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From wellness to learning: Integrating health promotion into classrooms

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Authors:
Tebalelo M. Aphane[1]
Mmapeu M. Manyaka[2]

Affiliations:
[1]Department of Curriculum and Instructional Studies, College of Education, University of South Africa, Pretoria, South Africa

[2]Department of Early Childhood Education, College of Education, University of South Africa, Pretoria, South Africa

Corresponding author:
Tebalelo Aphane,
eaphantm@unisa.ac.za

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Background: In South African no-fee primary schools, learners' physical, emotional and social well-being is closely linked to their ability to participate meaningfully in classroom learning. While national policies promote holistic learner support, health promotion is often implemented through fragmented programmes rather than integrated into teaching and learning.

Aim: This study explored how school-based stakeholders and a partnering non-governmental organisation (NGO) understand, support and integrate health promotion into Grade 1 and 2 teaching and learning within no-fee primary schools.

Setting: Selected no-fee public primary schools in Gauteng province, South Africa.

Methods: A qualitative case study design was employed. Data were generated through semi-structured interviews with nine purposively selected participants, including teachers, School Management Team members, School-Based Support Team members and an NGO representative. Thematic analysis guided by the Health Promoting Schools framework was used to interpret the data.

Results: Participants recognised learner wellness as essential for learning; however, health promotion was treated as an added responsibility rather than a core teaching priority. Barriers included limited time, inadequate training, weak structural support and inconsistent support from School-Based Support Teams and external services.

Conclusion: A disconnect exists between policy intentions and classroom practice, with health promotion insufficiently integrated into teaching and learning. Greater collaboration and clearer pedagogical guidance are needed.

Contribution: This study clarifies how health promotion can be enacted as a pedagogical enabler in under-resourced primary schools.

Keywords: health-promoting schools; learner wellness; Foundation Phase; no-fee schools; school-based support teams; school management teams; pedagogical integration; South Africa.

Introduction

While it is widely accepted that learning begins at birth, formal schooling represents a structured transition in which teaching and learning are deliberately organised and systematised across many South African classrooms, and learning begins long before a teacher opens a textbook; it begins with the physical, emotional and social realities learners carry into school each day. Educational research increasingly acknowledges that learners experiencing hunger, emotional distress, poor health or unsafe conditions are less able to focus, participate and engage actively in class activities (Stewart-Brown 2006; World Health Organization [WHO], United Nations Children's Fund [UNICEF] & United Nations Educational, Scientific and Cultural Organization [UNESCO] 2023). Building on this global perspective, the South African context presents unique challenges that amplify this interdependence. In this sense, wellness is not separate from learning; it is a set of physical, emotional and social conditions that serve as a pedagogical enabler, facilitating learner participation and engagement. While health promotion encompasses the integrated strategies used to weave these conditions into everyday activities (Barnekow Rasmussen & Rivett 2000; WHO 2023), learner support refers to policy and institutional mechanisms, such as the Screening, Identification, Assessment and Support (SIAS) policy (Department of Basic Education [DBE] 2014) that address barriers to learning. Psychosocial support, in turn, focuses more specifically on learners' emotional and social needs. This study conceptualises wellness as the broader state of well-being that underpins learners' readiness to learn

when health is treated as a core educational priority rather than a marginal welfare concern.

World Health Organization (2023) and Barnekow Rasmussen and Rivett (2000) emphasise this interdependence by calling for integrated strategies that weave health promotion into everyday classroom activities, thereby supporting both learner well-being and academic performance. Consequently, grasping how these conditions play out in classroom settings is central to primary school education.

In South Africa (SA), this relationship is especially evident in no-fee public primary schools, where socio-economic constraints intensify wellness-related challenges. Arendse and Ross (2025) note that a substantial number of learners arrive at school while dealing with food insecurity, psychosocial burdens, inadequate access to healthcare and a range of challenges in their broader communities. In such settings, schools increasingly serve as spaces where educational and social support overlap, thereby placing greater responsibilities on teachers and school leadership to address learners' holistic needs. The SIAS (DBE 2014) acknowledges this complexity by promoting coordinated structures within schools to address learners' holistic needs. Although national policies and global frameworks advocate for integrated approaches, health promotion in South African schools often remains fragmented and externally driven. This fragmentation occurs because wellness is typically relegated to the Life Skills 'curricular silo' rather than being embedded in everyday classroom practice (Kwatubana & Kheswa 2014; Mbatha, McCrindle & Shirinde 2024). Consequently, a significant gap remains regarding the pedagogical enactment of wellness. Specifically, current scholarship offers limited insight into how teacher practices and multi-stakeholder collaboration (involving School-Based Support Teams [SBSTs] and non-governmental organizations [NGOs]) intersect to integrate health-promoting actions into everyday classroom routines in under-resourced settings.

Against this backdrop, the study addressed the main research question: *How is health promotion understood and embedded in the pedagogical practices of no-fee primary schools?* To answer this question, three sub-questions were formulated, aligned with the study's core analytical dimensions:

- *How do school-based and external stakeholders understand the relationship between learner wellness and classroom learning?*
- *What roles do various stakeholders play in supporting health-promoting practices in no-fee primary schools?*
- *How is health promotion integrated into pedagogical practices and the broader curriculum?*

By addressing these questions, the study contributes to understanding how health promotion is understood, supported and integrated within everyday teaching and learning in under-resourced primary school contexts.

The study is guided by three interconnected concepts: health promotion, wellness-oriented practices and classroom integration. Health promotion is understood as a holistic educational strategy, aligned with the Health Promoting Schools (HPS) framework, through which schools seek to embed health and well-being within the core mission of schooling rather than treating them as peripheral welfare concerns (Sonowal, Chandak & Muraleedharan 2025; WHO 1998). Within this broader framework, wellness-oriented practices refer to classroom-level pedagogical actions and routines that support learners' physical, emotional and social readiness to learn, drawing on evidence that links supportive learning environments and health-related activities to improved educational outcomes (Brown, Wilmot & Paton Ash 2015; Stewart-Brown 2006). Classroom integration, in turn, refers to the extent to which such wellness-oriented practices are embedded across teaching and learning activities rather than being confined to a single curriculum area. Together, these concepts provide the analytical lens through which the study examines how health promotion is understood, supported and enacted within Grade 1 and 2 teaching and learning. In this regard, wellness is conceptualised as a cross-curricular pedagogical enabler that supports learner participation, engagement and access to learning opportunities throughout the Foundation Phase.

International experiences offer valuable insights into how health promotion can be integrated into classroom practice (Meiklejohn, Peeters & Palermo 2021; Nordmyr, Tuomela & Forsman 2024; Pan-Canadian Joint Consortium for School Health 2025). Although many of these initiatives are situated in high-income contexts, they consistently affirm that learner well-being is foundational to participation, engagement and learning, rather than an added concern (Stewart-Brown 2006; WHO, UNICEF & UNESCO 2023). This relationship is not dependent on the abundance of resources but reflects the broader interdependence between health and education recognised by the HPS framework (Barnekow Rasmussen & Rivett 2000; WHO 2023). In South African no-fee schools, where poverty, food insecurity and psychosocial challenges shape learners' readiness to learn (Arendse & Ross 2025; Shaik Mahomed & Etokabeka 2025), this interdependence is particularly pronounced.

Consequently, international evidence should be viewed not as transferable models but as guiding principles. Rather than promoting replication, this study draws on global insights to explore how integrated wellness can be adapted to the specific constraints of Grade 1 and 2 education in SA (Brown et al. 2015; Mbatha et al. 2024).

International evidence further suggests that the successful integration of health promotion within schools requires a combination of institutional coordination and context-responsive implementation. Across diverse educational settings, health-promoting initiatives have been most effective when supported by coordinated policy frameworks, dedicated implementation teams, data-informed planning and participatory practices that actively engage teachers and

learners (Meiklejohn et al. 2021; Nordmyr et al. 2024; Pan-Canadian Joint Consortium for School Health 2025; Pearson et al. 2015). These studies collectively demonstrate that wellness initiatives are more sustainable when embedded within everyday school routines and teaching practices rather than delivered as isolated or event-based interventions.

European research reinforces this view. In Finland, the Finnish Institute for Health and Welfare runs a national School Health Promotion study that provides biennial, data-driven insights into learners' physical, emotional and social well-being, guiding school planning and targeted interventions (Nordmyr et al. 2024). Building on this evidence base, the CONSENSUS project, as reported by Nordmyr et al. (2024), demonstrates that participatory approaches to promoting mental well-being in Finnish primary schools can enhance learner engagement when aligned with existing educational structures. Similarly, Pearson et al. (2015) emphasise, based on United Kingdom (UK) research, that maintaining long-term impact requires integrating health-promoting behaviours into regular classroom and school procedures that are backed by teacher–learner reciprocity and adaptability. However, despite these global lessons, South African research continues to show gaps in classroom-level integration.

Current scholarship emphasises policy and whole-school interventions yet offers limited insight into how health promotion is enacted in daily classroom practices. For instance, Samdal and Rowling (2012) identified the implementation components of HPS but did not examine how these components translate into teacher-led classroom actions. Recent South African studies also emphasise broader school settings rather than pedagogical contexts (Mbatha et al. 2024; Pillay, Patel & Setlhare-Kajee 2023). This gap is significant because, while teachers in at-risk South African primary schools identify nutrition, physical activity and socio-emotional support as urgent priorities (Shaik Mahomed & Etokabeka 2025), there is limited evidence on how these priorities are translated into specific pedagogical actions within the classroom.

Research further shows limited attention to how teachers are supported by school-based and external stakeholders, including SBSTs, school management, NGOs and district officials, to integrate health promotion into teaching. While initiatives such as Communities of Practice (CoP) aim to strengthen SBST capacity (Communities for Child Wellbeing 2025), their specific impact on stakeholder support for classroom integration of health promotion remains underexplored. Research on the South African Grade 1 and 2 indicates that sustainable, meaningful change in classrooms is most successful when it is rooted in everyday practice and informed by a thorough understanding of children's developmental needs (Brown et al. 2015). Therefore, examining how stakeholders support teachers in positioning wellness as a core pedagogical enabler rather than a marginal add-on is critical to enhancing educational outcomes in no-fee schools. This gap is particularly evident in no-fee primary schools where wellness challenges are severe.

Emerging qualitative studies show that while teachers are committed to wellness initiatives, they continue to face fixed systemic barriers that impede effective classroom integration. For example, Arnaiz et al. (2024) found that teachers embraced health initiatives like KaziKidz but faced structural constraints, while Ngwenya (2020) reported that inadequate stakeholder coordination and resource limitations obstructed sustained integration.

Although teachers demonstrate commitment to wellness-oriented practices, persistent systemic barriers continue to limit their integration into everyday teaching. By examining how these practices shape learner participation, engagement and readiness to learn in under-resourced school contexts, the study contributes new insights into the multi-stakeholder dynamics that influence classroom-level health promotion.

Theoretical framework

The theoretical framework of this study is grounded in the HPS framework, which emphasises integrating health and well-being into schools' core educational mission (WHO 1998). This approach is particularly relevant for South African no-fee primary schools, where learners' physical, emotional and social well-being plays a crucial role in their capacity to participate in meaningful learning. The HPS framework, developed and initiated through the WHO, promotes a holistic approach to health by integrating educational, social and health processes within the school setting.

Based on Stewart-Brown's synthesis of research on school health promotion, programmes that integrate health promotion into routine school activities are more likely to deliver lasting improvements in both health and educational outcomes (Stewart-Brown 2006). Instead of emphasising one-off initiatives, the HPS framework promotes a whole-school approach that brings policies, routines, relationships and environments into alignment to support learner well-being.

The HPS framework also facilitates an exploration of the roles of various stakeholders, including the SBSTs, school management and external organisations. This emphasis on collaboration is necessary because it enables analysis of how these support systems might either facilitate or obstruct the incorporation of wellness-oriented practices in teaching. The acknowledgement of shared responsibility among stakeholders resonates with the Integrated School Health Policy (ISHP) (DBE & Department of Health 2012) and the SIAS Policy (DBE 2014), which advocate coordinated efforts to address learners' holistic needs.

Recent scholarship affirms the continued relevance of the HPS framework in shaping health-supportive classroom

practice, with Balasooriya Lekamge et al. (2025) showing that whole-school, HPS-aligned interventions significantly reduce cyberbullying, smoking and cyber-aggression, highlighting the value of coordinated curriculum, school environment and family–community engagement strategies. Similarly, Sonowal et al.'s (2025) scoping review and bibliometric analysis highlight sustained global growth in school health-promotion research, particularly around mental health, capacity building and comprehensive learner support, further reinforcing the HPS framework as a relevant lens for understanding contemporary school-health dynamics.

The HPS framework serves as a comprehensive framework that not only highlights the importance of health and well-being in educational settings but also underlines the need for collaborative efforts among stakeholders to effectively integrate health promotion into classroom practices. This approach is essential for addressing the complex needs of learners in under-resourced settings, ultimately enhancing their educational experiences and outcomes.

Research methods and design

Study design

This study employed a qualitative, exploratory case study design situated within an interpretive paradigm. The case study design was selected because the study sought to understand a contemporary educational phenomenon within its natural setting. The interpretive paradigm informed all stages of the research process. It assumes that reality is socially constructed and that participants assign meaning to their experiences within specific contexts (Pervin & Mokhtar 2022). Consequently, the study sought to understand how teachers and stakeholders interpreted learner wellness and health promotion within their everyday practice. During data generation, participants were encouraged to share their subjective experiences. During analysis, themes were developed through an interpretive examination of meanings embedded within participants' narratives. The researchers acknowledged their own positioning as education scholars interested in learner wellness and engaged reflexively throughout the study to minimise the influence of personal assumptions on data interpretation. Examining health promotion within no-fee schools enabled the researchers to investigate how wellness practices are experienced, interpreted and enacted by diverse school-based and external stakeholders, thereby directly addressing the research questions concerning understanding, support and classroom integration. A case study design is particularly appropriate for examining current educational phenomena rooted within real-life school contexts where socio-economic and institutional conditions influence practice (Merriam & Tisdell 2016; Yin 2018).

Setting

The study was conducted in two no-fee primary schools (Quintile 3) located in the same under-resourced township in SA. These schools served as bounded settings through which the broader case of integrating health promotion into classroom practice was explored (Creswell & Creswell 2017). Following Yin (2018), the case was bounded institutionally by the two participating schools, geographically by one district in Gauteng province, temporally by data collected during the 2025 academic year, and in terms of participants by stakeholders directly involved in health-promotion activities, including teachers, School Management Team (SMT) members, SBST representatives and an NGO representative. This context is significant because it provides deeper insight into the challenges children face in low-income settings, where access to essential resources such as adequate nutrition, healthcare and educational support may be constrained.

Sampling

Purposive sampling was used to recruit information-rich participants with direct roles in integrating health promotion into classroom practice. Although the two participating schools formed part of a broader engaged scholarship project aimed at strengthening health-promotion capacity in no-fee contexts, eligibility for this study was based on independent, role-specific inclusion criteria rather than project participation alone. Guided by Merriam and Tisdell's (2016) view that purposive sampling enables rich, context-dependent inquiry in qualitative case study designs and supported by Creswell and Creswell's (2017) argument that it facilitates the deliberate selection of participants best placed to illuminate the phenomenon of interest, this strategy aligned with the interpretive, classroom-centred focus of the study. Recent methodological developments, particularly the updated framework proposed by Ahmad and Wilkins (2025), further informed the researchers' approach by treating purposive sampling as a process that requires upfront planning, ongoing evaluation and alignment with evolving research aims across the entire study.

To maintain methodological coherence, the researchers established explicit inclusion criteria, such as professional function, school environment and direct interaction with classroom-linked wellness activities. The researchers then evaluated the evolving sample against these criteria throughout the data gathering process. To enhance transparency about how purposive sampling was operationalised, the researchers drew on contemporary typologies that distinguish among criterion, homogeneous and maximum-variation strategies, selecting criterion purposive sampling (role-based, context-specific) to ensure participants could speak directly to classroom integration of health promotion in no-fee schools. This decision aligns with current recommendations to explicitly describe selection criteria and identify the purposive reasoning employed in qualitative education research.

Consistent with these principles, nine participants were recruited across two no-fee (Quintile 3) primary schools and organised into four role groups to surface multi-perspective insights: four teachers (two Grade 1 and two Grade 2), SMT members, SBST representatives and a social worker

from a partnering NGO. This composition prioritised depth and relevance over breadth, a hallmark of purposive designs aiming for analytic illumination rather than statistical representativeness. To protect participant confidentiality while providing sufficient contextual information, direct quotations are accompanied by the participant code, gender, professional role and school or organisational affiliation. Teachers are identified by their grade level, role and school (e.g. G1TA refers to the Grade 1 Teacher from School A and G2TB refers to the Grade 2 Teacher from School B). School-based leadership and support staff are identified by their institutional role and school suffix (e.g. SMT-1 and SBST-1 for School A; SMT-2 and SBST-2 for School B). Finally, the representative from the partnering NGO is identified as the NGO Social Worker.

Finally, in line with current commentary on common pitfalls, particularly the risk of blending purposive and convenience sampling, the researchers documented decision points, inclusion criteria and role justifications to mitigate selection bias and avoid over-interpretation of findings.

Data collection

Data were generated through semi-structured interviews, which ensured a consistent focus on the questions while allowing participants to expand on their experiences. Interview guides were tailored for each group to explore understandings of health promotion, its integration within teaching and perceived enablers and constraints. All interviews were conducted in person at the schools, lasted 20–30 min, were audio-recorded with consent and subsequently transcribed to ensure accuracy and depth in analysis. While most interviews fell within this timeframe because of school-based time constraints, the interview with the NGO representative lasted longer, allowing for a more in-depth exploration of cross-school support dynamics.

Data analysis

Kiger and Varpio (2020) note that thematic analysis is well suited to identifying patterned meanings across participants' experiences, and their position informed the choice of this analytic approach in the study. Building on this foundation, the researchers approached participants' recollections as valuable data warranting careful exploration, synthesis and detailed description. In operationalising the analysis, the study followed Braun and Clarke's (2006) six-step framework, which provides a systematic process for coding, theme development and interpretive reporting within qualitative research. Researchers began by familiarising themselves with the transcripts, thoroughly reading them to understand the content and note significant features. Next, they generated initial codes by identifying and labelling relevant segments, which enabled them to organise ideas into manageable pieces. Subsequently, the researchers searched for themes by collating codes into potential groups, thereby identifying broader patterns. The identified themes were reviewed for accuracy and clarity to ensure they accurately represented the dataset. The final report combined themes and direct quotations from the participants.

Researcher positionality and reflexivity

The researchers' ongoing involvement in a broader engaged scholarship project in no-fee schools established pre-existing relationships with participants that required explicit reflexive attention. This proximity shaped both access to participants and the interpretation of findings, necessitating what Pillow (2003) describes as both 'reflexivity as recognition' and 'reflexivity as resistance'. Participants had prior exposure to the researchers' interest in health promotion and learner well-being, which may have influenced how they framed their responses. While such familiarity facilitated trust, access and contextual understanding, it also carried the risk of overfamiliarity and socially desirable responses (Berger 2015; Savvides et al. 2014).

To address these concerns, clear boundaries were maintained between the broader engaged scholarship project and the present study. Participants were informed that the interviews formed part of an independent research process and that there were no expected responses. Throughout data collection and analysis, the researchers maintained reflexive notes to critically examine how prior knowledge, assumptions and professional commitments might shape data interpretation. Emerging findings were continually compared against participant accounts and supporting evidence to ensure that interpretations remained grounded in the data rather than the researchers' prior experiences within the schools. Particular attention was paid to identifying data that challenged or complicated the researchers' assumptions regarding the implementation of health-promoting school practices. This process enhanced interpretive transparency and strengthened the credibility and trustworthiness of the findings.

Trustworthiness

Trustworthiness in this study was established using Lincoln and Guba's (1985) criteria of credibility, transferability, dependability and confirmability, as cited by Adler (2022). The credibility of the findings was strengthened through member checking and ongoing engagement with the data. After a preliminary thematic analysis, emerging themes related to learner wellness and its impact on teaching and learning were summarised and shared with selected participants for feedback on their accuracy and relevance. This input affirmed the findings, with minor clarifications integrated into the final analysis. In line with the work of Birt et al. (2016), member checking was viewed not only as a validation tool but also as a collaborative process. This approach encouraged participants to engage with the researchers' interpretations, allowing them to clarify, challenge or refine the analysis. Consequently, member

checking enhanced the interpretive depth and authenticity of the qualitative findings.

Transferability was promoted by providing rich descriptions that encompassed the school context, participant characteristics and research findings. This approach enables readers to assess the applicability of the findings to similar educational settings. Confirmability was enhanced through reflexive engagement with the data and through the incorporation of verbatim participant quotations, ensuring that interpretations remained grounded in participants' lived experiences. Collectively, these strategies significantly enhanced the rigour and trustworthiness of the study.

Ethical considerations

Ethical clearance to conduct this study was obtained from the Unisa College of Education Ethics Review Committee (No. 2022/11/09/90214331/41/AM). This study adhered strictly to ethical guidelines established by institutional protocols and Department of Education standards. Prior to the commencement of the research, formal approval was obtained to conduct the study within school settings, with a primary emphasis on safeguarding the integrity of all participants. Individual written informed consent was obtained from each participant prior to data collection. To ensure confidentiality, pseudonyms were used throughout the research process.

Results

Thematic analysis of transcribed interviews with teachers, SBST members, SMT members and an NGO social worker generated three interconnected dimensions relating to the understanding, support and integration of learner wellness within Grade 1 and 2 teaching and learning.

Dimension 1: Understanding wellness as a pedagogical enabler

Participants consistently described learner wellness not as an additional school service but as the fundamental condition that enables learning. Across all stakeholder groups, wellness was framed as a prerequisite for attention, participation and behavioural regulation in the classroom. One SMT member explained:

> 'A child who is hungry or stressed cannot concentrate, cannot participate … health promotion is not something extra; it is central to learner development and academic progress.' (SMT 1, female, school A)

Teachers reinforced this perspective through their daily experiences. One teacher noted:

> 'When learners are fed and emotionally okay, they learn better.' (G1TA, female, school A)

Another participant echoed this view:

> 'A hungry or stressed child cannot listen or write properly; health comes first before learning.' (G1TB, female, school B)

Taken together, these responses indicate that participants regarded health as a prerequisite for cognitive engagement and academic success.

Nutrition emerged as the most immediate determinant of learner participation and performance. Teachers consistently described visible changes in behaviour after mealtimes. One teacher explained:

> 'The feeding scheme plays a big role in my class. I can clearly see the difference before and after they eat … After eating, they concentrate better.' (G2TA, female, school A)

Similarly, the SMT emphasised that for many learners, school meals are the only reliable source of food, which makes the nutrition programme essential for regular school attendance. Teachers also acknowledged the limits of health messaging within the contexts of poverty. As one teacher reflected:

> 'Even if we encourage healthy lunchboxes, they bring what is available at home.' (G2TB, female, school B)

These observations highlight nutrition as both an educational and socioeconomic factor that shapes learners' readiness to learn.

Emotional well-being emerged as a second foundational aspect of learner health. Participants described classrooms as spaces where community trauma is visible. An SMT member observed that many learners were exposed to violence and neglect, which directly affected behaviour and learning. Teachers responded by adopting psychosocial duties, as one explained:

> 'We create a safe space where they feel comfortable and can trust me enough to talk about issues they experience at school or at home.' (G2TA, female, school A)

An SBST member echoed this extended role:

> 'My duty goes beyond identification of learners with academic challenges. Emotional well-being, physical activity, and nutrition are all important for learning.' (SBST 1, female, school A)

These accounts illustrate how emotional support became embedded in daily teaching despite limited formal counselling services.

Physical activity was also linked to readiness to learn. Teachers associated movement with motivation and concentration. One participant explained:

> 'They enjoy physical exercises the most … When they move, they become excited and motivated.' (G2TB, female, school B)

Another added:

> 'Even simple stretching in class helps them to calm down and focus again.' (G1TA, female, school A)

Collectively, these narratives demonstrate how teachers and support staff interpreted wellness as an essential pedagogical condition enabling classroom engagement.

Dimension 2: Supporting health-promoting pedagogical practices

Participants identified the National School Nutrition Programme (NSNP) and school vegetable gardens as the most visible and immediate health-promoting practices within the schools. Teachers repeatedly described the feeding scheme as essential for stabilising learner behaviour and attention in the classroom. One SMT member explained:

> 'The school feeding scheme is critical because for some learners, that is the only proper meal they receive in a day.' (SMT 1, female, school A)

This was confirmed by teachers across both schools, who reported noticeable shifts in learner readiness and participation after meals. As one teacher noted:

> 'I can clearly see the difference before and after they eat. When they come in hungry, they are tired and short-tempered. After eating, they concentrate better.' (G1TA, female, school A)

These findings suggest that participants viewed nutrition not merely as a welfare intervention but as a pedagogical resource that supports learner attention, participation and engagement with Grade 1 and 2 learning activities. In this way, wellness was understood as a prerequisite for curriculum access rather than a supplementary service.

Another teacher echoed this sentiment:

> 'When learners feel safe, clean, and fed, they are ready to learn. Otherwise, learning becomes very difficult.' (G1TB, female, school B)

These accounts show that the feeding scheme enabled learners to participate more actively in classroom tasks, sustain attention during lessons and engage meaningfully with instructional activities. Participants also emphasised the need for extending nutritional assistance beyond school hours. An SBST member shared:

> 'Some learners are starting to open up, like they would tell us that at home, there is no food.' (SBST 1, female, school A)

An SMT member added:

> 'We communicate with school feeding scheme coordinators so they can organise food parcels for learners to take home.' (SMT 1, female, school A)

These reflections illustrate how the NSNP serves as a gateway to broader welfare support, reinforcing the interconnectedness of wellness and learning.

In addition, participants from School B described the school vegetable garden as an effort to shift from short-term relief to sustainable food production. One teacher explained:

> 'We also receive donations from an external company to support our school garden … The company provided seedlings and gardening materials so that we could establish a functional garden.' (G2TB, female, school B)

Another noted:

> 'We now have a garden with spinach, beetroot, cabbage, and onions, and it supplements the school nutrition programme.' G1TB, female, school B)

Such initiatives demonstrate attempts to move from immediate nutritional support towards more sustainable forms of health promotion.

Dimension 3: Integrating wellness into teaching and learning

Curriculum integration

Despite recognising the importance of learner wellness, participants indicated that health promotion was primarily confined to the Life Skills subject rather than integrated across the curriculum. Teachers described Life Skills as the main subject, with topics such as nutrition, hygiene, emotional well-being and physical activity. One teacher explained:

> 'I include health topics during Life Skills.' (G2TA, female, school A)

A similar approach was described in School B, where concrete and sensory methods were used to enhance understanding:

> 'Life Skills is the main subject, and we use real objects like fruits and vegetables so learners can see and touch them.' (G1TB, female, school B)

These accounts illustrate that while Life Skills served as the main vehicle for health-promotion content, some teachers attempted cross-curricular connections to make health messages more meaningful.

Despite these positive practices, the data show that health promotion remained largely informal and teacher-driven rather than supported by a coherent school framework. Implementation depended on individual teachers' commitment and interpretation of the curriculum. This reliance on Life Skills was reinforced by another participant who stated:

> 'I only teach my learners about healthy eating and allow them to engage in physical training during the Life Skills period.' (G2TB, female, school B)

The SMT echoed this narrow focus:

> 'The school only relies on the Life Skills period to engage learners in physical activity.' (SMT 2, female, school B)

One teacher attempted to integrate wellness into other subjects, noting:

> 'I even remind them during Maths, like when we count fruits.' (G1TA, female, school A)

Although participants recognised the importance of learner wellness, implementation remained largely confined to Life Skills. While some teachers attempted to make cross-curricular connections, for example, integrating discussions

of healthy eating into mathematics activities, such practices were inconsistent and dependent on individual teacher initiative. Opportunities to embed wellness concepts across literacy, mathematics and everyday classroom routines were therefore limited. Consequently, health promotion remained peripheral to everyday pedagogy rather than systematically integrated into Grade 1 and 2 teaching and learning.

The findings further revealed that stakeholder groups contributed differently to classroom-level health promotion. Teachers emerged as the primary enactors of wellness integration, incorporating health-related concepts into Life Skills lessons (G2TA; G1TB) and, in some instances, extending these discussions into Mathematics activities (G1TA). School Management Team members played a facilitative role by supporting school-wide wellness initiatives, including nutrition programmes and the organisational structures necessary for their implementation (SMT-1; SMT-2). In contrast, SBST members primarily described their role in terms of learner identification, referrals and case management (SBST-1; SBST-2), with limited involvement in classroom-based wellness practices. External stakeholders, such as the NGO social worker, provided counselling, food support and awareness programmes but acknowledged that these interventions were not intentionally linked to curriculum processes (NGO Social Worker). Collectively, these findings suggest that while multiple stakeholders contribute to learner wellness, responsibility for integrating wellness into everyday teaching and learning rests largely with classroom teachers.

Stakeholder collaboration

These findings suggest that SBSTs remain largely reactive structures focused on referral and compliance processes. As a result, opportunities to support teachers with classroom-based wellness strategies and health-promoting pedagogical practices remain limited. This reliance on referrals can hinder a cohesive approach, making it difficult to support learners' holistic development effectively. A more integrated strategy that encourages communication and cooperation among all parties is essential to achieve better outcomes in learner wellness initiatives. The SBSTs confirmed their role is focused on identification and case management, in line with the SIAS policy requirements, rather than on proactive whole-school wellness leadership. The SBSTs acknowledged the shortfalls:

> 'I do not engage in learner physical activity and other aspects that are key to promoting wellness. As a committee, we delve deeply into the learners' poor academic achievement and referrals to the district.' (SBST 2, female, school B)

This was echoed by a school A SBST member:

> 'While psychosocial issues were addressed through referrals, classroom-based health promotion received minimal guidance.' (SBST 1, female, school A)

The same participant further added:

> 'The SBST committee is supposed to share strategies on how to integrate health promotion in the classroom.' (SBST 1, female, school A)

In addition, external structures were recognised as significant providers of food support, counselling and life-skills programmes. However, their activities were seldom aligned with curriculum processes. The NGO social worker reflected:

> 'We do not intentionally link our programmes to the classroom curriculum.' (NGO, female, social worker)

The social worker further said:

> 'If we align our programmes with what teachers are covering in the curriculum, the impact would be stronger.' (NGO, female, social worker)

This finding indicates that external wellness programmes operate largely alongside the curriculum rather than through it, limiting their potential to reinforce classroom learning and learner engagement.

Across both schools, stakeholder interactions were described as event driven. Collaboration occurred mainly when problems occurred:

> 'Mostly through referrals. Teachers refer learners to us, and we communicate back if we notice something concerning them … We only plan together when there is a specific event like awareness campaigns.' (NGO, female, social worker)

School-Based Support Team-1 noted a similar pattern, indicating that partnerships were limited to discrete activities such as health talks and corporate donations, rather than forming part of sustained curriculum collaboration.

Structural scarcity as a barrier to holistic integration

This dimension of the findings highlights how institutional and resource limitations obstruct the integration of health promotion into teaching and learning. Participants noted that while some nutrition programmes exist, a broader implementation of wellness strategies is limited by a lack of trained personnel, specialised support and suitable spaces for psychosocial care and physical activity. Consequently, teachers often take on additional roles to provide emotional support, performing partial therapeutic duties. This structural scarcity limits the ability to implement a coordinated health-promoting approach, making wellness initiatives reliant on individual teacher efforts rather than systematic institutional support. One teacher noted:

> 'Management encourages health awareness, but we lack resources and specialist support. Therefore, teachers end up acting as counsellors.' (G2TA, female, school A)

Based on these findings, management promotes health awareness, but because of scarce resources and limited specialist support, teachers routinely take on partial therapeutic roles, redirecting time and professional energy from core instructional tasks (lesson planning, curriculum delivery and in-class support) to meet learners' emotional and psychosocial needs, creating role strain and highlighting gaps in institutional support.

The analysis identifies a significant tension between school-based health education and the harsh socio-economic realities of the learners' home environments.

On the other hand, teachers educate learners on 'healthy eating' yet acknowledge that many families cannot afford vegetables or healthy options. In these contexts, poverty and household size force families to choose cheaper, less nutritious food to feed everyone.

Schools report a lack of specialised, designated sports fields and sports equipment. This limits the ability to implement physical education and extracurricular activities. One teacher explained:

> 'The school do not participate in extramural activities because we do not have a sporting ground and equipment for different sporting codes.' (G2TA, female, school A)

Time pressures negatively impacted wellness initiatives by prioritising curriculum coverage over well-being:

> 'We teach and forget about wellness. The issue of curriculum coverage is a challenge as we do not have enough time to deal with health promotion.' (G2TB, female, school B)

This notion was also shared by all teachers from both schools:

> 'As teachers, we do not have time to focus on integrating health promotions because we are under pressure to complete the syllabus.' (G1TA, female, School A)

> 'Unfortunately, the timetable is so tight that we cannot allocate extra time for teachers to intentionally discuss health issues in the classroom. They only do so when teaching certain subjects, such as Life Skills.' (SMT 2, female, school B)

The NGO social worker echoed these structural limitations, emphasising unstable funding and risk management:

> 'Funding is quarterly and not stable, which affects programme continuity.' (NGO, female, social worker)

Such constraints demonstrate how the implementation of health promotion within the participating schools remains significantly shaped by structural scarcity, which undermines the comprehensive approach envisioned by the HPS framework

Discussion

The study highlights a significant gap between the goals of the HPS framework and its implementation in under-resourced no-fee primary schools. While participants acknowledged learner wellness as critical to learning, it was only partially integrated into classroom practices. The findings indicate that health promotion is conceptually valued but lacks the institutional and pedagogical integration that the WHO (1998, 2023) advocates.

The first analytical dimension, wellness as a pedagogical enabler, supports the HPS premise that health and learning are interdependent. Participants linked nutrition, emotional well-being and physical activity to learners' engagement, aligning with Stewart-Brown's (2006) research, which shows that health status influences educational outcomes. World Health Organization and UNICEF (2023) also affirm that learner well-being is crucial for educational participation. However, teachers in these school contexts viewed wellness not just as a health outcome but as essential for accessing the curriculum. In contexts of poverty and adversity, learner wellness is seen as a prerequisite for learning. This aligns with the findings by Shaik Mahomed and Etokabeka (2025), which emphasise that teachers prioritise nutrition and emotional support to enhance classroom engagement. Thus, health promotion must be seen as a pedagogical necessity in low socio-economic contexts. However, the study reveals a critical limitation in HPS implementation. Although wellness is recognised as imperative, the responsibility for addressing learners' health and psychosocial needs often lies solely with teachers, who assume the role of counsellors without adequate training. This contradiction reflects broader systemic issues in which teachers embrace health initiatives but struggle to implement them because of resource constraints, as reported by Arnaiz et al. (2024). Thus, merely recognising learner wellness is insufficient, effective health promotion requires institutional capacity and shared responsibility.

Regarding the second analytical dimension, supporting health-promoting practices, although wellness is acknowledged as vital for educational success, health promotion is often relegated to the periphery of standard teaching practices. The findings emphasise the significance of the school contexts and support systems within the HPS framework. Participants highlighted the NSNP and school vegetable gardens as key health-promoting initiatives that enhance learner concentration, attendance and participation. Research indicates that supportive school environments improve health and educational outcomes (Meiklejohn et al. 2021; Pearson et al. 2015). However, these initiatives are vulnerable because of reliance on external donations and unstable funding, reflecting socio-economic inequalities in no-fee schools. This dependence leads to a reactive approach to health promotion, undermining developmental and preventative goals. The findings point to a limitation of the HPS framework, indicating that, to effectively implement its principles in South African no-fee schools, there needs to be greater recognition of the socio-economic factors affecting the sustainability of wellness initiatives. The findings reveal a significant gap between policy objectives and classroom realities regarding the integration of wellness in teaching and learning. While participants recognised the importance of health promotion, its implementation was predominantly restricted to the Life Skills curriculum. Topics such as nutrition, hygiene, emotional well-being and physical activity were often taught as isolated subjects rather than integrated into everyday teaching (Mbatha et al. 2024).

From an HPS perspective, this lack of integration is concerning, as curriculum integration is a core principle of the HPS framework. Although a few teachers attempted to incorporate health concepts into Mathematics, these efforts were sporadic and depended on individual initiative, without a clear pedagogical framework. This issue is echoed internationally, where health promotion programmes struggle to influence classroom practices when they focus on events rather than pedagogical methods (Pearson et al. 2015; Samdal & Rowling 2012). The findings indicate that the challenge lies in the absence of structured pedagogical guidance for teachers, rather than in a lack of awareness regarding wellness.

Regarding the third analytical dimension, integrating wellness into teaching and learning, weaknesses in stakeholder collaboration also emerged, which is critical for effective health-promoting schools. Collaboration within participating schools was predominantly reactive and event based, with SBSTs focusing mainly on learner identification and compliance with procedures (Moyo & Hove 2025). Thus, wellness support was fragmented and lacked a shared pedagogical vision, undermining the HPS framework's assumption that collaboration fosters coherence between health promotion and education. Additionally, there is a missed opportunity for instructional leadership and capacity building. While sustained professional support can enhance teaching practices (Glover, Reddy & Crouse 2023), participants reported limited guidance on integrating wellness into teaching. From an HPS perspective, schools need both wellness programmes and supportive structures for teachers.

While the three dimensions of the HPS framework, curriculum, school environment and partnerships exist in the participating schools, they operate in a fragmented manner. The main challenge in no-fee schools is not the absence of health-promotion activities but the insufficient integration across educational, organisational and community structures. To promote health effectively, wellness should be repositioned as a fundamental pedagogical resource that enhances student engagement and achievement, requiring stronger integration, improved teacher capacity, proactive involvement of SBSTs and better alignment between schools and external support services. Only then can the transformative potential of the HPS framework be realised in South African no-fee primary schools.

Despite these insights, the study has certain limitations. The findings are based on a small qualitative sample from two schools and rely on self-reported perceptions, which may limit transferability to other contexts. While the relatively short duration of most interviews may have constrained the depth of responses, noting that authors such as Seidman (2006) and Kvale and Brinkmann (2009) typically advocate for more extended sessions to achieve reflective depth, the limited and inconsistent integration of health promotion within everyday classroom practice is also reflected in participants' accounts. In this sense, the succinctness of responses is not solely a methodological constraint but provides insight into the absence of systematically embedded wellness practices in the participating schools. Future research should utilise longitudinal and observational methods across diverse settings to better understand how health promotion can be more systematically integrated into teaching and learning.

Conclusion

This study demonstrates that teachers widely recognise learner wellness as a prerequisite for meaningful teaching and learning in no-fee schools. The findings reveal that health promotion is not an activity that occurs alongside education but is deeply intertwined with learners' capacity to participate, engage and succeed academically. However, the study also stresses a significant misalignment between the principles of the HPS framework and their execution in classroom practice. While health promotion activities are evident at the school level, they are often implemented as fragmented interventions rather than as integrated pedagogical practices that support learning. Consequently, wellness remains largely peripheral to curriculum delivery despite its recognised influence on learner participation and achievement.

The study contributes to the growing body of research advocating for a more holistic understanding of educational quality in contexts of poverty and inequality. It demonstrates that effective schooling in no-fee contexts requires attention not only to curriculum coverage and academic performance but also to the social, physical and emotional conditions that enable learning. The findings therefore reinforce the central premise of the HPS framework: that learner well-being and educational success are mutually reinforcing rather than separate goals. Future research should explore how health-promoting principles can be systematically embedded in teaching and learning processes, and how schools can move from isolated wellness interventions to more integrated and sustainable approaches to learner development.

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CRediT authorship contribution

Tebalelo M. Aphane: Data curation, Formal analysis, Investigation, Methodology, Writing – original draft, Writing – review & editing. Mmapeu M. Manyaka: Conceptualisation, Funding acquisition, Investigation, Project administration, Writing – original draft, Writing – review & editing. All authors reviewed the article, contributed to the discussion of results, approved the final version for submission and publication and take responsibility for the integrity of its findings.

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Data availability

The data that support the findings of this study are available from the corresponding author, Tebalelo M. Aphane, upon reasonable request. De-identified data may be shared for research purposes, subject to ethical approval and maintaining participant confidentiality.

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