around class observation and use of logbooks for student assessment during the intervention.

The design of the intervention phase can be explored in line with the highlighted gaps of the use of manuals specifically tailored for the project and how the intervention could differ from the normal orientation program taught in the schools in order to bring some leverage to the life orientation teaching considered not to be taken seriously.

The training of teachers for the capacity building could make the program in the health promotion for the schools be more sustainable. The questionnaire for the learners requires validation in some items as some answers seemed to be guided by other factors which were not highlighted in the questions to avoid ambiguity. Future research could focus on the development of more inclusive instruments to determine the impact of the intervention within existing school challenges like recent high incidences of violence in South African schools.

It can be concluded, based on the theory guiding this current study that the most important component of the comprehensive approach to health promotion is to address both the reciprocal interplay between self-regulatory and environmental determinants (Bandura, 1998) and that a comprehensive approach of health promotion requires changing the practices of social systems that have widespread detrimental effects on health rather than solely changing the habit of an individual. It is very important to identify the fundamental beliefs that promote or sabotage participation. Where possible the programme should be voluntary and the self-regulatory and self-evaluation should be encouraged in future research.. Performance indicators need to be transparent and visible to every relevant participant.

It is also suggested that instead of the programme to be evaluated at the end it should be an ongoing process and where necessary deviation be allowed to satisfy intended results. This should not be confused with process evaluation where any methods of implementation are recorded, but instead, as part of the implementation and intervention in that where things are not working well, it should not be left for the end if it needs alteration such should be afforded and documented. Such documentation should be for accountability purpose. Evaluation at short interval need to considered in future research as built up for longer as built up for longer intervals.

Performance objectives and measures should be put in place for appropriate requisition of external resources and identify inadequate capacity and advancement that might be needed.

It is important therefore to contextualise the aim and objective of the evaluation into the theoretical base that will be understood by the implementers. In other words, people need to understand the theory that is guiding the intervention in that sense they will know and understand the desired effect.

It is clear from the reviews in this study that there are some identified strategies and suggestions on how to improve the HPS programme implementation and evaluation. It is therefore recommended that further research be done to come up with a framework for an improved contextualized HPS implementation Framework. Still to be identified are margins on how and when to go out of the norms of HPS programme implementation to cater to the site-specific needs which may sometime seem to be out of range.

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APPENDIX A: LEARNER QUESTIONNAIRE ENGLISH

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STUDENT QUESTIONNAIRE
LASH (POLOKWANE)
ENGLISH

Questionnaire number------------- **school name------------**

Date------------------------------------- **Follow up------------------**

Youth Health Survey: Follow up survey

This is a questionnaire that is used to gather information about young people's health. It is voluntary for you to participate in this study. You can withdraw from the study at any time, and you can also skip questions that you find too personal to answer. Please do not write your name on this questionnaire. All the information you give us will be kept private; nobody will know who filled in this questionnaire. Your teachers, neighbours, family and other learners will not see your answers.

We are trying to find out better ways of improving the health and oral health of young people. Your responses are of great value and will help to keep young people in this country healthy. Please help us by filling in this questionnaire.

This is not a test and there are no right or wrong answers. PLEASE BE HONEST IN YOUR ANSWERS.

Please take your time and answer carefully. In questions where there are boxes, please check the box next to the answer you want to give. If you have any questions, please raise your hand and ask the project staffs present in the classroom.

The present study is carried out by the University of Limpopo (Turfloop Campus).

THANK YOU VERY MUCH FOR YOUR HELP!

LASH Questionnaire: …………………Questionnaire No.: ……………

Date: ………………….   School No.: ……………………

1a How old are you?

Age _________

1.1b What is your date of birth

Year--------------Month---------day

1.2 What is the name of your school?

____

1.3 What is your gender?

- ❑ *Male*
- ❑ *Female*

1.4 What grade and class are you in?

____

1.5 What is your religion?

- ❑ *Christian – catholic*
- ❑ *Christian - protestant*
- ❑ *Islam*
- ❑ *Other (please specify)*

1.6 Which of the following languages are spoken at home? Tick all that apply.

- ❑ *English*
- ❑ *Sepedi*
- ❑ *Xitsonga*
- ❑ *Venda*
- ❑ *Other (please specify)*------------------

1.7 How do you identify yourself?

- ❑ *Black*

- ❑ *White*
- ❑ *Coloured*
- ❑ *Indian*
- ❑ *Other (please specify)__________*

1.8Do you live with your mother?

- ❑ *Yes*
- ❑ *No*

1.9 Do you live with your father?

- ❑ *Yes*
- ❑ *No*

1.10 What is the highest level of education your father has?

- ❑ *No formal education*
- ❑ *Less than Primary education*
- ❑ *Primary education*
- ❑ *Secondary education*
- ❑ *College/university education*
- ❑ *I do not know/ don't have a father*

1.11 What is the highest level of education your mother has?

- ❑ *No formal education*
- ❑ *Less than primary education*
- ❑ *Primary education*
- ❑ *Secondary education*
- ❑ *College/University education*
- ❑ *I do not know*
- ❑ *I don't have a mother*

1.12 Do you have any of the following things in your home? Only answer "Yes" if you have them and they work.

a) Television

- ❑ *Yes*

❑ *No*

b) Electricity

❑ *Yes*
❑ *No*

c) Bicycle

❑ *Yes*
❑ *No*

d) Tap water

❑ *Yes*
❑ *No*

e) Flush toilet

❑ *Yes*
❑ *No*

f) Motor car

❑ *Yes*
❑ *No*

g) Computer

1.13 Which of the following best describes your home?

❑ *Shack/hut*
❑ *Wendy house or backyard dwelling*
❑ *Tent or traditional dwelling*
❑ *Brick house or flat*
❑ *Other (please specify)*

____

1.14 How many people sleep in the same room with you at night when you are at home?

____

1.15 Which of the following is true of your home? Please mark the statement that best describes your situation:

❑ *We don't have enough money for food*
❑ *We have enough money for food, but not other basic items such as clothes*
❑ *We have enough money for food and clothes but are very short of many other things*
❑ *We have the most important things, but few luxury goods*
❑ *We have money for luxury goods and extra things*

1.16 Have you ever repeated a school year due to failing exams?

❑ *Yes*
❑ *No*

1.17. How many days were you absent from school during the last school term?

____

1.18 Do you think you will complete your schooling up to grade 12?

❑ *Yes*
❑ *No*
❑ *I don't know*

1.19What do you think you will do when you finish grade 12?

❑ *Attend university, technical college or other tertiary institution*
❑ *Go to trade school (FET)*
❑ *Do some vocational training*
❑ *Get a paid job*
❑ *Start a business*
❑ *I will probably be unemployed for a long time*
❑ *I don't know*

1.20 "The food that we bought just didn't last, and we didn't have money to get more." Was that statement often, sometimes, or never true for your household in the last 12 months?

❑ *Often true*
❑ *Sometimes true*

- [ ] *Never true*
- [ ] *Don't know*

1.21 "We couldn't afford to eat balanced meals." Was that often, sometimes, or never true for your household in the last 12 months?

- [ ] *Often true*
- [ ] *Sometimes true*
- [ ] *Never true*
- [ ] *Don't know*

1.22 In the last 12 months did you or adults in your household ever cut the size of your meals or skip meals because there wasn't enough money for food?

- [ ] *Yes*
- [ ] *No (Go to question 1.25)*
- [ ] *Don't know(Go to question 1.25)*

1.23 If your family ever cut the size of meals or skip meals because there wasn't enough money for schools, how often did this happen – almost every month, some months but not every month, or in only one or two months?

- [ ] *Almost every month*
- [ ] *Some moths, but not every month*
- [ ] *In only 1 or 2 months*
- [ ] *My family has not needed to cut the size of meals or skip meals in the past 12 months*
- [ ] *Don't know*

1.24 In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?

- [ ] *Yes*
- [ ] *No*
- [ ] *Don't know*

1.25 In the last 12 months, were you ever hungry but didn't eat because there wasn't enough money for food?

- [ ] *Yes*
- [ ] *No*

- ❑ *Don't know*

1.26 During the past 30 days, how often did you go hungry because there was not enough food in your home?

- ❑ *Never*
- ❑ *Rarely*
- ❑ *Sometimes*
- ❑ *Often*
- ❑ *Very often*

2. General about your health

2.1 How satisfied are you with your health?

- ❑ *Very satisfied*
- ❑ *Satisfied*
- ❑ *Dissatisfied*
- ❑ *Very dissatisfied*

2.2 During the past 3 months, how often has your health, or how you are feeling, making it difficult for you to get to school?

- ❑ *Rarely or never*
- ❑ *One to two times a month*
- ❑ *Once or twice a week*
- ❑ *Every or nearly every day*

2.3 During the past 3 months, how often has your health, or how you are feeling, making it difficult for you to spend time with your friends?

- ❑ *Rarely or never*
- ❑ *Once or twice a month*
- ❑ *Once or twice a week*
- ❑ *Every or nearly every day*

2.4 During the past 3 months, how often has your health, or how you are feeling, making it difficult to participate in activities with your family?

- ❑ *Rarely or never*
- ❑ *Once or twice a month*

- [ ] *Once or twice a week*
- [ ] *Every or nearly every day*

3. Alcohol and drug use

3.1 Have you ever tasted alcohol?

- [ ] *Yes*
- [ ] *No*

3.2 During the past 30 days, on how many days did you have at least one drink containing alcohol?

- [ ] *1 or 2 days*
- [ ] *3 to 5 days*
- [ ] *6 to 9 days*
- [ ] *10 to 19 days*
- [ ] *20 to 29 days*
- [ ] *All 30 days*

3.3 During the past 30 days, on the days you drank alcohol, how many drinks did you usually drink per day?

- [ ] *I did not drink alcohol in the last 30 days*
- [ ] *Less than 1 drink*
- [ ] *1 drink*
- [ ] *2 drinks*
- [ ] *3 drinks*
- [ ] *4 drinks*
- [ ] *5 or more drinks*

3.4 How many of your friends drink alcohol regularly?

- [ ] *None of them*
- [ ] *Some of them*
- [ ] *Most of them*
- [ ] *All of them*

3.5 Have you ever tried to use drugs/substances of abuse such as dagga or cocaine**?**

- [ ] *Yes*
- [ ] *No*

3.6 During the past 30 days, how many times have you used drugs/substances of abuse such as dagga or cocaine?

- ❑ *0 times*
- ❑ *1-2 times*
- ❑ *3-9 times*
- ❑ *10 or more times*

3.7 Have you ever tried any of the drugs listed below?.

- ❑ *I have never tried any of these drugs*
- ❑ *Marijuana/Dagga*
- ❑ *Tranquilisers or sedatives without a doctor or nurse telling you to do so*
- ❑ *Amphetamines*
- ❑ *Methamphetamine*
- ❑ *A crack or other forms of cocaine*
- ❑ *Solvents or inhalants*
- ❑ *Some other drug*

3.8 How many of your friends have tried drugs/substances of abuse such as dagga or cocaine?

- ❑ *None of them*
- ❑ *Some of them*
- ❑ *Most of them*
- ❑ *All of them*

3.9 During this school year, were you taught in any of your classes the dangers of drug use?

- ❑ *Yes*
- ❑ *No*
- ❑ *I don't know*

4. Dietary Behaviours

4.1 During the past 30 days, how often did you eat breakfast?

- ❑ *Never*
- ❑ *Only a few times*

- [ ] *1-2 day a week*
- [ ] *3-4 days a week*
- [ ] *5-6 days a week*
- [ ] *Every day*

4.2 During the past 30 days, how often did you bring lunch to school?

- [ ] *Never*
- [ ] *Only a few times*
- [ ] *1-2 day a week*
- [ ] *3-4 days a week*
- [ ] *5-6 days a week*
- [ ] *Every day*

4.3 During the past 30 days, how often were you hungry at school?

- [ ] *Never*
- [ ] *Only a few times*
- [ ] *1-2 day a week*
- [ ] *3-4 days a week*
- [ ] *5-6 days a week*
- [ ] *Every day*

4.4 During the past 30 days, how often did you usually eat fruit such as ripe bananas, oranges, pawpaws, mangoes or pineapples?

- [ ] *Never*
- [ ] *Only a few times*
- [ ] *1-2 day a week*
- [ ] *3-4 days a week*
- [ ] *5-6 days a week*
- [ ] *Every day*

4.5 During the past 30 days, how often did you usually eat vegetables such as pumpkin, cabbage, spinach, beetroot or carrots?

- [ ] *Never*
- [ ] *Only a few times*
- [ ] *1-2 day a week*
- [ ] *3-4 days a week*

- [ ] *5-6 days a week*
- [ ] *Every day*

4.6 During the past 30 days, how often do you drink sugar-sweetened soft drinks, such as Coke or Fanta?

- [ ] *Never*
- [ ] *Only a few times*
- [ ] *1-2 day a week*
- [ ] *3-4 days a week*
- [ ] *5-6 days a week*
- [ ] *Every day*

4.7 During the past 30 days, how often do you eat sweets like chocolate and candy?

- [ ] *Never*
- [ ] *Only a few times*
- [ ] *1-2 day a week*
- [ ] *3-4 days a week*
- [ ] *5-6 days a week*
- [ ] *Every day*

4.8 How do you describe your weight?

- [ ] *Very underweight*
- [ ] *Slightly underweight*
- [ ] *About the right weight*
- [ ] *Slightly overweight*
- [ ] *Very overweight*

4.9 Which of the following are you trying to do about your weight?

- [ ] *I am not trying to do anything about my weight*
- [ ] *Lose weight*
- [ ] *Gain weight*
- [ ] *Stay the same weight*

4.10 During the past 12 months, have you been weighed and measured?

- [ ] *Yes*
- [ ] *No*

4.11 During this school year, were you taught in any of your classes about the benefit of eating healthy food?

- ❑ *Yes*
- ❑ *No*
- ❑ *I don't know*

5. Hygiene

5.1 Is there a source of clean water for drinking at your school?

- ❑ *Yes*
- ❑ *No*

5.2 During this school year, were you taught in any of your classes how to avoid worm infections?

- ❑ *Yes*
- ❑ *No*
- ❑ *I don't know*

5.3 During this school year, were you taught in any of your classes where to get treatment for a worm infection?

- ❑ *Yes*
- ❑ *No*
- ❑ *I don't know*

5.4 During the past 30 days, how often did you use the toilets or latrines at school?

- ❑ *There are no latrines or toilets at school*
- ❑ *Never*
- ❑ *Sometimes*
- ❑ *Most of the times*
- ❑ *Always*

5.5 During the past 30 days, how often did you wash your hands after using the toilet or the latrine

- ❑ *Never*
- ❑ *Sometimes*
- ❑ *Most of the times*
- ❑ *Always*

5.6 During the past 30 days, how often did you wash your hands before eating?

- ❑ *Never*
- ❑ *Sometimes*
- ❑ *Most of the times*
- ❑ *Always*

5.7 During the past 30 days, how often did you use soap when washing your hands?

- ❑ *Never*
- ❑ *Sometimes*
- ❑ *Most of the times*
- ❑ *Always*

5.8 During this school year, were you taught in any of your classes the importance of handwashing?

- ❑ *Yes*
- ❑ *No*

6. Mental Health

6.1 During this school year, were you taught in any of your classes how to handle stress in healthy ways?

- ❑ *Yes*
- ❑ *No*
- ❑ *I don't know*

6.2 In general, how do you feel about your life?

- ❑ *I feel very happy*
- ❑ *I feel happy*
- ❑ *I feel not very happy*
- ❑ *I do not feel happy at all*

6.3 In general, how do you think about yourself?

- ❑ *I am very satisfied*
- ❑ *I am quite satisfied*
- ❑ *I am not very satisfied*
- ❑ *I am not satisfied at all*

6.4 I often feel sad (depressed) without knowing why.

- ❑ *I strongly agree*
- ❑ *I agree*
- ❑ *I neither agree or disagree*
- ❑ *I disagree*
- ❑ *I strongly disagree*

6.5 Sometimes I feel everything is so hopeless, that I do not want to do anything.

- ❑ *I strongly agree*
- ❑ *I agree*
- ❑ *I neither agree or disagree*
- ❑ *I disagree*
- ❑ *I strongly disagree*

6.6 Sometimes I have been thinking that my life is not worth living.

- ❑ *I strongly agree*
- ❑ *I agree*
- ❑ *I neither agree or disagree*
- ❑ *I disagree*
- ❑ *I strongly disagree*

6.7 During this school year, were you taught in any of your classes how to deal with mental health issues?

- ❑ *Yes*
- ❑ *No*
- ❑ *I don't know*

7. Physical Activity

7.1 During this school year, on how many days did you go to physical education class each week?

- ❑ *0 days*
- ❑ *1 day*
- ❑ *2 days*
- ❑ *3 days*
- ❑ *4 days*
- ❑ *5 or more days*

7.2 During this school year, were you taught in any of your classes the benefits of physical activity?

- ❑ *Yes*
- ❑ *No*
- ❑ *I don't know*

7.3 Outside school hours, how often do you usually exercise so much that you get out of breath or sweat?

- ❑ *Every day*
- ❑ *4-6 times a week*
- ❑ *2-3 times a week*
- ❑ *Once a week*
- ❑ *Once or twice a month*
- ❑ *Never*

7.4 How do you normally get to and from school?

- ❑ *Walking*
- ❑ *Cycling*
- ❑ *Bus*
- ❑ *Private car*
- ❑ *Other (specify)*

7.5 If you walk to school, about how long does it take you to walk EACH WAY?

- ❑ *Less than 9 minutes each way*
- ❑ *10 to 19 minutes each way*
- ❑ *20 to 29 minutes each way*

- *30 to 39 minutes each way*
- *40 to 49 minutes each way*
- *50 to 59minutes each way*
- *60 or more minutes each way*

7.6 During a week how many hours do you spend watching television or videos/DVD?

- *Less than ½ hour*
- *½ to 2 hours*
- *2 ½ to 4 hours*
- *4 ½ to 6 hours*
- *More than 6 hours*

7.7 During a week how many hours do you spend on the computer or the internet?

- *Less than ½ hour*
- *½ to 2 hours*
- *2 ½ to 4 hours*
- *4 ½ to 6 hours*
- *More than 6 hours*

8. Sexual Behaviors

8.1 Have you ever had a girl-/boyfriend?

- *Yes*
- *No*

8.2 Have you ever had more than one girl-/boyfriend at the same time?

- *Yes*
- *No*

8.3 Have you ever had vaginal sexual intercourse? This means intimate contact with someone during which the penis enters the vagina (female private parts).

- *Yes*
- *No*

8.4 Have you ever had oral sex? This means intimate contact with someone during which the penis is in the mouth or mouth to vagina or mouth to anus.

- ❑ *Yes*
- ❑ *No*

8.5 Have you ever had anal sex? This means sexual intercourse during which the penis enters the anus

- ❑ *Yes*
- ❑ *No*

8.6 During the past 12 months, how many times did you have sexual intercourse?

- ❑ *0 times*
- ❑ *1 time*
- ❑ *2 or 3 times*
- ❑ *4 to 9 times*
- ❑ *10 to 29 times*
- ❑ *30 or more times*

8.7 Have you ever used a condom during sexual intercourse?

- ❑ *I have never had sexual intercourse*
- ❑ Yes
- ❑ *No*

8.8 The last time you had sexual intercourse, did you or your partner use any method of birth control, such as withdrawal, rhythm (safe time), birth control pills, or any other method to prevent pregnancy?

- ❑ *I have never had sexual intercourse*
- ❑ *Yes*
- ❑ *No*
- ❑ *I don't know*

8.9 During the past 12 months, with how many people have you had sexual intercourse?

- ❑ *I have never had sexual intercourse*
- ❑ *I have had sexual intercourse, but not during the past 12 months*
- ❑ *1 person*
- ❑ *2 people*

- [ ] *3 people*
- [ ] *4 people*
- [ ] *5 people*
- [ ] *6 or more people*

8.10 How many of your friends have had sexual intercourse?

- [ ] *None of them*
- [ ] *Some of them*
- [ ] *Most of them*
- [ ] *All of them*

8.11 During this school year, were you taught in any of your classes how to use a condom?

- [ ] *Yes*
- [ ] *No*
- [ ] *I don't know*

8.12 During this school year, were you taught in any of your classes how to avoid HIV infection or AIDS?

- [ ] *Yes*
- [ ] *No*
- [ ] *I don't know*

8.13 During this school year, were you taught in any of your classes where to get tested for HIV infection or AIDS?

- [ ] *Yes*
- [ ] *No*
- [ ] *I don't know*

8.14 During this school year, were you taught in any of your classes about sexuality?

- [ ] *Yes*
- [ ] *No*
- [ ] *I don't know*

9. Tobacco Use

9.1 Have you ever tried or experimented with cigarette smoking, even one or two puffs?

- ❑ *Yes*
- ❑ *No*

9.2 During the past 30 days, on how many days did you smoke cigarettes?

- ❑ *0 days*
- ❑ *1 or 2 days*
- ❑ *3 to 5 days*
- ❑ *6 to 9 days*
- ❑ *10 to 19 days*
- ❑ *20 to 29 days*
- ❑ *Every day*

9.3 During the past 30 days, on how many days did you use any other form of tobacco, such as tobacco roll, snuff, or chew tobacco?

- ❑ *0 days*
- ❑ *1 or 2 days*
- ❑ *3 to 5 days*
- ❑ *6 to 9 days*
- ❑ *10 to 19 days*
- ❑ *20 to 29 days*
- ❑ *Every day*

9.4 During the past 30 days, did anyone ever refuse to sell you cigarettes because of your age?

- ❑ *I did not try to buy cigarettes during the past 30 days*
- ❑ *Yes, someone refused to sell me cigarettes because of my age sell me cigarettes because of my age*
- ❑ *No, my age did not keep me from buying cigarettes*

9.5 Has a cigarette company representative ever offered you a free cigarette?

- ❑ *Yes*
- ❑ *No*

9.6 How many of your friends smoke cigarettes regularly?

- ❑ *None of them*
- ❑ *Some of them*
- ❑ *Most of them*
- ❑ *All of them*

9.7 During this school year, were you taught in any of your classes the dangers of tobacco use?

- ❑ *Yes*
- ❑ *No*
- ❑ *I don't know*

10. Violence

10.1 During the past 12 months, how many times were you physically attacked?

- ❑ *0 times*
- ❑ *1 time*
- ❑ *2 or 3 times*
- ❑ *4 or 5 times*
- ❑ *6 or 7 times*
- ❑ *8 or 9 times*
- ❑ *10 or 11 times*
- ❑ *12 or more times*

10.2 During the past 12 months, how many times were you in a physical fight?

- ❑ *0 times*
- ❑ *1 time*
- ❑ *2 or 3 times*
- ❑ *4 or 5 times*
- ❑ *6 or 7 times*
- ❑ *8 or 9 times*
- ❑ *10 or 11 times*
- ❑ *12 or more times*

10.3 During the past 12 months, how many times were you seriously injured?

- ❑ *0 times*

- ❑ *1 time*
- ❑ *2 or 3 times*
- ❑ *4 or 5 times*
- ❑ *6 or 7 times*
- ❑ *8 or 9 times*
- ❑ *10 or 11 times*
- ❑ *12 or more times*

10.4 During the past 30 days, on how many days were you bullied?

- ❑ *0 days*
- ❑ *1 to 2 days*
- ❑ *3 to 5 days*
- ❑ *6 to 9 days*
- ❑ *10 to 19 days*
- ❑ *20 to 29 days*
- ❑ *All days*

10.5 During the past 30 days, on how many days did you carry a weapon, such as a gun, knife, club etc.?

- ❑ *0 days*
- ❑ *1 day*
- ❑ *2 or 3 days*
- ❑ *4 or 5 days*
- ❑ *6 or more days*

10.6 During the past 12 months, has someone ever threatened to use a knife or other weapon against you?

- ❑ *Yes*
- ❑ *No*

10.7 During the past 12 months, have you ever threatened s a girl-/boyfriend ever threatened to someone with a knife or other weapon?

- ❑ *Yes*
- ❑ *No*

10.8 During the past 12 months, have you been physically forced to have sexual intercourse when you did not want to?

❑ *Yes*
❑ *No*

10.9 During this school year, were you taught in any of your classes how to reduce and avoid violence?

❑ *Yes*
❑ *No*
❑ *I don't know*

11. Social network and decision-making

There are many different ways to make a decision or a choice. In the past 12 months, how often have you talked to the following people for help or help to make a decision?

11.1 Talked to your parents?

❑ *Never*
❑ *Sometimes*
❑ *Often*
❑ *Very Often*

11.2 Talked to some other adult in your family besides your parent (for example, your grandmother, an uncle, your older sister?)

❑ *Never*
❑ *Sometimes*
❑ *Often*
❑ *Very Often*

11.3 Talked to your best friend?

❑ *Never*
❑ *Sometimes*
❑ *Often*
❑ *Very Often*

11.4 Talked to a teacher?

❑ *Never*

- ❑ *Sometimes*
- ❑ *Often*
- ❑ *Very Often*

11.5 Talked to religious leader?

- ❑ *Never*
- ❑ *Sometimes*
- ❑ *Often*
- ❑ *Very Often*

11.6 Talked to a healthy person like a doctor or a nurse or a healer?

- ❑ *Never*
- ❑ *Sometimes*
- ❑ *Often*
- ❑ *Very Often*

11.7 How confident are you that you could say no to drink alcohol when you do not want to drink alcohol?

- ❑ *Not at all confident*
- ❑ *Not very confident*
- ❑ *Somewhat confident*
- ❑ *Very confident*

11.8 How confident are you that you could say "no" if you were offered a cigarette?

- ❑ *Not at all confident*
- ❑ *Not very confident*
- ❑ *Somewhat confident*
- ❑ *Very confident*

11.9 How confident are you that you could say "no" if you were offered marijuana?

- ❑ *Not at all confident*
- ❑ *Not very confident*
- ❑ *Somewhat confident*
- ❑ *Very confident*

11.10 How confident are you that you could avoid a physical fight if someone wanted to start a fight with you?

- ❑ *Not at all confident*
- ❑ *Not very confident*
- ❑ *Somewhat confident*
- ❑ *Very confident*

11.11 How confident are you that you could say "no" to have sexual intercourse against your will?

- ❑ *Not at all confident*
- ❑ *Not very confident*
- ❑ *Somewhat confident*
- ❑ *Very confident*

11.12 How confident are you that you could ask a person who is bothering you to stop?

- ❑ *Not at all confident*
- ❑ *Not very confident*
- ❑ *Somewhat confident*
- ❑ *Very confident*

11.13 How confident are you that you could get a healthy amount of physical activity?

- ❑ *Not at all confident*
- ❑ *Not very confident*
- ❑ *Somewhat confident*
- ❑ *Very confident*

11.14 How confident are you that you could eat a healthy amount of fruits and vegetables?

- ❑ *Not at all confident*
- ❑ *Not very confident*
- ❑ *Somewhat confident*
- ❑ *Very confident*

11.15 How confident are you that you could avoid eating too many sweets?

- ❑ *Not at all confident*
- ❑ *Not very confident*

- [ ] *Somewhat confident*
- [ ] *Very confident*

11.16 How confident are you that you could avoid eating too many fried foods?

- [ ] *Not at all confident*
- [ ] *Not very confident*
- [ ] *Somewhat confident*
- [ ] *Very confident*

11.17 How confident are you that you could use a condom when having sexual intercourse?

- [ ] *Not at all confident*
- [ ] *Not very confident*
- [ ] *Somewhat confident*
- [ ] *Very confident*

12. School environment. Please agree or disagree with the following statements about your school

12.1 I like to go to school

- [ ] *Strongly agree*
- [ ] *Agree*
- [ ] *Neither agree or disagree*
- [ ] *Disagree*
- [ ] *Strongly disagree*

12.2 There are enough toilets or latrines at my school

- [ ] *Strongly agree*
- [ ] *Agree*
- [ ] *Neither agree or disagree*
- [ ] *Disagree*
- [ ] *Strongly disagree*

12.3 The toilets and latrines at my school are easy to get to

- [ ] *Strongly agree*
- [ ] *Agree*

- ❑ *Neither agree or disagree*
- ❑ *Disagree*
- ❑ *Strongly disagree*

12.4 There is water to wash my hands after using the toilet at my school

- ❑ *Strongly agree*
- ❑ *Agree*
- ❑ *Neither agree or disagree*
- ❑ *Disagree*
- ❑ *Strongly disagree*

12.5 There is water to wash my hands before I eat meals or snacks at my school.

- ❑ *Strongly agree*
- ❑ *Agree*
- ❑ *Neither agree or disagree*
- ❑ *Disagree*
- ❑ *Strongly disagree*

12.6 I have the freedom to express my meanings and opinions at school.

- ❑ *Strongly agree*
- ❑ *Agree*
- ❑ *Neither agree or disagree*
- ❑ *Disagree*
- ❑ *Strongly disagree*

12.7 My school is concerned about my health and well-being.

- ❑ *Strongly agree*
- ❑ *Agree*
- ❑ *Neither agree or disagree*
- ❑ *Disagree*
- ❑ *Strongly disagree*

12.8 Students at my school are involved in planning health education programs for youth.

- ❑ *Strongly agree*
- ❑ *Agree*
- ❑ *Neither agree or disagree*

- ❑ *Disagree*
- ❑ *Strongly disagree*

12.9 I am encouraged by my school to take part in meetings and help plan youth health activities.

- ❑ *Strongly agree*
- ❑ *Agree*
- ❑ *Neither agree or disagree*
- ❑ *Disagree*
- ❑ *Strongly disagree*

12.10 My school discourages students from using tobacco

- ❑ *Strongly agree*
- ❑ *Agree*
- ❑ *Neither agree or disagree*
- ❑ *Disagree*
- ❑ *Strongly disagree*

12.11 My school discourages students from drinking alcohol

- ❑ *Strongly agree*
- ❑ *Agree*
- ❑ *Neither agree or disagree*
- ❑ *Disagree*
- ❑ *Strongly disagree*

12.12 My school discourages students from using drugs

- ❑ *Strongly agree*
- ❑ *Agree*
- ❑ *Neither agree or disagree*
- ❑ *Disagree*
- ❑ *Strongly disagree*

12.13 I have chances to play and be active while I am at school

- ❑ *Strongly agree*
- ❑ *Agree*
- ❑ *Neither agree or disagree*
- ❑ *Disagree*

- *Strongly disagree*

12.14 I feel safe at school

- *Strongly agree*
- *Agree*
- *Neither agree or disagree*
- *Disagree*
- *Strongly disagree*

12.15 My school expects students to be respectful to each other

- *Strongly agree*
- *Agree*
- *Neither agree or disagree*
- *Disagree*
- *Strongly disagree*

12.16 My school expects that teachers are respectful of students

- *Strongly agree*
- *Agree*
- *Neither agree or disagree*
- *Disagree*
- *Strongly disagree*

12.17 My school cares if students are hungry during the day

- *Strongly agree*
- *Agree*
- *Neither agree or disagree*
- *Disagree*
- *Strongly disagree*

12.18 If I was sick or needed help when I was at school, my teachers would help me

- *Strongly agree*
- *Agree*
- *Neither agree or disagree*
- *Disagree*

- ❑ *Strongly disagree*

12.19 Girls are treated the same as boys at my school

- ❑ *Strongly agree*
- ❑ *Agree*
- ❑ *Neither agree or disagree*
- ❑ *Disagree*
- ❑ *Strongly disagree*

12.20 My school cares about my sexual health

- ❑ *Strongly agree*
- ❑ *Agree*
- ❑ *Neither agree or disagree*
- ❑ *Disagree*
- ❑ *Strongly disagree*

12.21 During the past 30 days, how often was lunch offered to you at school?

- ❑ *Never*
- ❑ *Rarely*
- ❑ *Sometimes*
- ❑ *Most of the time*
- ❑ *Always*

12.22 During the past 30 days, how often was breakfast offered to you at school?

- ❑ *Never*
- ❑ *Rarely*
- ❑ *Sometimes*
- ❑ *Most of the time*
- ❑ *Always*

12.23 During the past 30 days, how often was a snack offered to you at school?

- ❑ *Never*
- ❑ *Rarely*
- ❑ *Sometimes*
- ❑ *Most of the time*

❑ *Always*

12.24 In the past 30 days, when you ate food at school, where did the food come from? Please mark all that apply

❑ *I didn't have any foods in school in the last 30 days*
❑ *I did bring food from home*
❑ *My school provides food for students*
❑ *Families provide foods for students*
❑ *Community members provide foods for students*

12.25 During the past 30 days, on how many days did you feel unsafe at school or on your way to and/or from school?

❑ *0 times*
❑ *1 time*
❑ *2 or 3 times*
❑ *4 or 5 times*
❑ *6 or more times*

13. Community and village environment

13.1 To what extent do people of your age in your village participate in sport and recreation?

❑ *To a very large extent*
❑ *To a large extent*
❑ *To some extent*
❑ *Not at all*

13.2. To what extent do people of your age in your village participate in economic activities in the village?

❑ *To a very large extent*
❑ *To a large extent*
❑ *To some extent*
❑ *Not at all*

13.3 To what extent do people of your age in your village participate in health-promoting activities?

❑ *To a very large extent*
❑ *To a large extent*

- [ ] *To some extent*
- [ ] *Not at all*

13.4 To what extent do people of your age in your village participate in defence and security of the community?

- [ ] *To a very large extent*
- [ ] *To a large extent*
- [ ] *To some extent*
- [ ] *Not at all*

13.5 To what extent do people of your age in your village participate in leadership and community management?

- [ ] *To a very large extent*
- [ ] *To a large extent*
- [ ] *To some extent*
- [ ] *Not at all*

13.6 People of my age are involved in planning and setting priorities regarding community activities concerning youth?

- [ ] *I strongly agree*
- [ ] *I agree*
- [ ] *I neither agree or disagree*
- [ ] *I disagree*
- [ ] *I strongly disagree*

13.7 People of my age play an important role in how my community run?

- [ ] *I strongly agree*
- [ ] *I agree*
- [ ] *I neither agree or disagree*
- [ ] *I disagree*
- [ ] *I strongly disagree*

14. Health service

14.1 During the past 12 months, did you ever consult anyone with an issue regarding your health?

- [ ] *Yes*
- [ ] *No*

14.2 If you need health care service, how easy would it be for you to obtain such service?

- ❑ *Very easy*
- ❑ *Easy*
- ❑ *Neither easy nor difficult*
- ❑ *Difficult*
- ❑ *Very difficult*

14.3 If you needed health service, would you be able to afford these services?

- ❑ *Very likely*
- ❑ *Likely*
- ❑ *Neither likely or unlikely*
- ❑ *Unlikely*
- ❑ *Very unlikely*

APPENDIX B: LEARNER QUESTIONNAIRE NORTHERN SOTHO

DINYAKIŠIŠO KA TŠA MAPHELO A BASWA

Ye ke potšišobaka (questionnaire) yeo e šomišwago go kgoboketša ditaba mabapi le tša maphelo a baswa. Ke ka boithaopo bja gago gore o tšee karolo mo go tlatšeng letlakala le. O kanna wa ikgogela morago goba gona go lesa go tlatša nako yengwe le yengwe, ebile o kanna wa tshela dipotšišo tšeo o bonago e kare di go ama kudu go ka di araba. Hle o se ke wa ngwala leina lagago mo letlakaleng le. Ditaba kamoka tšeo o tlogo go refa tšona di tla bewa polokelong ya sephiri, gago motho yoo a tlogo go tseba gore ke mang yo a arabilego. Barutiši, baagišane, meloko le barutwana ba bangwe ba ka se bone dikarabo tša gago.

Re leka go hwetša mekgwa le ditsela tše kaone tša go kaonafatša maphelo a baswa. Dikarabo tša gago di bohlokwa kudu gomme di tla re thuša gore baswa ba naga ye ba phele ga botse. Ka kgopelo re thuše ka go tlatša questionnaire ye.
Se ga se thlahlobo (test) ebile ga gona dikarabo tša nnete goba tša go fošagala.
HLE ARABA KA BOTSHEPEGI.

Ka kgopelo tšea nako gomme o arabe ka kelo hloko. Mo dipotšišong tšeo dinago le mapokisana, swaya ka gare ga lepokisana leo le lebanego le karabo eo o nyakago go e fa. Ge o na le potšišo, ka kgopelo emiša letsogo gomme o botšiše mošomedi wa phorotjeke ye yoo alego ka phaphušing. Dinyakišišo tše di dirwa ke ba Unibesithi of Limpopo (Turfloop Campus).

RE LEBOGA KUDU THUšO YA LENA!

LASH Questionnaire: ………………… Questionnaire No.: ……………

Date: …………………. School No. : ……………………

1.1 O belegwe ka ngwaga mang? Ngwaga 19_______

1.2 O ithlaloša seng sag ago bjang?

❑ Monna

❑ Mosadi nngwe

1.3 Ngwala leina la sekolo sa gaga

____

1.4 O bala mphato (grade) ofe?

______(mohlala 8)

1.5 O wela ka go bodumedi bofe?

❑ Mokreste wa katoliki

❑ Mokreste wa phuthego ye nngwe

❑ Islam

❑ Ga ke tsene kereke

❑ Enngwe (thlalosa hle)

1.6 Le bolela maleme afe ka gae go ao a latelago? Swaya ka moka moo go swanetsego

❑ English

❑ Sepedi

❑ Xitsonga

❑ Tshivenda

❑ yenngwe (thlalosa hle)

1.7 O ithlaloša bjang?

❑ Motho yo moso

❑ lekgowa

❑ Lekhalate

❑ Mointia
❑ Go gongwe (thlaloša)___________

1.8 O dula le mme wa gago?

❑ Ee
❑ Aowa

1.9 O dula le tate (papa) wa gago?

❑ Ee
❑ Aowa

1.10 Tate (papa) wa gago o rutegile go fihla kae?

❑ Ga se a rutega
❑ Thuto ya ka fase ga phoraimari
❑ Thuto ya phoraimari
❑ Thuto ya sekolong se se phagamego
❑ Thuto ya kholetšheng/Unibesithi
❑ Ga ke tsebe/ ga ke na tate

1.11 Mme wa gago o rutegile go fihla kae?

❑ Ga se a rutege
❑ Thuto ya ka fase ga phoraimari
❑ Thuto ya phoraimari
❑ Thuto ya sekolong se se phagamego
❑ Thuto ya kholetšheng/Unibesithi
❑ Ga ke tsebe/ ga ke na mme

1.12 E kaba le na le se sengwe gare ga tšeo di latelago ka ga geno? Kgetha *Ee* feela ge ele gore lena le sona ebile se a šoma.

a) TV

❑ Ee
❑ Aowa

b). Mohlagase

- ❑ Ee
- ❑ Aowa

c). Paesekela

- ❑ Ee
- ❑ Aowa

d). Pompi ya meetse

- ❑ Ee
- ❑ Aowa

e). Ntlwana ya boithomelo ya go folaša

- ❑ Ee
- ❑ Aowa

f) Koloi

- ❑ Ee
- ❑ Aowa

1.13 Ke eng gare ga tšeo di latelago seo se hlalosago legae la geno?

- ❑ Mokhukhu/zozo/kokoiši
- ❑ Ntlwana ya ka morago
- ❑ Tente/ ntlo ya mabu
- ❑ Ntlo ya samente goba folete
- ❑ yenngwe (thlalosa hle)__________________

1.14 Ke batho ba ba kae bao ba robalago le wena ka kamoreng e tee bošego ge ole gae? _______

1.15 Ke sefe gare ga tšeo di latelago seo se lego nnete ka ga lapa la geno ? Ka kgopelo swaya boemo bjo bo thlalošago seemo sa gago:

- ❑ Ga rena tšhelete yeo e lekanego ya dijo
- ❑ Re na le tšhelete yeo e lekanego ya dijo, fela e se go dinyakwa tše dingwe tša go swana le diaparo
- ❑ Re na le tšhelete yeo e lekanego ya dijo le diaparo fela re hloka dinyakwa tše dingwe tše di ntšhi
- ❑ Re na le dilo tša bohlokwa kudu, fela e se go tše di ntšhi tša go ithabiša
- ❑ Re na le tšhelete ya go reka tša go ithabiša le tše dingwe tše di ntšhi

1.16 E ka ba o kile wa boeletša mphato (grade) ka baka la go palelwa ke dithlahlobo?

- ❑ Ee
- ❑ Aowa

1.17 Ke matšatši a ma kae ao o ilego wa sebe gona sekolong kotareng ya go feta ya sekolo? _______

1.18 O nagana gore o tla fetša mphato wa gago wa marematlou?

- ❑ Ee
- ❑ Aowa
- ❑ Ga ke tsebe

1.19 E ka ba o nagana gore otla dira eng morago ga go phetha dithuto tša sekolo seo se phagamego?

- ❑ Go tsena Unibesithi, Thekhinikone goba Thešiare.
- ❑ Go ya sekolong sa matsogo/ diatla
- ❑ Go dira dikhoso

❑ Go ikhweletša mošomo wo o lefelago

❑ Go thoma kgwebo

❑ Go na le kgonagalo ya gore ke se hwetše mošomo lebaka le le telele

❑ Ga ke tsebe

1.20 "Dijo tšeo re direkilego ga se di fetše nako, gomme re be re se na tšhelete ya go hwetša tše dingwe." Naa e ka ba seemo se go diragalela gantši, nako tše dingwe, goba ga sa ke se go diragalele mo kgweding tše 12 tša go feta?.

❑ Gantši

❑ Nako tše dingwe

❑ Ga sa ka sa ntiragalele

❑ Ga ke tsebe

1.21 Re be re sa fihlelele go ja dijo tša maleba. Naa e ka ba se se diragetše gantši, nako tše dingwe goba ga sa ka sa diraga mo kgweding tše 12 tša go feta?

❑ Gantši

❑ Nako tše dingwe

❑ Ga sa ka se ntiragalela

❑ Ga ke tsebe

1.22 Mo dikgweding tše 12 tša go feta naa e ka ba wena goba ba bagolo ka gae le ile la fokotša bontši bja dijo go ba la tshidiša go ja ka gobane go be go se na tšhelete yeo e lekanego ya go reka dijo?

❑ Ee

❑ Aowa (fetela go potšišo 1.25)

❑ Ga ke tsebe (fetela go potšišo 1.25)

1.23 Ge e kaba lapa la geno le ile la fokotša bontši bja dijo go makgetlo a go ja ka lebaka la go hloka tšhelete yeo e lekanego ya sekolo, naa seo se diregile ga kae- nyakile ele kgwedi ye ngwe le ye engwe, dikgwedi tše dingwe fela e sego kgwedi le kgwedi, kgwedi e tee goba tše pedi?

- ❑ nyakile ele kgwedi ye nngwe le ye nngwe
- ❑ dikgwedi tše dingwe fela e se go kgwedi le kgwedi
- ❑ kgwedi ye tee goba tše pedi
- ❑ Lapa la gešo ga le a ka la hloka go fokotša dijo mo dikgweding tše 12 tša go feta
- ❑ Ga ke tsebe

1.24 Mo dikgweding tše 12 tša go feta, o ile wa ja dijo tše dinnyane e le ka ge o kwele o swanetše ka gobane go be go se na tšhelete yeo e lekanego ya dijo?

- ❑ Ee
- ❑ Aowa
- ❑ Ga ke tsebe

1.25 Mo dikweding tše 12 tša go feta ke ga kae moo o ilego wa swarwa ke tlala e le ka gobane go be go se na tšhelete eo e lekanego ya dijo?

- ❑ Ee
- ❑ Aowa
- ❑ Ga ke tsebe

1.26 Mo ma tša tšing a 30 a go feta, ke ga kae moo o ilego wa swarwa ke tlala e le ka gobane go se na tšhelete eo e lekanego ya dijo?

- ❑ Ga sa ka
- ❑ E se go gantši
- ❑ Ka nako tše dingwe
- ❑ Gantšhi

- [ ] Gantšhi kudu

2. Kakaretšo ya tša maphelo a gago

2.1 O kgotsofetše ga kaakang ka tša maphelo a gago?

- [ ] Ke kgotsofetše kudu
- [ ] Ke kgotsofetše
- [ ] Ga se ke kgotsofale
- [ ] Ga se ke kgotsofale le ga tee

2.2 Mo dikgweding tše 3 tša go feta ke ga kae moo e le go gore tša maphelo a gago goba ka fao o be go o ikwa ka gona go ile gwa dira gore go ya sekolong go be bothatha go wena?

- [ ] Ga se gantši /Ga sa ka
- [ ] Ga tee go iša go ga bedi ka kgwedi
- [ ] Ga tee goba ga bedi mo bekeng
- [ ] Letšatši le lengwe le le lengwe

2.3 Mo dikgweding tše 3 tša go feta ke ga kae moo e le go gore tša maphelo a gago goba ka fao o be go o ikwa ka gona go ile gwa dira gore go ba le nako le bagwera bagago go be bothatha go wena?

- [ ] Ga se gantši /Ga sa ka
- [ ] Ga tee goiša go ga bedi ka kgwedi
- [ ] Ga tee goba ga bedi mo bekeng
- [ ] Letšatši le lengwe le le lengwe

2.4 Mo dikgweding tše 3 tša go feta ke ga kae moo e lego gore tša maphelo a gago goba ka fao o be go o ikwa ka gona go ile gwa dira gore go tšea karolo mo mererong ya ka gae go be bothatha go wena?

- [ ] Ga se gantši /Ga sa ka

- [ ] Ga tee goiša go ga bedi ka kgwedi
- [ ] Ga tee goba ga bedi mo bekeng
- [ ] Letšatši le lengwe le le lengwe

---

3. Bjala le tšhomišo ya ditagi

3.1 Naa o kile wa nwa bjala?

- [ ] Ee
- [ ] Aowa

3.2 Mo matšatšing a 30 a go feta ke ga kae mo o kilego wa nwa bonnyane bja seno se tee sa go ba le bjala?

- [ ] Letšatši goba a mabedi
- [ ] Matšatši a 3 goiša go 5
- [ ] Matšatši a 6 go iša go 9
- [ ] Matšatši a 10 go iša go 19
- [ ] Matšatši a 20 go iša go 29
- [ ] Matšatši kamoka a 30

3.3 Mo matšatšing ao o nwelego ka ona go a 30 a go feta, o nwele dino tše kae ka letšatši?

- [ ] Ga se ke nwe bjala mo matšatšing a 30 a go feta
- [ ] Ka fase ga seno se se tee
- [ ] Seno se se tee
- [ ] Dino tše pedi
- [ ] Dino tše tharo
- [ ] Dino tše nne
- [ ] Dino tše hlano le go feta

3.4 Ke bagwera bagago ba ba kae bao ba nwago bjala kgafetšakgafetša?

- ❑ Ga go o tee wa bona
- ❑ Ba ba banwge ba bona
- ❑ Bontši bja bona
- ❑ Kamoka ga bona

3.5 Naa o ile wa leka go šomiša ditagi goba diretebatši blalo ka patše goba cocaine?

- ❑ Ee
- ❑ Aowa

3.6 Mo matšatšing a 30 a go feta ke a kae mo o šomišitšego ditagi?

- ❑ Ga sa ka
- ❑ Ga 1-2
- ❑ Ga 3-4
- ❑ Ga 10 goba go feta

3.7 Naa o ile wa leka ditagi tšeo dilatelago:

- ❑ Ga sa ka ka leka le e tee ya tšona
- ❑ Patše
- ❑ Diphilisi tša go okobatša ntle le go difiwa ke mooki
- ❑ Diritibatši (cacaina)
- ❑ Ditagi tša go kgogwa (glue, spirit)
- ❑ Diritibatši tše dingwe

3.8. Ke bagwera bagago ba ba kae bao ba ilego ba leka ditagi tša go swana le patše goba cocaine.

- ❑ Gago o tee wa bona
- ❑ Ba bangwe ba bona
- ❑ Bontši bja bona

❑ Ka moka ga bona

3.9 Mo ngwageng wona wo, naa o ile wa rutwa ka phaphušing ka ga kotsi ya go šomiša ditagi?

❑ Ee

❑ Aowa

❑ Ga ke tsebe

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4. Mekgwa ya go ja

4.1 Mo matšatšing a 30 a go feta, ke ga kae mo o ilego wa ja dijo tša mesong?

❑ Ga sa ka

❑ Di nako tše mmalwa

❑ Matšatši a 1-2 mo bekeng

❑ Matšatši a 3-4 mo bekeng

❑ Matšatši a 5-6 mo bekeng

❑ Tšatši le lengwe le le lengwe

4.2 Mo matšatšing a 30 a go feta ke ga kae moo o tlilego le dijo tša mosegare sekolong?

❑ Ga sa ka

❑ Dinako tše mmalwa

❑ Matšatši a 1-2 mo bekeng

❑ Matšatši a 3-4 mo bekeng

❑ Matšatši a 5-6 mo bekeng

❑ Tšatši le lengwe le le lengwe

4.3 Mo matšatšing a 30 a go feta ke ga kae moo o ilego wa swarwa ke tlala o le mosekolong?

- ❑ Ga sa ka
- ❑ Dinako tše mmalwa
- ❑ Matšatši a 1-2 mo bekeng
- ❑ Matšatši a 3-4 mo bekeng
- ❑ Matšatši a 5-6 mo bekeng
- ❑ Tšatši le lengwe le le lengwe

4.4 . Mo matšatšing a 30 a go feta ke ga kae moo o hlwago o eja dienywa tša go swana le dipanana, namune, phophou, apola goba phaenepola?

- ❑ Ga sa ka
- ❑ Dinako tše mmalwa
- ❑ Matšatši a 1-2 mo bekeng
- ❑ Matšatši a 3-4 mo bekeng
- ❑ Matšatši a 5-6 mo bekeng
- ❑ Tšatši le lengwe le le lengwe

4.5. Mo matšatšing a 30 a go feta ke ga kae moo o hlwago o eja merogo bjalo la sepenetšhe, khabetšhe, lephotse, kherote le pitiruti.

- ❑ Ga sa ka
- ❑ Dinako tše mmalwa
- ❑ Matšatši a 1-2 mo bekeng
- ❑ Matšatši a 3-4 mo bekeng
- ❑ Matšatši a 5-6 mo bekeng
- ❑ Tšatši le lengwe le le lengwe

4.6 Mo matšatšing a 30 a go feta ke ga kae moo o ilego wa nwa dino tša go ba le swikiri bjalo ka khoukhu, goba fantha

- ❑ Ga sa ka
- ❑ Dinako tše mmalwa
- ❑ Matšatši a 1-2 mo bekeng
- ❑ Matšatši a 3-4 mo bekeng
- ❑ Matšatši a 5-6 mo bekeng
- ❑ Tšatši le lengwe le le lengwe
- ❑ Tšatši le lengwe le lengwe

4.7 Mo matšatšing a 30 a go feta ke ga kae moo o ilego wa ja malekere go swana le tšhokolete chocolate goba khendy?

- ❑ Ga sa ka
- ❑ Dinako tše mmalwa
- ❑ Matšatši a 1-2 mo bekeng
- ❑ Matšatši a 3-4 mo bekeng
- ❑ Matšatši a 5-6 mo bekeng
- ❑ Tšatši le lengwe le le lengwe

4.8 Naa o hlaloša bjang boima bja mmele wa gago?

- ❑ Ke otile kudu
- ❑ Ke otile
- ❑ Ke lokile
- ❑ Ke na le le mmele o mogolwane
- ❑ Ke na le mmele o mogolo kudu

4.9 Naa ke eng sa tšeo di latego seo e leng gore o leka go se dira ka boima bja mmele wa gago?

- ❑ Ga go seo ke lekago go se dira ka bogolo bja mmele waka
- ❑ Go fokotša mmele
- ❑ Go oketša mmele
- ❑ Go dula ka mokgwa woo ke lego ka gona

4.10 Mo dikgweding tše 12 tša go feta, o ile wa kala boima goba gona go tšea botelele bja gago?

- ❑ Ee
- ❑ Aowa

4.11 Mo ngwageng wona wo, naa o ile wa rutwa ka phaphušing ka ga dipoelo/bohlokwa bja go ja dijo tša phepo?

- ❑ Ee
- ❑ Aowa
- ❑ Ga ke tsebe

5. Hlweko

5.1 Naa go na le moo le hwetšago meetsi a go nwewa ao a hlwekilego mo sekolong sa lena?

- ❑ Ee
- ❑ Aowa

5.2 Mo ngwageng wona wo, naa o ile wa rutwa ka phaphušing ka ga mokgwa wa go efoga bolwetši bja dibokwana?

- ❑ Ee
- ❑ Aowa

5.3 Mo ngwageng wona wo, naa o ile wa rutwa ka phaphušing moo o ka hwetšago kalafo ya tshwaetšo ya dibokwana?

- ❑ Ee
- ❑ Aowa

5.4 Matšatšing a 30 a go feta o ile wa šomiša ntlwana y boithomelo (toilet) ya mo sekolong?

- ❑ Ga go dintlwana tša bo ithomelo mo sekolong
- ❑ Ga sa ka
- ❑ Ka dinako tše dingwe
- ❑ Ka dinako tše dintši
- ❑ Ka dinako tšohle

5.5 Matšatšing a 30 a go feta ke ga kae moo o ilego wa hlapa matsogo ge ofetša go šomiša ntlwana ya boithomelo?

- ❑ Ga sa ka
- ❑ Ka dinako tše dingwe
- ❑ Ka dinako tše dintši
- ❑ Ka dinako tšohle

5.6 Matšatšing a 30 a go feta ke ga kae moo o ilego wa hlapa matsogo pele o tla ja?

- ❑ Ga sa ka
- ❑ Ka dinako tše dingwe
- ❑ Ka dinako tše dintši
- ❑ Ka dinako tšohle

5.7 Matšatšing a 30 a go feta ke ga kae moo o ilego wa šomiša sesepe ge o hlapa matsogo?

- ❑ Ga sa ka
- ❑ Ka dinako tše dingwe

- ❑ Ka dinako tše dintši
- ❑ Ka dinako tšohle

5.8 Mo ngwageng wona woo, o ile wa rutwa ka mo phaphošing ka ga bohlokwa bja go hlapa matsogo?

- ❑ Ee
- ❑ Aowa

6. Maphelo a tša monagago

6.1 Mo ngwageng wona woo, o ile wa rutwa ka mo phaphošing mokgwa wa go lebana le kgatelelo ya monagago ka tsela yeo e lokilego/phepa?

- ❑ Ee
- ❑ Aowa
- ❑ Ga ke tsebe

6.2 Ka kakaretšo, o ikwa bjang ka bophelo bja gago?

- ❑ Ke kwa ke thabile kudu
- ❑ Ke kwa ke thabile
- ❑ Ke kwa ke sa thaba kudu
- ❑ Ga ke kwe ke thabile le ga tee

6.3 Ka kakaretšo, o nagana bjang ka ga wena?

- ❑ Ke kgotsofetše kudu
- ❑ Ke kgotsofetše
- ❑ Ga se ke kgotsofale kudu
- ❑ Ga se ke kgotsofale le ga tee

6.4 Gantši ke kwa ke nyamile ntle le go tseba gore gobaneng.

- ❑ Ke dumela kudu
- ❑ Ke a dumela
- ❑ Ga ke dumele ebile gake gane
- ❑ Ga ke dumele

❑ Ga ke dumele le ga tee

6.5 Ka dinako tše dingwe ke kwa ke se na tshepo, moo elego gore ga ke nyake go dira selo.

❑ Ke dumela kudu

❑ Ke a dumela

❑ Ga ke dumele ebile ga ke gane

❑ Ga ke dumele

❑ Ga ke dumele le ga tee

6.6 Ka dinako tše dingwe ke be ke nagana gore ga go bohlokwa gore ke bophele

❑ Ke dumela kudu

❑ Ke a dumela

❑ Ga ke dumele ebile ga ke gane

❑ Ga ke dumele

❑ Ga ke dumele le ga tee

6.7 Mo ngwageng wona woo, o kile wa rutwa ka phaphušing gore o lebane bjang le tša maphelo a monagano?

❑ Ee

❑ Aowa

❑ Ga ke tsebe

7. Boitšhidullo

7.1 Mo ngwageng wona woo ke ga kae moo o ilego wa ya dithutong tša go itšhidulla beke ye ngwe le ye nwge?

❑ Matšatši a 0

❑ Matšatši a 1

❑ Matšatši a 2

❑ Matšatši a 3

❑ Matšatši a 4

❑ Matšatši a 5 goba go feta

7.2 Mo ngwageng wona woo o ile wa rutwa ka phaphošing ya gago bohlokwa bja go itšhidulla?

- ❑ Ee
- ❑ Aowa
- ❑ Ga ke tsebe

7.3 Ka nako yeo e sego ya sekolo, Ke ga kae moo elego gore o fela o ikwehliša moo o bilego o felela ke go hema le gona go tša mofufutšo?

- ❑ Tšatši le lengwe le le lengwe
- ❑ Ga 4-6 mo bekeng
- ❑ Ga 2-3 mo bekeng
- ❑ Ga tee ka beke
- ❑ Ga tee goba ga 2 ka kgwedi
- ❑ Ga senke

7.4 Naa gantši o o ya ka eng le go boya ka eng sekolong?

- ❑ Ka maoto
- ❑ Ka paesekela
- ❑ Ka pase
- ❑ Ka koloi
- ❑ Tše dingwe (thlaloša)

7.5 Ge e ka ba o tsamaya ka maoto, na go go tšea nako e kaakang leeto le lengwe le lengwe (go ya fela ke leeto le tee, go boya le gona ke leeto)?

- ❑ Ka fase ga metsotso e 9 leeto le tee
- ❑ Metsotso e 10-19 leeto le tee
- ❑ Metsotso e 30-39 leeto le tee
- ❑ Metsotso e 40-49 leeto le tee
- ❑ Metsotso e 50-59 leeto le tee

❑ Metsotso e 60 goba go feta leeto le tee

7.6 O tšea diiri tše kae ge o lebeletše thelebišeni goba DVD mo bekeng?

❑ Ka fase ga metsotso e 30

❑ Metsotso e 30 go iša go iri e tee

❑ Diiri tše 2 ½ -4

❑ Diiri tše 4 ½ - 6

❑ Go feta diri tše 6

7.7 O tšea diiri tše kae mo khomputheng mo bekeng?

❑ Ka fase ga metsotso e 30

❑ Metsotso e 30 go iša go iri e tee

❑ Diiri tše 2 ½ -4

❑ Diiri tše 4 ½ - 6

❑ Go feta diiri tše 6

8. Mekgwa le maitshwaro a tša thobalano

8.1. Naa o ile wa ba le lekgarebe

❑ Ee

❑ Aowa

8.2. Naa o ile wa ba le

Makgarebe /masogana a go feta le tee ka nako e tee?

❑ Ee

❑ Aowa

8.3. Naa o ile wa dira tša thobalano? (Se sera go kgomarelana le motho moo setho sa bonna se tsenago ka gare ga sa bosadi)

❑ Ee

❑ Aowa

8.4. Naa o ile wa dira thobalano ka ganong? (se se ra go kgomarelana le motho moo setho sa bonna se tsenago ka molomong goba molomo go marago goba molomo go setho sa bosadi)

❑ Ee

❑ Aowa

8.5. Naa o ile wa dira thobalano ka maragong? (se se ra thobalano moo setho sa bonna se tsenago ka maragong

❑ Ee

❑ Aowa

8.6. Mo kgweing tše 12 tša go feta, o ile wa dira tša thobalano ga kae?

❑ 0
❑ Ga tee
❑ Ga 2 goba ga 3
❑ Ga 4 goiša ga 9
❑ Ga 10 goiša go 29
❑ Ga 30 goba go feta

8.7 Naa o o ile wa šomiša condom ge o dira tša thobalano

❑ Ga sa ka ka dira tša thobalano

❑ Ee

❑ Aowa

8.8 La mafelelo ge o dira tša thobalano, naa ekaba wena goba molekani wa gago le šomišitše mokgwa o itšego wa go thibela pelegi, bjalo ka go kgogela setho sa bonna

morago, go efoga matšatši ao o ka imago ka wona, philisi, goba mokwga o mongwe wa go thibela go ima?

- ❑ Ga senke ka dira tša thobalano
- ❑ Ee
- ❑ Aowa
- ❑ Ga ke tsebe

8.9 Ke batho ba ba kae ba o ilego wa dira le bona tša thobalano mo dikgweding tše 12 tša go feta?

- ❑ Ga sa ka ka dira tša thobalano
- ❑ Ke ile ka dira tša thobalano, eupša e sego mo dikweding tše 12 tša go feta
- ❑ Motho o tee (1)
- ❑ Batho ba babedi (2)
- ❑ Batho ba bararo (3)
- ❑ Batho ba bane (4)
- ❑ Batho ba bahlano (5)
- ❑ Batho ba 6 le go feta

8.10 Ke ba ba kae ba bagwera bagago bao ba ilego ba tsenela tša thobalano?

- ❑ Ga go tee wa bona
- ❑ Ba bangwe ba bona
- ❑ Bontši bja bona
- ❑ Ka moka ga bona

8.11 Naa mo ngwageng wona woo o ile wa rutwa go šomiša khondomo?

- ❑ Ee
- ❑ Aowa
- ❑ Ga ke tsebe

8.12 Naa mo ngwageng wona woo o ile wa rutwa mekgwa ya go ka efoga HIV goba AIDS?

- ❑ Ee
- ❑ Aowa
- ❑ Ga ke tsebe

8.13 Naa mo ngwageng wona woo o ile wa rutwa ka ga mafelo a o o kayago go dira diteko tša HIV goba AIDS?

- ❑ Ee
- ❑ Aowa
- ❑ Ga ke tsebe

8.14 Mo ngwageng wona wo, o ile wa rutwa ka tša thobalano?

- ❑ Ee
- ❑ Aowa
- ❑ Ga ke tsebe

9. Tšhomišo ya motsoko

9.1 Naa o ile wa leka goba wa kgoga sekerete, le ge e le ga tee goba ga bedi?

- ❑ Ee
- ❑ Aowa

9.2 Mo matsatšing a 30 a go feta ke ga kae moo o ilego wa kgoga sekerete?

- ❑ Matšatši a 0
- ❑ Matšatši a 1 goba 2
- ❑ Matšatši a 3-5
- ❑ Matšatši a 6-9
- ❑ Matšatši a 10-19
- ❑ Matšatši 20-29

❑ Letšatši le lengwe le le lengwe

9.3 Mo matsatšing a 30 a go feta ke ga kae moo o ilego wa kgoga mekgwa e mengwe ya metsoko go swana le fola (seneifi)?

❑ Matšatši a 0

❑ Matšatši a 1 goba 2

❑ Matšatši a 3-5

❑ Matšatši a 6-9

❑ Matšatši a 10-19

❑ Matšatši 20-29

❑ Letšatši le lengwe le le lengwe

9.4 Mo matsatšing a 30 a go feta, naa go na le motho yoo a ilego a gana go go rekišetša sekerete lebaka e le mengwaga ya gago?

❑ Ga sa ka ka leka go reka sekerete mo matšatšing a 30 a go feta

❑ Ee, go na le motho yoo a gannego go nthekišetša sekerete ka lebaka la mengwaga ya ka

❑ Aowa, mengwaga yaka ga yaka ya ntšhitiša go reka sekerete

9.5 Naa e kaba gona le mošomedi wa khamphani ya sekerete yoo a ilego a go fa sekerete sa mahala?

❑ Ee

❑ Aowa

9.6 Ke bagwera bagago ba ba kae bao ba tsubago sekerete kgafetšakgafetša?

❑ Ga go o tee wa bona

❑ Ba bangwe ba bona

❑ Bontši bja bona

❑ Ka moka ga bona

9.7 Mo ngwageng wona woo, naa o ile wa rutwa ka ga kotsi ya go šomiša motsoko?

- ❑ Ee
- ❑ Aowa
- ❑ Ga ke tsebe

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10 Tša dintwa

10.1 Mo dikgweding tše 12 tša go feta, ke ga kae moo o ilego wa thlaselwa ka petho?

- ❑ Ga 0
- ❑ Ga 1
- ❑ Ga 2 goba 3
- ❑ Ga 4 goba 5
- ❑ Ga 6 goba 7
- ❑ Ga 8 goba 9
- ❑ Ga 10 goba 11
- ❑ Ga 12 goba go feta

10.2 Mo dikgweding tše 12 tša go feta, ke ga kae moo o ilego wa amega mo ntweng ya go bethana?

- ❑ Ga 0
- ❑ Ga 1
- ❑ Ga 2 goba 3
- ❑ Ga 4 goba 5
- ❑ Ga 6 goba 7
- ❑ Ga 8 goba 9
- ❑ Ga 10 goba 11
- ❑ Ga 12 goba go feta

10.3 Mo dikgweding tše 12 tša go feta, ke ga kae moo o ilego wa gobala kudu?

- ❑ Ga 0
- ❑ Ga 1

- ❑ Ga 2 goba 3
- ❑ Ga 4 goba 5
- ❑ Ga 6 goba 7
- ❑ Ga 8 goba 9
- ❑ Ga 10 goba 11
- ❑ Ga 12 goba go feta

10.4 Mo dikgweding tše 12 tša go feta ke matšatši a makae moo o ilego wa tswenywa ke bo ramaatla (bullies)?

- ❑ Matšatši a 0
- ❑ Matšatši a 1 -2
- ❑ Matšatši a 3-5
- ❑ Matšatši a 6-9
- ❑ Matšatši a 10-19
- ❑ Matšatši a 20-29
- ❑ Matšatši ka moka

10.5 Mo matšatšing a 30 a go feta, ke matšatši a ma kae mo o ilego wa šomiša sebetša sa go swana le sethunya, thipa?

- ❑ Ga 0
- ❑ Ga 1
- ❑ Ga 2 goba 3
- ❑ Ga 4 goba 5
- ❑ Ga 6 goba goba go feta

10.6 Mo dikgweding tše 12 tša go feta, naa go na le motho wo a ilego a go tšhošetša ka go šomiša thipa goba sebolai se sengwe mo go wena?

- ❑ Ee
- ❑ Aowa

10.7 Mo dikgweding tše 12 tša go feta naa o iile wa tšhošetša lekgarebe/lesogana la gago ka thipa goba sebolai se sengwe mo go yena?

- ❑ Ee
- ❑ Aowa

10.8 . Mo dikgweding tše 12 tša go feta naa o ile wa gapeletšwa ka maatla go dira tša thobalano o sa nyake?

- ❑ Ee
- ❑ Aowa

10.9 Mo ngwageng wona woo o ile wa rutwa ka phaphušing ya gago ka mekgwa ya go fokotša le go efoga dintwa?

- ❑ Ee
- ❑ Aowa
- ❑ Ga ke tsebe

11. Tša kgwerano le go tšea diphetho

Gona le mekgwa ya go fapana ya go tšea dipheto goba go dira khetho. Mo dikgweding tše 12 tša go feta, ke ga kae moo o boletšego le batho bao ba latelago gore ba go thuše go tšea sephetho?

11.1 O boletše le batswadi?

- ❑ Ga sa ka
- ❑ Ka dinako tše dingwe
- ❑ Gantši
- ❑ Gantši kudu

11.2 O boletše le motho yo mongwe yo mogolo yoo e se go motswadi wa gago (malome, koko, sesi)?

- ❑ Ga sa ka
- ❑ Ka dinako tše dingwe
- ❑ Gantši
- ❑ Gantši kudu

11.3 O boletše le mogwera wagago wa potego?

- ❑ Ga sa ka
- ❑ Ka dinako tše dingwe
- ❑ Gantši
- ❑ Gantši kudu
- ❑ Gantšhi kudu

11.4 O boletše le morutiši?

- ❑ Ga sa ka
- ❑ Ka dinako tše dingwe
- ❑ Gantši
- ❑ Gantši kudu

11.5 O boletše le moetapele wa phuthego

- ❑ Ga sa ka
- ❑ Ka dinako tše dingwe
- ❑ Gantši
- ❑ Gantši kudu

11.6 O boletše le mošomedi wa tša maphelo bjalo ka ngaka, mooki?

- ❑ Ga sa ka
- ❑ Ka dinako tše dingwe
- ❑ Gantši
- ❑ Gantšhi kudu

11.7 Naa o na le boitshepo bjo bo kaakang bja gore o ka kgona go gana go nwa bjala ge o sa nyake go nwa bjala?

- ❑ Ga ke na boitshepo le ga tee
- ❑ Ga ke na boitshepo bjo bontšhi
- ❑ Ke na le boitshepo bjo itšego
- ❑ Ke na le boitshepo bjo bontši

11.8 Naa o na le boitshepo bjo bo kaakang bja gore o ka kgona go gana ge o ka fiwa sekerete?

- ❑ Ga ke na boitshepo le ga tee
- ❑ Ga ke na boitshepo bjo bontšhi
- ❑ Ke na le boitshepo bjo itšego
- ❑ Ke na le boitshepo bjo bontši

11.9 Naa o na le boitshepo bjo bo kaakang bja gore o ka kgona go gana ge o ka fiwa patše?

- ❑ Ga ke na boitshepo le ga tee
- ❑ Ga ke na boitshepo bjo bontšhi
- ❑ Ke na le boitshepo bjo itšego
- ❑ Ke na le boitshepo bjo bontši

11.10 Naa o na le boitshepo bjo bo kaakang bja gore o ka kgona go efoga ntwa ya pethano ge motho o mongwe a nyaka go lwa le wena?

- ❑ Ga ke na boitshepo le ga tee
- ❑ Ga ke na boitshepo bjo bontšhi
- ❑ Ke na le boitshepo bjo itšego
- ❑ Ke na le boitshepo bjo bontši

11.11 Naa o na le boitshepo bjo bo kaakang bja gore o ka kgona go gana go dira thobalano kgahlanong le thato ya gago?

❑ Ga ke na boitshepo le ga tee

❑ Ga ke na boitshepo bjo bontšhi

❑ Ke na le boitshepo bjo itšego

❑ Ke na le boitshepo bjo bontši

11.12 Naa o na le boitshepo bjo bo kaakang bja gore o ka kgona go botša motho yo a go tshwenyago gore a tlogele go go tshwenya?

❑ Ga ke na boitshepo le ga tee

❑ Ga ke na boitshepo bjo bontšhi

❑ Ke na le boitshepo bjo itšego

❑ Ke na le boitshepo bjo bontši

11.13 Naa o na le boitshepo bjo bo kaakang bja gore o ka kgona go humana nako eo e lekanego ya go ikwetliša ?

❑ Ga ke na boitshepo le ga tee

❑ Ga ke na boitshepo bjo bontšhi

❑ Ke na le boitshepo bjo itšego

❑ Ke na le boitshepo bjo bontši

11.14 Naa o na le boitshepo bjo bo kaakang bja gore o ka kgona go ja dienywa le merogo yeo e lekanego phepho?

❑ Ga ke na boitshepo le ga tee

❑ Ga ke na boitshepo bjo bontšhi

❑ Ke na le boitshepo bjo itšego

❑ Ke na le boitshepo bjo bontši

11.15 Naa o na le boitshepo bjo bo kaakang bja gore o ka kgona go efoga go ja malekere a mantšhi?

❑ Ga ke na boitshepo le ga tee

- ❑ Ga ke na boitshepo bjo bontšhi
- ❑ Ke na le boitshepo bjo itšego
- ❑ Ke na le boitshepo bjo bontši

11.16 Naa o na le boitshepo bjo bo kaakang bja gore o ka kgona go efoga go ja dijo tšeo di gadikilwego ka makhura?

- ❑ Ga ke na boitshepo le ga tee
- ❑ Ga ke na boitshepo bjo bontšhi
- ❑ Ke na le boitshepo bjo itšego
- ❑ Ke na le boitshepo bjo bontši

11.17 Naa o na le boitshepo bjo bo kaakang bja gore o ka kgona go šomiša condom ge dira thobalano?

- ❑ Ga ke na boitshepo le ga tee
- ❑ Ga ke na boitshepo bjo bontšhi
- ❑ Ke na le boitshepo bjo itšego
- ❑ Ke na le boitshepo bjo bontši

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12. Tikologo ya sekolo: Hle dumelelana goba o ganane le mafoko ao a latelago mabapi le sekolo sago

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12.1 Ke rata go ya sekolong

- ❑ Ke dumela kudu
- ❑ Ke a dumela
- ❑ Ga ke dumele ebile ga ke gane
- ❑ Ga ke dumele
- ❑ Ga ke dumele le ga tee

12.2 Go na le dintlwana tša boithomelo (toilets) tšeo di lekanego mo sekolong

- ❑ Ke dumela kudu
- ❑ Ke a dumela

- ❑ Ga ke dumele ebile gake gane
- ❑ Ga ke dumele
- ❑ Ga ke dumele le ga tee

12.3 Go bonolo goya dintlwaneng tša boithomelo (toilets) tša mo sekolong.

- ❑ Ke dumela kudu
- ❑ Ke a dumela
- ❑ Ga ke dumele ebile ga ke gane
- ❑ Ga ke dumele
- ❑ Ga ke dumele le ga tee

12.4 Go na le meetsi a go hlapa matsogo ge o fetša go šomiša ntlwana ya boithomelo mo sekolong

- ❑ Ke dumela kudu
- ❑ Ke a dumela
- ❑ Ga ke dumele ebile ga ke gane
- ❑ Ga ke dumele
- ❑ Ga ke dumele le ga tee

2.5 Go na le meetsi a go hlapa matsogo pele ke eja dijo mo sekolong

- ❑ Ke dumela kudu
- ❑ Ke a dumela
- ❑ Ga ke dumele ebile ga ke gane
- ❑ Ga ke dumele
- ❑ Ga ke dumele le ga tee

12.6 Ke na le tokologo ya go ntšha sa mafahleng a ka le go bontšha mogopolo waka mo sekolong

- ❑ Ke dumela kudu
- ❑ Ke a dumela

- [ ] Ga ke dumele ebile ga ke gane
- [ ] Ga ke dumele
- [ ] Ga ke dumele le ga tee

12.7 Sekolo sa ka se tshwenyega ka maphelo le go itekanela ga mmele ga ka

- [ ] Ke dumela kudu
- [ ] Ke a dumela
- [ ] Ga ke dumele ebile ga ke gane
- [ ] Ga ke dumele
- [ ] Ga ke dumele le ga tee

12.8 Barutwana ba mo sekolong sa ka ba tšea karolo mo go thaleng lenaneo la thuto ya tša maphelo a baswa

- [ ] Ke dumela kudu
- [ ] Ke a dumela
- [ ] Ga ke dumele ebile ga ke gane
- [ ] Ga ke dumele
- [ ] Ga ke dumele le ga tee

12.9 Ke thlohleletšwa ke sekolo sa ka go tšea karolo mo dikopanong le go thuša go beakanya dithuto tša maphelo a baswa

- [ ] Ke dumela kudu
- [ ] Ke a dumela
- [ ] Ga ke dumele ebile ga ke gane
- [ ] Ga ke dumele
- [ ] Ga ke dumele le ga tee

12.10 Sekolo saka ga se hlohloletše barutwana gore ba kgoge motsoko

- [ ] Ke dumela kudu
- [ ] Ke a dumela

❑ Ga ke dumele ebile gake gane

❑ Ga ke dumele

❑ Ga ke dumele le ga tee

12.11 Sekolo sa ka ga se thlohleletše barutwana gore ba nwe bjala

❑ Ke dumela kudu

❑ Ke a dumela

❑ Ga ke dumele ebile ga ke gane

❑ Ga ke dumele

❑ Ga ke dumele le ga tee

12.12 Sekolo saka ga se thlohleletše barutwana gore ba šomiše ditagi

❑ Ke dumela kudu

❑ Ke a dumela

❑ Ga ke dumele ebile gake gane

❑ Ga ke dumele

❑ Ga ke dumele le ga tee

12.13 Ke na le monyetla wa go bapala ke go ba le mahlaahla ge ke le mo sekolong

❑ Ke dumela kudu

❑ Ke a dumela

❑ Ga ke dumele ebile ga ke gane

❑ Ga ke dumele

❑ Ga ke dumele le ga tee

12.14 Ke ikwa ke bolokegile mo sekolong

❑ Ke dumela kudu

❑ Ke a dumela

- ❑ Ga ke dumele ebile ga ke gane
- ❑ Ga ke dumele
- ❑ Ga ke dumele le ga tee

12.15 Sekolo sa ka se letetše go barutwana gore ba hlomphane ka bobona

- ❑ Ke dumela kudu
- ❑ Ke a dumela
- ❑ Ga ke dumele ebile ga ke gane
- ❑ Ga ke dumele
- ❑ Ga ke dumele le ga tee

12.16 Sekolo sa ka se letetše go barutiši gore ba hlomphe barutwana

- ❑ Ke dumela kudu
- ❑ Ke a dumela
- ❑ Ga ke dumele ebile ga ke gane
- ❑ Ga ke dumele
- ❑ Ga ke dumele le ga tee

12.17 Sekolo sa ka se na le taba ge barutwana ba swara ke tlala mo mosegareng

- ❑ Ke dumela kudu
- ❑ Ke a dumela
- ❑ Ga ke dumele ebile ga ke gane
- ❑ Ga ke dumele
- ❑ Ga ke dumele le ga tee

12.18 Ge nka babjwa goba ka nyaka thušo ke le mo sekolong, barutiši ba ka nthuša

- ❑ Ke dumela kudu
- ❑ Ke a dumela

- [ ] Ga ke dumele ebile ga ke gane
- [ ] Ga ke dumele
- [ ] Ga ke dumele le ga tee

12.19 Basetsana ba swara ka mokgwa wa go swana le yeo masogana a swarwago ka gona mo sekolong

- [ ] Ke dumela kudu
- [ ] Ke a dumela
- [ ] Ga ke dumele ebile ga ke gane
- [ ] Ga ke dumele
- [ ] Ga ke dumele le ga tee

12.20 Sekolo sa ka se ela hloko maphelo a ka a tša thobalano

- [ ] Ke dumela kudu
- [ ] Ke a dumela
- [ ] Ga ke dumele ebile ga ke gane
- [ ] Ga ke dumele
- [ ] Ga ke dumele le ga tee

12.21 Mo matšatšing a 30 a go feta ke ga kae moo o ilego wa fiwa dijo mo sekolong?

- [ ] Ga sa ka
- [ ] Ka go rothela
- [ ] Ka dinako tše dingwe
- [ ] Gantši
- [ ] Ka dinako tšohle

12.22 Mo matšatšing a 30 ago feta ke ga kae moo o ilego wa fiwa dijo tša mesong mo sekolong?

- [ ] Ga sa ka
- [ ] Ka go rothela
- [ ] Ka dinako tše dingwe

❑ Gantši

❑ Ka dinako tšohle

12.23 Mo matšatšing a 30 ago feta ke ga kae moo o ilego wa fiwa dijo tša go kgefutša ka ganong (snacks) mo sekolong?

❑ Ga sa ka

❑ Ka go rothela

❑ Ka dinako tše dingwe

❑ Gantši

❑ Ka dinako tšohle

12.24 Mo matšatšing a 30 a go feta, ge o be o eja mo sekolong, naa dijo tšeo di be di etšwa kae? Ka kgopelo swaya dikarabo kamoka tšeo e lego tša maleba

❑ Ga sa ka ka ba le dijo mosekolong mo matšatšing a 30 a go feta

❑ Ke tlile le dijo go tšwa gae

❑ Sekolo sa ka se fa barutwana dijo

❑ Malapa ke ona a fago barutwana dijo

❑ Maloko a setšhaba ke ona a a fago barutwana dijo

12.25 Mo matšatšing a 30 a go feta, ke ga kae mo o kilego wa ikwa o sa bolokega mo sekolng goba tseleng ya go ya goba gona go tšwa sekong?

❑ Ga 0

❑ Ga 1

❑ Ga 2 goba 3

❑ Ga 4 goba 5

❑ Ga 6 goba go feta

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13. Tikologo ya setšhaba le mo motseng

13.1 Naa dithaka tša gago tša mo motseng wa geno di tšea karolo go fihla kae mo go tša dipapadi le go ikwetliša?

❑ Kudu kudu

❑ Kudu

❑ Kutšwana

❑ Le ga tee

13.2 Naa dithaka tša gago tša mo motseng wa geno di tšea karolo go fihla kae mo go tša moruo(ekonomi) wa motse

❑ Kudu kudu

❑ Kudu

❑ Kutšwana

❑ Le ga tee

13.3 Naa dithaka tša gago tša mo motseng wa geno di tšea karolo go fihla kae mo go tša tutuetšo ya dithuto tša maphelo?

❑ Kudu kudu

❑ Kudu

❑ Kutšwana

❑ Le ga tee

13.4 Naa dithaka tša gago tša mo motseng wa geno di tšea karolo go fihla kae mo go tša tšhireletšo ya setšhaba?

❑ Kudu kudu

❑ Kudu

❑ Kutšwana

❑ Le ga tee

13.5 Naa dithaka tša gago tša mo motseng wa geno di tšea karolo go fihla kae mo ketelelong pele le taolong ya setšhaba?

❑ Kudu kudu

❑ Kudu

❑ Kutšwana

❑ Le ga tee

13.6 Dithaka tšaka di tšea karolo mo peakanyong le go bea ka tatelelano go ya ka bohlokwa mananeong a setšhaba mabapi le baswa

- ❑ Ke dumela kudu
- ❑ Ke a dumela
- ❑ Ga ke dumele ebile ga ke gane
- ❑ Ga ke dumele
- ❑ Ga ke dumele le ga tee

13.7 Dithaka tšaka di bapala karolo ya bohlokwa mo tshepidišong ya motse wa gešo

- ❑ Ke dumela kudu
- ❑ Ke a dumela
- ❑ Ga ke dumele ebile ga ke gane
- ❑ Ga ke dumele
- ❑ Ga ke dumele le ga tee

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14 . Ditirelo tša maphelo

14.1 Mo dikgweding tše 12 tša go feta o ile wa etela motho mang goba mang mabapi le tša maphelo a gago?

- ❑ Ee
- ❑ Aowa

14.2 Ge o kabe o ile wa nyaka diterelo tša maphelo, naa go kabe go ile gwa ba bonolo ga kaakang mo go wena go hwetša ditirelo tšeo?

- ❑ Bonolo kudu
- ❑ Bonolo
- ❑ Magareng
- ❑ Boima
- ❑ Boima kudu

14.3 Ge o kabe o ile wa nyaka ditirelo tša maphelo, o be o tla kgona go lefela ditirelo tšeo?

- ❑ Kgonagalo ke e kgolo
- ❑ Go na le kgonagalo
- ❑ Magareng
- ❑ Ga go kgonagale
- ❑ Ga go kgonagale le ga tee

14.4 Ke mang yoo o ka dumago go bolela le yena ge ona le mathata a tša maphelo? (O dumeletšwe go swaya karabo ya go feta e tee ge o bona go le bohlokwa)

- ❑ Motho yo mongwe wa cliniking
- ❑ Ngaka ya sekgowa
- ❑ Nyaka ya setšo
- ❑ Mma/Mohlokomedi waka wa mosadi
- ❑ Papa/mohlokomedi waka wa monna
- ❑ Wa leloko
- ❑ Morutiši
- ❑ Mogwera

Yo mongwe (thlaloša)-----------

APPLICATION FOR RESEARCH ETHICS CLEARANCE

- **Type** in the required information.
- Complete only form A Part I and Part II for experimental research.
- Complete only form B Part I and Part II for research using human participants (non-experimental research).
- Complete relevant sections of Part III and Part IV for form A and form B.

FORM A – PART I

PROJECT TITLE: **Outcome Evaluation of a Health Promoting School Approach Intervention: an impact analysis of mental health outcomes among High School learners in the Capricorn District, Limpopo Province.**

PROJECT LEADER: **RAISIBE CYNTHIA LANGA**

DECLARATION

I, the signatory, hereby apply for approval to execute the experiments described in the attached research proposal and declare that:

1. I am fully aware of the guidelines and regulations for ethical research and that I will abide by these guidelines and regulations as set out in documents (available from the Secretary of the Ethics Committee); and

2. I undertake to provide every person who participates in this research project with the relevant information in Part III. Every participant will be requested to sign Part IV.

Name of Researcher: **RAISIBE CYNTHIA LANGA**
Signature:

____

Date: 12 -03 -2015

For Official use by the Ethics Committee:

Approved/Not approved
Remarks:……………………………………………………………………………………………..
………………………………………………………………………………………………………..
………………………………………………………………………………………………………..

Signature of Chairperson:………………………………………..

Date:…………………………………………………………..

FORM A - PART II

PROJECT TITLE: **Outcome Evaluation of a Health Promoting School Approach Intervention: an impact analysis of mental health outcomes among High School learners in the Capricorn District, Limpopo Province.**

PROJECT LEADER: RAISIBE CYNTHIA LANGA

Protocol for the execution of experimental research **(N/A)**

1. Department: PSYCHOLOGY

2. Title of project:

3. Full name, surname and qualifications of project leader:

4. List the name(s) of all persons (Researchers and Technical Staff) involved with the project and identify their role(s) in the conduct of the experiment:

   Name: Qualifications: Responsible for:

5. Name and address of principal researcher:

6. Procedures to be followed: Administration of questionnaires.

7. Nature of discomfort: N/A

8. Description of the advantages that may be expected from the results of the study:

   N/A

Signature of Project Leader:………………………………………………………………………

Date:……………………

FORM B – PART I

PROJECT TITLE: **Outcome Evaluation of a Health Promoting School Approach Intervention: an impact analysis of mental health outcomes among High School learners in the Capricorn District, Limpopo Province.**

PROJECT LEADER **RAISIBE CYNTHIA LANGA**

DECLARATION

I, the signatory, hereby apply for approval to conduct the research described in the attached research proposal and declare that:

1. I am fully aware of the guidelines and regulations for ethical research and that I will abide by these guidelines and regulations as set out in documents (available from the Secretary of the Ethics Committee); and

2. I undertake to provide every person who participates in this research project with the relevant information in Part III. Every participant will be requested to sign Part IV.

Name of Researcher: **RAISIBE CYNTHIA LANGA**

Signature:

____

Date:.12-03-2015

For Official use by the Ethics Committee:

Approved/Not approved

Remarks:………………………………………………………………………………………..

……………………………………………………………………………………………….

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………………………………………………………………………………………………..

………………………………………………………………………………………………..

Signature of Chairperson:………………………………………..

Date:………………………

FORM B - PART II

PROJECT TITLE: Outcome Evaluation of a Health Promoting School Approach Intervention: an impact analysis of mental health outcomes among High School learners in the Capricorn District, Limpopo Province.

PROJECT LEADER: RAISIBE CYNTHIA LANGA

Protocol for conducting research using human participants

1. Department: **PSYCHOLOGY**
2. Title of project: **Outcome Evaluation of a Health Promoting School Approach Intervention: an impact analysis of mental health outcomes among High School learners in the Capricorn District, Limpopo Province.**
3. Full name, surname and qualifications of project leader:
   RAISIBE CYNTHIA LANGA
4. List the name(s) of all persons (Researchers and Technical Staff) involved with the project and identify their role(s) in the conduct of the experiment:

Name:	Qualifications:	Responsible for:
Langa RC	**MA (PSYCHOLOGY)**	**The whole project**

5. Name and address of principal researcher: **Langa RC**
   No 9 Emmanuel Park
   Outspan Drive
   Bendor
   Polokwane
   0699
6. Procedures to be followed: Permission will be requested from participants to partake in the study. The researcher will explain the instruction of completing the questionnaires and for the school profiling assessment the principal or representative of a school will fill in the school profiling questionnaire

7. Nature of discomfort: the only discomfort that participants may experience is completing the information about their sexual behaviours and being asked to give information about their socioeconomic status

8. Description of the advantages that may be expected from the results of the study:
   Site-specific issues will be taken into consideration when doing health-promoting school project and each school will be treated as unique by highlighting the challenges raised by learners for future correction by the institution.

Signature of Project Leader

Date:12-03-2019

PART III

INFORMATION FOR PARTICIPANTS

PROJECT TITLE: **Outcome Evaluation of a Health Promoting School Approach Intervention: an impact analysis of mental health outcomes among High School learners in the Capricorn District, Limpopo Province.**

PROJECT LEADER: **RAISIBE CYNTHIA LANGA**

1. You are invited to participate in the following research project:

   Outcome Evaluation of a Health Promoting School Approach Intervention: an impact analysis of mental health outcomes among High School learners in the Capricorn District, Limpopo Province.

2. Participation in the project is completely voluntary and you are free to withdraw from the project (without providing any reasons) at any time.

3. It is possible that you might not personally experience any advantages during the project, although the knowledge that may be accumulated through the project might prove advantageous to others.

4. You are encouraged to ask any questions that you might have in connection with this project at any stage. The project leader and her/his staff will gladly answer your question. They will also discuss the project in detail with you.

5. This is a research project whereby you are requested to give information about your health behaviour and the information about your school. This project may ask you some personal questions like your sexual encounters which may sometimes trigger some unpleasant memories which may cause discomfort in answering them. Though answering this may not advantage you spontaneously as an individual the information you provide will assist in helping young people who are in a similar position with you.

6. Should you at any stage feel unhappy, uncomfortable or is concerned about the research, please contact **Ms Noko Shai-Ragoboya at the University of Limpopo, Private Bag X1106, Sovenga, 0727, tel: 015 268 2401**.

PART IV
CONSENT FORM

PROJECT TITLE: **Outcome Evaluation of a Health Promoting School Approach Intervention: an impact analysis of mental health outcomes among High School learners in the Capricorn District, Limpopo Province.**

PROJECT LEADER: **CYNTHIA LANGA**

I, ____ hereby voluntarily consent to participate in the following project: **Outcome Evaluation of a Health Promoting School Approach Intervention: an impact analysis of mental health outcomes among High School learners in the Capricorn District, Limpopo Province.**

I realise that:

1. The study deals with the evaluation of a Health Promoting School Approach Intervention Among High School Learners in Capricorn District of the Limpopo Province to be able to identify Profiles for Sustainability of Mental Health Promotion**.**

2. The procedure or treatment envisaged may hold some risk for me that cannot be foreseen at this stage.

3. The Ethics Committee has approved that individuals may be approached to participate in the study.

4. The research project, ie. the extent, aims and methods of the research, has been explained to me.

5. The project sets out the risks that can be reasonably expected as well as possible discomfort for persons participating in the research, an explanation of the anticipated advantages for myself or others that are reasonably expected from the research and alternative procedures that may be to my advantage.

6. I will be informed of any new information that may become available during the research that may influence my willingness to continue my participation.

7. Access to the records that pertain to my participation in the study will be restricted to persons directly involved in the research.

8. Any questions that I may have regarding the research or related matters, will be answered by the researcher/s.

9. If I have any questions about, or problems regarding the study, or experience any undesirable effects, I may contact a member of the **research team or Ms Noko Shai-Ragoboya.**

10. Participation in this research is voluntary and I can withdraw my participation at any stage.

11. If any medical problem is identified at any stage during the research, or when I am vetted for participation, such condition will be discussed with me in confidence by a qualified person and/or I will be referred to my doctor.

12. I indemnify the University of Limpopo and all persons involved with the above project from any liability that may arise from my participation in the above project or that may be related to it, for whatever reasons, including negligence on the part of the mentioned persons.

SIGNATURE OF RESEARCHED PERSON

SIGNATURE OF WITNESS

SIGNATURE OF PERSON THAT INFORMED THE RESEARCHED PERSON

SIGNATURE OF PARENT/GUARDIAN

Signed at_________________________ this ____ day of _________________ 20__