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A CASE STUDY ON HOW PUBLIC PRIMARY
SCHOOLS PROMOTE HEALTH

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ABSTRACT

A CASE STUDY ON HOW PUBLIC PRIMARY
SCHOOLS PROMOTE HEALTH

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The main drive of this study is to investigate how urban public primary schools promote health in Turkey with a qualitative study conducted in a middle-sized urban school, in Ankara. The current health promotion practices in Turkish urban public primary schools were examined through a case study utilizing semi-structured interviews conducted with 9 classroom teachers, 2 school administrators, 2 parents that are parent-teacher association members and 2 canteen operators. In addition, a classroom activity was done with 252 primary school students to obtain data to understand their nutrition habits.

The findings of this case study suggest that the policies and programs executed in the school studied to promote health are inadequate. The classroom teachers are found to be poorly educated and empowered to promote the health of their students. The school administration does not have sufficient monetary and political resources and the physical condition of the school is not

appropriate in terms of infrastructure and service for a health promoting school. Also, the parents are thought to be poorly educated and motivated to promote their children's health. The parent-teacher association is found not to be effective in terms of evoking the families, teachers and administrators to promote health.

This case study yields data and implications that can assist social policy makers to develop and implement new policies and programs required to promote health in urban public primary schools that are located in neighbourhoods with low socio-economic status, and whose populations consist of internal migrants from rural areas.

Keywords: health promotion, health promoting school, education policy, teachers' role in health promotion

ÖZ

İLKOKULLARIN SAĞLIĞI NASIL TEŞVİK ETTİĞİ VE GELİŞTİRDİĞİ KONULU BİR VAKA ÇALIŞMASI

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Bu çalışmanın ana amacı, Türkiye'de şehirlerde yerleşik devlet ilkokullarının sağlığı nasıl teşvik edip geliştirdiklerini, Ankara'da bulunan orta büyüklükteki bir devlet ilkokulunda gerçekleştirilen niteliksel bir çalışma ile araştırmaktır. Türkiye devlet ilkokullarında geçerli olan sağlığın teşviki ve geliştirilmesi uygulamaları, 9 sınıf öğretmeni, 2 okul yöneticisi, 2 okul aile birliği üyesi veli ve 2 kantin çalışanı ile gerçekleştirilen yarı yapılandırılmış mülakatların kullanıldığı bir vaka çalışması ile araştırılmıştır. Ayrıca, 252 öğrencinin beslenme alışkanlıkları sınıf içi bir etkinlik ile araştırılmıştır.

Bu vaka çalışmasının bulguları, söz konusu okulda okul çocuklarının sağlığını teşvik etmek ve geliştirmek için uygulanan politika ve programların yetersiz olduğunu önermektedir. Sınıf öğretmenleri, öğrencilerinin sağlığını teşvik etmek ve geliştirmek için yeterince eğitilmemiş ve

güçlendirilmemişlerdir. Okul yönetiminin, sağlığı teşvik eden bir okul için gereken mali ve politik kaynaklara sahip olmadığı anlaşılmaktadır. Okulun fiziksel koşulları, altyapı ve hizmet açısından sağlığı teşvik etmek ve geliştirmek için uygun değildir. Ayrıca, ebeveynlerin çocuklarının sağlığını geliştirmek için yeterince eğitim alamadıkları ve gerekli motivasyona sahip olmadıkları düşünülmektedir. Okul aile birliğinin, sağlığı teşvik etmek ve geliştirmek için aileleri, öğretmenleri ve yöneticileri harekete geçirmek bakımından yeterince etkili olmadığı düşünülmektedir.

Bu vaka çalışması, şehirlerdeki düşük sosyo-ekonomik düzeye sahip semtlerde yerleşik ve popülasyonları iç göçle kırsal kesimden gelenlerden oluşan devlet ilkokullarında, sağlığı teşvik edecek ve geliştirecek yeni politika ve programlar oluşturmak ve uygulamak için, sosyal politika yapıcılara yardımcı olabilecek veri ve öneriler ortaya koymaktadır.

Anahtar Kelimeler: sağlığın teşviki ve geliştirilmesi, sağlığı teşvik eden okul, eğitim politikası, öğretmenlerin sağlığın teşviki ve geliştirilmesindeki rolü

To My Family

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LIST OF ABBREVIATIONS

IUHPE	International Union for Health Promotion and Education
MEB	Republic of Turkey Ministry of National Education
OECD	Organisation for Economic Co-operation and Development
PTA	Parent- Teacher Association
SHE	Schools for Health in Europe
TUIK	Turkish Statistical Institute
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USA	United States of America
WHO	World Health Organization

CHAPTER 1

INTRODUCTION

The role of schools and teachers in health promotion is recognized both by educators and health professionals since a few decades. However, schools are mainly focused on their core business: educational outcomes, rather than the reduction of health problems and health promotion. But, the literature demonstrates that promoting health and reducing health disparities in schools will not only increase the likelihood that these children live healthier lives as adults too, but also, improve the achievement levels of schools by providing the motivation and ability these children require to be academically successful. It is recognized that there is an apparent need for health promotion at schools and this study is basically focused on how Turkish public (state governed) primary schools promote health.

In order to emphasize the need for a health promoting education system this chapter will talk about the background of this study, purpose of this study, significance of this study and finally state the definition of basic terms in this chapter.

The second chapter is focusing on the review of literature. The international and national literature written on health promotion, health education and school health are scanned and the leading studies are examined to build a research base for this case study. The association between health and education is explained in detail in this chapter. The definition of health promotion and the reasons for promoting health at schools are stated afterwards. Later in this chapter, the theories and research findings are classified in order to determine teachers' role and impact of curriculum in health promotion. Moreover, significance of teacher education and the findings on Turkish schools

are explained. The policy documents and recent regulations in Turkey are reviewed and summarized, lastly.

The third chapter is explaining the methodology that this case study pursued. The overall research design, sampling, data collection instruments, trustworthiness, data collection, data analyses and limitations are explained in detail to picture the quantitative characteristics of this in-depth case study.

The fourth chapter is focused on the results gathered throughout this case study and their discussion. In the first part of the chapter the interviews with the classroom teachers, school administration, parent-teacher association and canteen staff are concluded regarding the perceptions, barriers and recommendations for promoting health at primary schools. Also the physical condition of the school and a classroom activity about the breakfast habits of students are used as data sources to reach comprehensive outcomes. In the second part of this chapter, the results of this study are discussed in the light of the literature written on health promotion. The similarities with previous findings and the reasons behind these findings are discussed in the discussion part of sixth chapter.

The last chapter is concluding the study and giving recommendations to improve the education, health and social policy in Turkish public primary schools.

1.1 Background to the Study

Education and health are associated closely to social policy, since education and health policies are still mainly directed by states in most of the countries. Moreover, education and health policies are directly related with the wellbeing of citizens. World Health Organization defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The wellbeing of citizens is mainly provided by the

education and health services given under the authorization of the state. This holistic approach takes attention to the previous research findings that healthier children are better learners (Basch, 2010). Thus, raising healthy children in schools is a must for a high performing educational system that is fundamental in achieving national and economic competitiveness (Ross and Wu, 1995). In Turkey, teachers are crucial agents for establishing health education and promotion due to their active role in the education system. This research is aiming to find out the current situation of health promotion and education in primary schools in Turkey, by mainly analysing the views, perceptions and recommendations of primary school teachers. Taking into consideration that 97.4 per cent of primary school children are attending public schools in Turkey and only 2.6 per cent to the private schools (MEB, 2012), this study will focus on public schools to investigate the general understanding of health promotion issue in schools.

It is neither realistic nor reasonable to expect that, schools can close the gaps in health education, health promotion or elimination of health disparities on their own among the nation's youth. Schools should not be solely responsible for addressing these complex problems. There are essential roles to be played by families, communities, health care systems, legislators, media, and by economic and social policy (WHO, 1996). All of these (and other) social institutions should, and must, contribute to solving these problems. There are no simple solutions. However, with nearly 25.5 million students in Turkey spending a significant portion of their daily lives in primary or secondary schools, this social context is surely one of the most powerful social institutions shaping the next generation of youth. Due to this fact, this research will focus mainly on the health promotion and health education awareness and related activities conducted at primary schools.

In order to promote health and grow up healthy generations in schools, teachers are the main actors in Turkey, since the others like school nurses or

other health agents are not present in public schools. In private schools the situation may be brighter. However, private and public, all types of formal education in Turkey put teachers as the main actor in the centre of education system. Thus, defining the teacher's role is very crucial since responsibility for children's health lies primarily between the teachers and the parents (Prelip, Erausquin, Slusser, Vecchiarelli, Weightman, Lange, and Neumann, 2006). According to the Turkish National Education Basic Law, teaching is seen as a special occupation which takes the charge of the state's educational and the related management duties (Milli Eğitim Temel Kanunu, no 1739, issue 43). Teachers are responsible for executing their duties in accordance with the aims and principles of Turkish National Education. In this study, awareness of the teachers about their role in health promotion is investigated. Also, whether they build attainments on health education in primary schools through public or private domains during their occupational education and experience is questioned.

According to previous literature, the essential elements of health promoting schools are healthy school policies, school environment (physical and social), individual health skills and action competencies, community links, and health services (IUHPE, 2008). To implement a health promotion programme, these guidelines mean a very powerful tool. Anyhow, schools give low priority to health education and promotion in most countries, and school staff, mainly teachers, have little awareness of their role in health promotion (SHE and IUHPE, 2009). Studies show that trained teachers are tend to be more involved in health promotion activities in schools (Jourdan, 2010) Staff training is then also a main challenge for the future of health promotion. Given the low priority associated with health promotion and health education in teacher education the effect of health promotion initiatives in schools is limited. This challenge is shared globally. Teacher education on health education and promotion is questioned in this research to end up with recommendations for the policy

makers and decision takers of the education system, so that the awareness of the state, ministry, schools and the teachers are enhanced. Furthermore, pathways leading to a healthier school environment and competent teachers in health education are exemplified regarding the survey results.

To conclude, from a social policy perspective, how public primary schools in Turkey promote health is investigated throughout this research. A case study is conducted at an urban public primary school located in Ankara. The classroom teachers, the school administration, the parent teacher association and canteen staff are interviewed. Investigating whether the classroom teachers in Turkey are given the education to develop a holistic health promotion approach specifically adapted to the needs of their students in their schools, whether they are aware of their role in maintaining healthy generations, what their opinions and recommendations for a better health education and what are the barriers in front of health promotion are the main questions of this research. The opinions of school administration, school-parent association and other school staff will be gathered to strengthen the validity of this research. The school building and facilities are examined to determine whether they are appropriate for generating a healthy school environment. A classroom activity is delivered to the primary school students to understand their breakfast habits. The reflections of recent policy focus supported by basic education curriculum and regulations on nutrition education and healthy eating activities in schools are questioned and observed in detail throughout this research. The policy documents and primary school curriculum are reviewed to understand the perspective of policy makers for health promotion and education. Analysis of the findings shapes this paper's social policy implications required for building a health concerning education system by which children maintain academic achievement, live healthy lives and ensure fulfilling employment and income in the future.

1.2 Purpose of the Study

Regarding the significance of health promotion at schools both for raising healthy generations and gathering better educational attainment and achievement, the main drive of this study is to investigate how urban public primary schools promote health in education through a case study. The case study is conducted at a public primary school and tries to answer the following questions:

1. What is the current situation of health promotion in public primary schools in Turkey according to the perceptions of primary school teachers with respect to the on-going health education and health promotion policies?

2. What are the attitudes of primary school classroom teachers towards health promotion and health education?

3. What are the barriers in front of the teachers and the school to reach a health promoting education system?

4. How appropriate are the school environment and facilities designed for students to become and survive as healthy individuals?

5. What does the school population think about Turkey's health education policies and related implementations at urban public primary schools?

6. What are the teachers', the school administrators' and the parent-teacher association's recommendations for developing the current health promotion policies in public primary schools?

1.3 Significance of the Research

Improving the health of children is a reputable goal for education. Because, even if health factors had no effect on educational outcomes, they clearly influence the quality of life for youth and their ability to contribute and live productively in a democratic society (Basch, 2010). Thus, it is essential to understand the current status in Turkey, and to name the need for an extensive and trustworthy health promotion system for the well-being of society and the state.

Health promotion, which improves the health status of individuals, families, communities, states, and the nation, is a behavioural social science that draws from the biological, environmental, psychological, physical and medical sciences to promote health and prevent disease, disability and premature death through education-driven voluntary behaviour change activities (O'Donnell, 1989).Health promotion is an ancient concern for societies, since health is a resource that needs to be maintained and protected for all individuals of the society. Due to this significance of health promotion, for a long time, schools are seen as appropriate places with their universal knowledge to teach rules for good health (MacDonald, 2003). In our century, health education and promotion is not anymore only about encouraging children and young people to eat well and to exercise; but it contains a much broader approach.

In the holistic view of health, all aspects of health must be considered, as should all the factors that determine health, which can be biological, psychological, social, economic, cultural and environmental. In other words, health is akin to well-being and thus, health authorities cannot be the only responsible ones to provide this (Ottawa Charter, 1986). All institutions and regulatory provisions involved in how people live must take their share of responsibility (Jourdan, 2011). In their role as places in which people live, schools play a great role in the well-being and health of the children and young

people within them. The international scientific literature show the importance of schools as places where health promotion happens, due to the facts that an entire cohort attends a school for several years, and also there has been close links between health and education. Promoting pupil health helps with educational attainment: increasing levels of education helps to improve levels of health.

Teachers are the main actors of educational system to gather the aimed educational outcomes as they are the living role models, and implementers of all predetermined polices at schools. However, for a teacher who has many priorities, including building literacy and numeracy skills, scientific and artistic competencies, societal, historical and cultural dimensions, and who have in fact to provide the means for all to succeed, it is not easy to have a clear view of his or her own contribution to health promotion. This is compounded by the increasing pressure schools and teachers are under resulting from changes in the organization of educational systems, teacher workload, low wages, low job attraction, and low teacher morale. Therefore, globally attracting and retaining teaching staff is difficult to maintain. In this context then the first aim of teacher education in health promotion should be to help teachers have a clear view of their mission and ethical limits. Before giving them methodological tools, teacher education should aim to help them build their professional identity.

Studies show that teachers who have received health promotion training tend to be involved more frequently in health promotion projects and have a more comprehensive approach to health education (Celebuski and Farris, 2000) (Yager and O'dea, 2005) (Prelip et al., 2006). Given the low priority associated with health promotion and health education in teacher education, the effect of health promotion initiatives in schools is limited.

There are still countries where this positive correlation between health and education is neither realized, nor given value. In some countries, schools seldom take into consideration health promotion and school staffs (mainly

teachers) have little awareness of their potential role in health promotion. In some others, schools are seen as places which have their own values and missions for national education competencies and they shouldn't simply be a tool of public health policy (WHO, 1997a). However, the truth is the compromising function of the educational system: it cannot ignore public health issues or social demands but it has to also challenge such pressures with its core business: educational outcomes. Otherwise, it is apparent that they cannot achieve even their core educational targets with those health ignorant, unmotivated and disabled (in learning) children, either.

To understand the point of view of Turkish education system on health promotion, and education the legislation should be examined. In Turkey's National Education Law, the second general aim of the Turkish National Education is defined as "to grow up individuals who have a physically, mentally, morally, spiritually and emotionally healthy and balanced…. personality and character". But, interestingly the duty of considering this aim is left to the mass education instead of the formal education. One of the private aims of mass education is announced as to make citizens who did not enter in formal education before, or entered and then left the formal education at any levels; adopt healthy living styles and procedures in order to improve the economic power of the country. In most of the developed countries health is a concern of formal education, too. Especially, due to the rise in the number of children with diseases related to wrong nutrition and lack of physical activity in the last few decades, health education became a significant concern of formal education. In schools, national health education and health promotion programmes are in action and the results are measured regularly in most of the developed countries. But in Turkey, health promotion is a very new concern and is yet perceived as a matter of healthy nutrition in policy documents. The current situation of these policies will be evaluated in the following parts of this study.

In Turkey, the main aim of the health policies is to reach a healthy society which is consisted of healthy individuals. In order to reach a healthy society, the school period is important, since this period is the time when healthy nutrition behaviours are developed, physical, cognitive and social improvement is quick and the roots of healthy living is placed. Due to this fact, implementing health promoting school programmes and policies encouraging interdisciplinary cooperation is needed in the health issue. In 2011, Turkey has made a policy attempt to create healthier environments in schools. The Ministry of Health and the Ministry of National Education came together and signed a regulation arranging the requirements of food served at schools. The sales of junk food and drink such as chips, fried food and carbonated drinks are prohibited in all kinds of canteens, restaurants and cafes of primary and secondary schools. Also, a program called “Turkey Healthy Nutrition and Active Life Program” is put into action by the Ministry of Health.

As mentioned before, healthier lives and better learning capabilities are mainly available for children who get health education at schools in which they spend a significant portion of their lives. Here, in this paper the need for a policy and legislation change in order to improve the health concern in formal education is questioned. Mainly, the focus of this research is on the views of primary school teachers, but also the opinions of school administrations, the school-parent associations, and other school staff are planned to be taken. Also, the related policy documents will be analysed and the physical condition of the school and eating facilities will be observed to picture the current situation of health education and promotion in details. In order to conclude accurate social policy findings, this thesis report requires a broad perspective and a comprehensive in-depth case study.

1.4 Definition of Terms

Health: In this study, the definition of World Health Organization is accepted as the explanation of health. It is a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity (WHO, 1948). Within the context of health promotion, health has been considered less as an abstract state and more as a means to an end which can be expressed in functional terms as a resource which permits people to lead an individually, socially and economically productive life. Health is a resource for everyday life, not the object of living. It is a positive concept emphasizing social and personal resources as well as physical capabilities. A comprehensive understanding of health implies that all systems and structures which govern social and economic conditions and the physical environment should take account of the implications of their activities in relation to their impact on individual and collective health and well-being (WHO, 1998a).

Health Promoting School: A school that constantly strengthens its capacity as a healthy setting for living, learning and working (WHO, 1997a). To achieve this goal, a health promoting school engages health and education officials, teachers, students, parents and community leaders in efforts to promote health. It fosters health and learning with all the measures at its disposal. Supportive environments for health and a range of key school health education and promotion programs and services are provided. A health promoting school implements policies, practices and other measures that respect an individual's self-esteem, provide multiple opportunities for success, and acknowledge good efforts and intentions as well as personal achievements. It strives to improve the health of school personnel, families and community members as well as students (WHO, 1997a).

Social policy: Social policy primarily refers to the guidelines, principles, legislation and activities that affect the living conditions conducive to human welfare and looks for the question how best to maximise the well-being of people (Wikipedia, 2013). The areas of health care, human services, criminal justice, inequality, education, and labour are under the consideration of social policy according to The Malcolm Wiener Centre for Social Policy at Harvard University (Rittel and Webber, 1973).

Social Policy is focused on those aspects of the economy, society and polity that are necessary to human existence and the means by which they can be provided. These basic human needs include: food and shelter, a sustainable and safe environment, the promotion of health and treatment of the sick, the care and support of those unable to live a fully independent life; and the education and training of individuals to a level that enables them fully to participate in their society (London School of Economics and Political Science, 2012). The study of Social Policy is designed to reflect on the ways in which different societies have developed ways of meeting these needs, or have failed to do so. Some societies rely on informal or family institutions, some on private markets and individual actions, and some on governmental actions through what is often termed the welfare state.

Education: The term education in this case study is mainly referring to the formal education given at the formal school context of this case study. In broader terms, this study defines education as transmitting socio-culturally relevant knowledge to the members of the society by pre-determined inputs, structures, processes and aims. Family is the first place where this transmission of knowledge takes place. Later, children obtain knowledge from their community networks, from religious foundations, from media and other channels (Samoff, 2003). One of the most important institutions for knowledge transmission is school, today. Providing literacy to most children has been a

development of the last 150 or 200 years, or even last 50 years in some Third World countries, and until recent decades, very few children were able to benefit from formal education. Indeed, only a few children were formally educated through the use of tutors or through religious schools. But, now in modern times, education has been extended through the involvement of government, which is now the primary provider of formal education today.

Social Policy and Education: Another definition for social policy explains the concept as actions that affect the well-being of members of a society through shaping the distribution of and access to goods and resources in that society (Social Policy, 2013). In that sense education increases people's ability to add value resulting in increased human capital. Thus, education is one of the main play grounds of social policy. This is why educational policy and social policy are closely associated. Joel Samoff contends that "education is perhaps the most public of public policies". Education has politic, social, cultural and individual dimensions that last from birth to the grave (Samoff, 2003). Education is the social processes in which the individuals gain standards, beliefs and ways of living and working of the society. In that sense, education can be the most public of public policies.

Inequalities in access to education and variations in educational outcomes, particularly social differences in attainments, have been a central concern of social policy. Education is a forward looking investment and at the core of the welfare state. In most advanced welfare democracies, state involvement in education precedes the development of other universal services. Against the backdrop of recent mass unemployment, raising the basic standards of competence achieved by school children has become a primary objective of governments across the OECD countries. A high performing educational system is taken to be fundamental in achieving national and European economic competitiveness. Children leaving primary schools with

difficulty in reading, writing and arithmetic or a meagre understanding of science are unlikely to achieve the qualifications at secondary school required to secure jobs that will raise them above a poverty line. Thus, education in primary schools is also important for economic welfare as well as health and social wellbeing. As it is mentioned while explaining the relationship between education and health, an education system ignoring the health promotion and education in schools cannot perform academically well, and these students with less health awareness and poorer health status cannot add the desired value to the economy.

Social Policy and Health: Improving the health status of society, living in a healthier world and enabling survival of future generations in better conditions is the aim of all countries (WHO, 2009). An effective, accessible and quality health system is indispensable for a society. Social policy is concerned with health care, treatment of sick and health promotion because health is one of the main aspects that directly affects the wellbeing of societies. Inequalities in the distribution of health services, and significant differences in the health status of different social groups create a need for policies that aim to maximize the wellbeing of all citizens, regardless of their income level and sociological background.

The primary duty of The Ministry of Health in Turkey is to provide a healthy environment for citizens, develop consciousness for protecting one's own health and establish the required infrastructure (Sağlık Bakanlığının Teşkilat ve Görevleri Hakkında Kanun Hükmünde Kararname, 181). Health promotion is said to be one of the primary aims of the ministry. The first aim written in the strategic plan of the ministry for the years 2010-2014 is "protecting society from health threatening risks". The subsection of this strategic aim is clarified as increasing the level of self-control and participation in decision making processes in order to protect individual's health and to

improve health status. The ministry says that they are mounting awareness rising campaigns with media partnerships about healthy living behaviours. These campaigns seem to be focused on the hazards of smoking and alcohol use until now.

In the international literature, it is seen that health policies have to go hand in hand with education to become successful. Health promotion is something that is more than creating awareness for an illness or teaching how to take care of an illness. It is an understanding that is supposed to provide healthy living throughout life by improving one's values and behaviours about health.

After settling the health and education under the umbrella of social policy in such a concrete association, it can be concluded that health promotion in primary schools should be one of the most important aspects of social policy in countries seeking for educated and healthy citizens required for a prosperous economy and welfare societies.

Education Policy as a Health Policy: Understanding the mechanism by which education affects health is important for social policy. There is strong evidence linking early childhood development to literacy, social competence, and success in school as to be mentioned in the next chapter. Personal health status and subsequent socioeconomic position are linked to educational attainment, also. A better-educated population is likely to participate more fully and effectively in the processes of a democratic society (Keating and Hertzman, 1999). Innovation and sustainable economic development are processes of democratic societies that are built through education and wellbeing. Medical expenses are the largest and fastest growing line item in the budgets of most of the states, thus improving health status of the society significant. By the improved health status, living quality of many people may develop and the health care costs may become more controllable for the states.

Research on the social determinants of health indicates that focusing social policies on optimizing both early childhood development and education is one of the best ways to improve the health of whole population (Low, Low, and Baumler, 2005). This study claims that, sufficient social and cognitive development in childhood is an indispensable condition for success in education, which in turn is closely and positively linked to health status. The learning process of human-being starts before birth, and the brain's capacity for future learning and emotional resilience depends on the quality of experience during the first three or four years of life. Thus the responsibilities of parents and states for universal education should start just after a child is born, not just when he or she enters school. But in Turkey, schools are still the main actors of education and thus educational attainment is directly related to schooling. It is true that nobody is born with the knowledge of being a good parent. Social policies focusing on education should take into account parental education to provide the adequate social and cognitive development in childhood. Hence health status is directly influenced by the educational attainment, childcare and formal education has to be melted in the same basket to structure and bring up a healthy society. This will be an innovative social policy approach. In order to promote and support new programs for the society, all agencies, from education and health to social welfare will have to agree on common objectives and create integrated policies (Low, Low, and Baumler, 2005). It must be well understood both by the policy makers and the public that education has an implication far more than an individual's employability and economic prospects. Promoting good health cannot be the sole province of the health care system. Education policies and family policies can establish new programs to promote health including an appropriate prenatal care and nutrition, provision for parent training and support, quality child care delivered by well-qualified child development specialists, progressive introduction of elemental education beginning at a few months of age, and regular assessment to ensure that developmental and

cognitive milestones are being met prior to entering primary school (Low, Low, and Baumler, 2005). But Turkey has just begun crawling in fields of preschool education and professional childcare policies. Thus, it can be claimed for Turkey that primary schools are still the main and preliminary institutions for formal education of children. Integrating the promotion of health and the formal education system and creating healthy school environments for children, in which they can accomplish their wellbeing by eating healthy food, taking cognitive and emotional support and adequate mental development is the preferential kind of social policy that the state should take into consideration for Turkey. These policy recommendations are to be founded on the case study conducted for this study to understand how primary schools in Turkey promote health in the following sections.

Education can be the key of breaking the cycle of intergenerational disadvantage and related health disparities. It can promote social mobility by providing the knowledge and skills necessary to fully participate in the labour force (Haveman and Smeeding, 2006). Investments to promote and increase educational attainment could have both humanistic and economic benefits. A recent analysis estimated that, if adult Americans who have not completed college experienced the lower death rates and better health of college graduates, the resulting improvements in health status and life expectancy would translate into potential gains estimated at more than $1 trillion annually (Braveman and Egerter, 2008) (Egerter and Braveman, 2009). One of the most effective strategies for reducing health disparities in Turkey could be to take steps to close the gaps in educational attainment.

CHAPTER 2

LITERATURE REVIEW

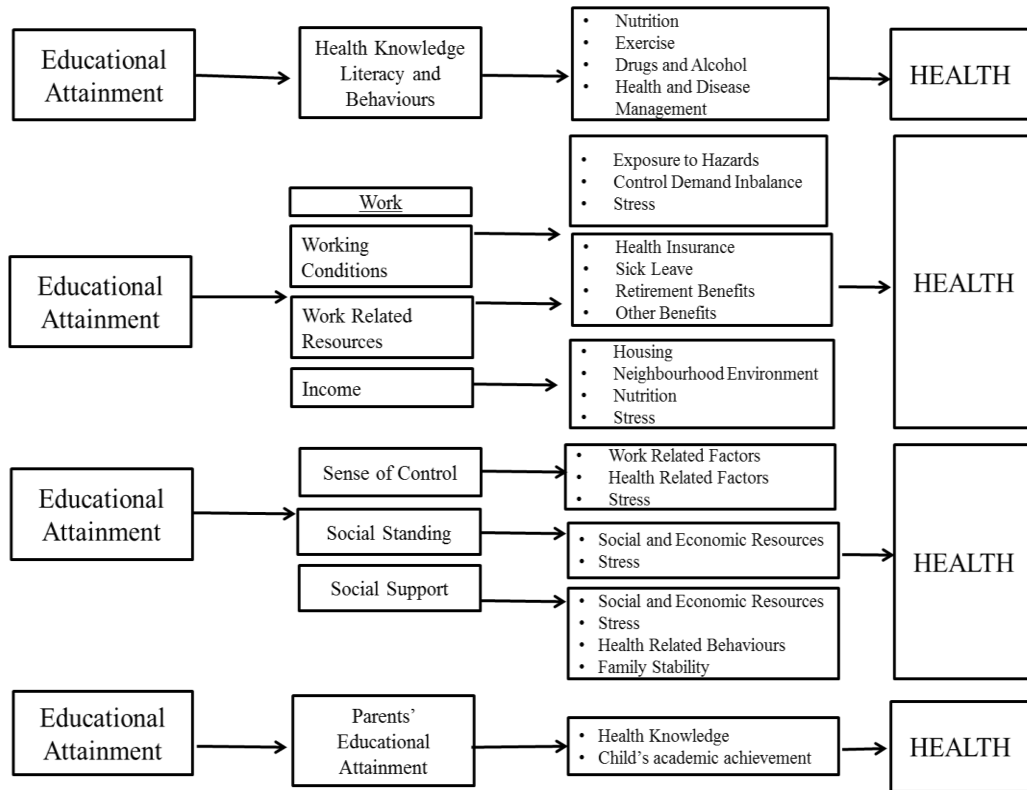
This thesis report is investigating how Turkish primary schools promote health with an in-depth case study. This case study examines the awareness and motivation among teachers to promote health, the barriers in front of teachers and school administration, the situation of school facilities and school environment in order to picture the current health promotion policy and implementations in Turkish public primary schools. To understand and name the findings of this research correctly, first of all, the literature written on health promotion in schools has to be reviewed and analysed properly.

The literature has been reviewed and relevant significant studies are summarized below to reveal the previous findings related to this study both in national and international terms. How health is promoted in Turkey and other countries and what are the factors affecting this promotion in schools are explained in the following paragraphs. The factors affecting the health promotion process of schools, the role of teachers and other school staff, curriculum and the barriers in front of implementing a successful health promotion programme are examined throughout this chapter. The basic education curriculum and recent regulations in Turkish politics about health promotion is reviewed to visualize the current situation in Turkey.

2.1 The Association between Health and Education

To clearly understand the rationale for conducting this thesis, first of all the relationship between education and health should be well brought into a sharp relief. To explain the strong links between education and health many

people think of first that education can lead to improved health by increasing health knowledge and healthy behaviours. The association between education and health can be summarized under four topics as mentioned below (Figure 2.1).



Adapted From: (Robert Wood Johnson Foundation, 2009)

Figure 2.1 Interrelated pathways through which educational attainment affects health.

2.1.1 Health Knowledge, Behaviors and Literacy

Education can increase people's knowledge and cognitive skills, enabling them to make better-informed choices among the health-related options

available for themselves and their families, including those related to obtaining and managing medical care (Ross and Wu, 1995). Greater educational attainment has been associated with health-promoting behaviours including increasing consumption of fruits and vegetables and other aspects of healthy eating, engaging in regular physical activity, and refraining from excessive consumption of alcohol and from smoking. A study conducted by Cutler and Lleras-Muney in 2006 reveals that individuals with an additional four years of education are less likely to smoke, drink a lot, be overweight or obese, or use illegal drugs. In addition, changes in health-related behaviours in response to new evidence, health advice and public health campaigns (about the risks of smoking, for example) tend to occur earlier among more-educated people(Cutler and Lleras-Muney, 2006).

Literacy is also important in explaining the links between education and health through health knowledge and behaviours at least in part by literacy. Illiteracy affects 2.8 million citizens in Turkey. There are 3.7 million people who have low literacy levels. Totally, twelve per cent of Turkish population is below the necessary literacy levels to perform everyday literacy activities (TUIK, 2013b). This percentage is important because it is known that health is directly affected from literacy level of citizens (Ross and Wu, 1995).In United States of America, statistical studies measuring “health literacy” are gathered regularly. Average health literacy (i.e., the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions and adhere to sometimes complex disease management protocols) increases with educational attainment. The proportion of American adults with “below basic” health literacy, for example, ranges from 3 per cent of college graduates to 15 per cent of high-school graduates and 49 per cent of adults who have not completed high school (Kutner, Greenberg, and Jin, 2006). Levels of health literacy in turn have been associated with self-reported overall health, which correlates strongly with

objective clinical assessments: compared with adults who have adequate functional health literacy, adults with inadequate functional health literacy are more likely to rate their health as poor (Baker, Parker, and Williams, 1997).

2.1.2 Better Work and Economic Conditions

Greater educational attainment leads to better work and economic conditions which are linked with better health. Education provides the knowledge and skills necessary for employment, which can shape health in many ways. More education generally means a greater likelihood of working full-time, having a job with healthier working conditions and more satisfaction, and higher wages (Ross and Wu, 1995).

In Turkey, people with lower educational attainment are more likely to be affected by fluctuations in the economy. While current unemployment rates are lower now than it was after 2008 economic crisis, the changes in the unemployment rates fluctuate more with lower educational attainment. The data gathered from Turkish Statistical Institute declares that the unemployment rate among illiterates was 8.8 per cent in February 2008 compared to 5.6 per cent in February 2013 (TUIK, 2008). The unemployment rates were 11.5 per cent for adults who had not graduated from high school, 13.8 per cent for high-school graduates, and 9.1 for those graduated from higher education at February 2008, just after the economic crisis. But in February 2013 the unemployment rates were 10.7 per cent for adults who had not graduated from high school, 12 per cent for high-school graduates, and 9.6 for those graduated from higher education (TUIK, 2013a). The biggest difference in the unemployment rates between economic downturns and recoveries is within the illiterates (3.2 per cent) These differences have major health implications; compared with their employed counterparts, people who are unemployed experience poorer health and higher mortality rates (Martikainen and Valkonen, 1996). Thus, it is not

wrong to conclude that people with lower educational attainment tend to lose their jobs, during economic crisis periods and they face health risks more than employees with better educational attainment.

Occupational hazards are more likely to affect workers with less formal education and training, who are employed in lower-paying jobs. These occupational hazards include environmental and chemical exposures (e.g., air pollution, noise pollution, pesticides) and poor working conditions (e.g. shift work with long working hours, potentially harmful tools) that put them at higher risk of injury and fatality (Cubbin, LeClere, and Smith, 2000). Psychosocial stresses at work are another hazard that is more likely to be experienced by less educated employees. This type of stress occurs when the high demands of the job is not balanced with enough opportunities for control and skill utilization. Psychosocial aspects of work including perceived balance between a worker's efforts and rewards, perceived justice and discrimination in the workplace, and social support among co-workers have been shown to have both short- and longer-term impacts on health, particularly through stressful working conditions (Almeida, Neupert, and Banks, 2005).

Workplace wellness programs, employer paid health insurance, paid sick and personal leave, child and elder care benefits, retirement benefits are more likely to be offered to higher-paid jobs while less-educated workers in lower-wage jobs are not generally receiving most of these benefits. In Turkey, 38 per cent of employees (8.7 million) are unregistered according to the official data gathered by TUIK. The unofficial data claims even more: half of the working labour force. Due to the fact that the health insurance is a benefit offered by social security institutions to registered individuals in Turkey, along with the 10.5 per cent (2.9 million) of unemployed population, 11,6 million people in Turkey have no active health insurance according to February 2013 data of TUIK. Although registration to one of the social security institutions by employers per each working employee is compulsory, employers with lower-

wage workers sometimes ignore social security registration and thus health insurance is not perceived as a right or common benefit for low-income workers. In Turkey, one of main reasons of unregistered employment is lack of high-value-adding employment. Supposing that an individual is paid in accordance with the value she/he added to the work, a worker's income will increase with the value added in employment. The value-added employment is proportionally increasing with educational attainment. Thus, more education means more value added employment and as a result a higher income job with registration to the health insurance (Arca, 2013).

For Turkish households, employment is the sole or main source of income which is a work-related resource that affects health through multiple well-documented direct and indirect pathways (TUIK, 2011). With limited exceptions, greater educational attainment generally corresponds with higher-paying employment. A recent study conducted in USA estimated that on average each additional year of schooling represents an 11 per cent increase in income (Rouse and Barrow, 2006). These differences are particularly dramatic when compounded over a person's lifetime: lifetime earnings (in 1999 dollars, and based on a 40-year, full-time work life) for adults who have graduated from high school but not attended college have been estimated at $1.2 million, compared with $2.1 million for those with bachelor's degrees and $4.4 million for those with post-baccalaureate professional degrees (Cheeseman Day and Newburger, 2002).

Workers with higher income have greater economic security and are able to accumulate wealth. This wealth accumulation enables individuals to obtain health care when necessary, to provide themselves and their families' nutritious diet, and to live in environments that are safer and healthier. The houses, neighbourhoods, parks and places to exercise that are part of this environment can promote good health by making it easier to adopt and maintain healthy behaviours. Work-related income may also affect health through reducing the

work related stress. Lower-paid workers experience greater stress because they have difficulties in coping both with everyday stress and family responsibilities that arose especially after the birth of a child or unexpected illness, due to the fewer financial resources.

2.1.3 Social and Psychological Factors

Education is linked with social and psychological factors that affect health. Education is linked with social and psychological factors, including social support, sense of control and social standing. These factors can improve health through reducing stress, influencing health-related behaviours and providing practical and emotional support.

Education may influence health by shaping people’s sense of control. Sense of control can be defined as an individual’s perceptions of the extent to which he/she can influence their life circumstances. Perceived powerlessness and lack of control which are the opposite of sense of control are beliefs that one's actions do not affect outcomes and the outcomes of situations are determined by forces external to one's own actions such as powerful others, luck, fate, or chance. However, personal control is a learned expectation that outcomes are contingent on one's own choices and actions that one can master, control, or effectively alter one's environment. Higher levels of education have been linked with greater perception of personal control, fostering skills, habits and attitudes, such as problem-solving, purposefulness, self-directedness, perseverance and confidence that contribute to people’s expectations that their own actions and behaviours shape what happens to them. Several studies have concluded that more education confers a greater sense of control, which perhaps is not surprising given the influence of education on prospects for jobs and income (Ross and Wu, 1995). Higher levels of self-rated health, decreased risk of chronic conditions and lower levels of physical impairment are health

outcomes linked with increased sense of control. Smoking, alcohol consumption, physical activity and diet are health-related behaviours that are more likely to be avoided by educated people who have high sense of control (Mirowsky and Ross 1998). Sense of control may also influence health through job-related pathways, for example by affecting a person's job seeking and performance (Stajkovic and Luthans, 1998). It is difficult to separate out the effects of sense of control and education on health, because an individual with a greater sense of control is more likely to achieve higher educational attainment.

Greater educational attainment typically is associated with higher social standing, which in turn has been linked with better health status. Thus, many experts believe that social standing is another important factor linking education with health (Black, Morris, and Smith, 1988). Educational attainment is an important determinant for determining the rank of an individual within social hierarchies reflecting status and influence, as well as income and occupation. "Subjective social status" which is an individual's perception of where she/he belongs, has been shown to powerfully predict the health status even after controlling for conventional measures of socioeconomic status such as occupation, income and education (Davis, 1956). While the association with health and subjective social status is not well understood, subjective social status may be a more comprehensive reflection of social and economic resources.

Social support is another factor relating education to health. Social support can be "emotional" (having someone to turn to for comfort or advice) or "practical" (having someone to turn to for practical or material help). Higher educational attainment, income and occupational status all have been associated with higher levels of social support (Ross and Wu, 1995). Higher educational attainment increases a person's likelihood of having close friends on whom to rely and of experiencing greater family stability, including a stable and supportive marriage (Mirowsky and Ross, 1998). Formal educational settings may encourage the development of friendships and interpersonal skills; people

with more education and related social advantages may also have more time and resources to maintain relationships and support friends emotionally and financially (Ross and Wu, 1995).

Better physical and mental health outcomes are linked with higher levels of social support. People with more social contacts are under lower mortality risk across multiple age groups and in both sexes, and disruptions in family stability have been linked with worse health among adults and poorer health behaviours and well-being among children (Mirowsky and Ross, 1998). Social support can buffer the health-damaging effects of stress by reducing negative emotional and behavioural responses to stressful situations. Larger social networks can provide easier access to employment, housing and other opportunities and resources that influence health. Health-related behaviours such as smoking, exercise and alcohol consumption are behaviour norms that can be influenced by support within social groups.

2.1.4 Parents' Education

Parents' education influences children's prospects for health during childhood and beyond. The educational attainment of parents, especially of mothers, significantly affects children's health as adults and their educational attainment (Chen, Martin, and Matthews, 2006).

Parents with lower educational attainment typically face greater obstacles including lack of knowledge, skills, time, money and other resources. These obstacles prevent the creation of healthy home environments and modelling healthy behaviours for their children. The quality of children's health and development in turn shapes health later in life, through both direct and indirect ways. A large body of research has consistently linked adverse effects on brain, cognitive and behavioural development early in life with important health outcomes later in life, including cardiovascular disease and stroke,

hypertension, diabetes, obesity, smoking, drug use and depression—conditions that account for a major portion of preventable morbidity and premature mortality in the United States. Healthy development in childhood can also affect health later in life through its association with greater academic achievement and educational attainment (Miller, Simon, and Maleque, 2009).

Children's educational attainment is directly affected by the parents' educational attainment which can also shape children's prospects for healthy lives. Parental education and related social and economic advantage are associated with children's academic achievement. The children born in lower-income families with less educated parents face greater obstacles to success in school and are less likely to go on to receive college educations (Figure 2.2) (Rouse and Barrow, 2006).

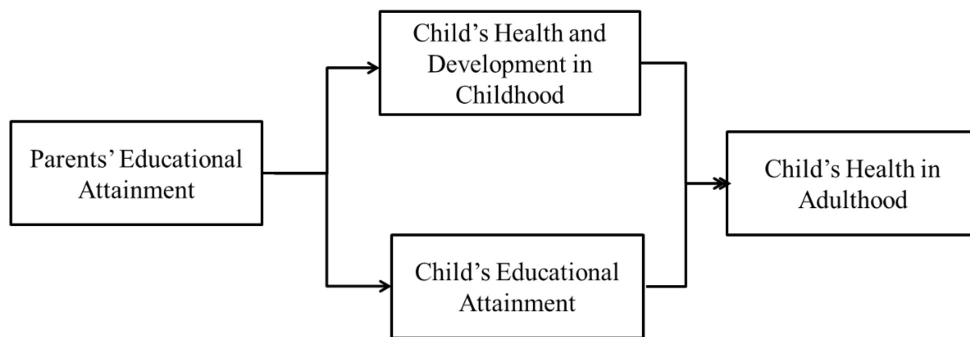


Figure 2.2 Impact of education on health across generations

Parents' education levels can affect their children's education prospects both directly, through the kinds of support and resources parents are able to provide at home, and indirectly, through the quality of schools their children are likely to attend. Less-educated parents are less likely to give importance to academic achievements of their children and they are less interested in creating stimulating and nurturing environments for their children (Davis-Kean, 2005).

Besides, less educated families tend to live in lower-income neighbourhoods in which schools may have insufficient resources. The level of educational attainment children eventually achieve affects their health as adults, as in the same way experienced by less educated parents. Then, it also affects the health of their own children in turn, perpetuating a dead-end intergenerational cycle of low educational attainment and poorer health.

Apart from these three aspects, another dimension of the relationship between health and education is observed clearly on the learning process of children. In the previous explanations of the association between education and health, it is revealed that educational attainment improves health in different ways. It is also true that the health status directly affect the educational attainment. No matter how well teachers are prepared to teach, no matter what accountability measures are put in place, no matter what governing structures are established for schools, educational progress will be profoundly limited if students are not motivated and able to learn. Health-related problems play a major role in limiting the motivation and ability to learn of youth, and interventions to address those problems can improve educational as well as health outcomes (Basch, 2010).

Educationally relevant health disparities impede motivation and ability to learn through at least five causal pathways: sensory perceptions; cognition; connectedness and engagement with school; absenteeism; and dropping out. Because educational outcomes are influenced by many forces differentially across various contexts, each health factor, addressed separately, should not be expected to have large or consistent effects on educational outcomes. For example, the effects of diet on the brain are integrated with effects of other factors such as exercise and sleep (Gomez-Pinilla, 2008). The child who is well nourished, physically active, and well rested is likely to have advantages regarding cognition compared with the child with deficits in any of these areas. The child who has difficulty seeing, difficulty paying attention, or is bullied at

school will struggle to succeed academically and will feel less connected and engaged with school. In turn, the child who is less connected and engaged with school will be less motivated to attend. Thus, beyond their individual effects, educationally relevant health disparities, collectively, can have an influential role in shaping the educational and social lives of the nation's urban minority youth. Further, there are synergistic effects of acquiring skills at earlier stages in life where by capabilities be get capabilities and influence long-term health (Heckman, 2008).

To sum, healthier students are better learners. Recent research in fields ranging from epidemiology and public health to neurosciences and child development provide compelling evidence for the causal role that educationally relevant health disparities play in the educational achievement gap that deranges youth (Basch, 2010). This is why reducing these health disparities must be a fundamental part of school programs.

> If children can't see well, if their eyes do not integrate properly with their brain and motor systems, they will have difficulty acquiring the basic and essential academic skills associated with reading, writing, spelling and mathematics. If their ability to concentrate, use memory, and make decisions is impeded by ill-nourishment or sedentary lifestyle, if they are distracted by negative feelings, it will be more difficult for them to learn and succeed in school. If their relationships at school with peers and teachers are negative, they will be less likely to be connected with and engaged in school, and therefore less motivated and able to learn. If they are not in school, because of uncontrolled asthma or because they are afraid to travel to or from school, they will miss teaching and learning opportunities. If they drop out, perhaps because they are failing or faltering; or because they are socialized to believe that, even if they complete school, there will be no better opportunities; or because they associate with peers who do not value school; or because they become pregnant and there are no resources in place that enable them to complete school while pregnant and after they have a new-born, it is not likely that they can succeed. If they cannot focus attention and succeed socially, it is unlikely that they will succeed academically (Basch, 2010, p: 76).

Although the links between health and education is apparent for many scientists, there are others who question the relationship between them. Cutler

and Lleras-Muney have evaluated the theories and evidence on the association between education and health and concluded that:

> The issue of causality is also important. Although there is evidence of causal effects of education on health at lower levels of schooling, it is not known if the education returns observed after that level are causal. Nor is it known if there are returns to higher quality education. Better understanding of the heterogeneity of the returns to education is also needed. In order to improve health, it may prove more cost effective to target populations with the largest returns to health, even though this may exacerbate inequities (Schoeni, House, Kaplan, and Pollack, 2008, p: 52).

They claim that even if a large part of the association between education and health is causal, and that increasing educational attainment improves health, some important questions remain before an appropriate policy response is given. Only when there occurs a market failure and individuals are investing at suboptimal levels, causal effects of education on health would call for education subsidies. Otherwise, people would consider health benefits and financial benefits together, when they give decisions about their education. Possible rationales for education subsidies include the idea that individuals may be unaware of the health benefits of education when they make their education decisions is the rationale for the supporters of the idea who think education should be subsidised .

It may be more cost effective to tap the mechanism than to increase educational attainment. For example, if all of the education effect operated through income, and income improved health, then it would possibly be cheaper to transfer income directly, rather than to subsidize schooling. But increasing educational attainment may prove to be the correct policy response if, for example, there is no alternative (or cheaper) method to acquire the skills that ultimately affect health.

In spite of these cautions, education policies have the potential to have a substantial effect on health directly and indirectly. There is no study in the

literature that can deny the links between health and education. Assuming that the observed correlations between education and health are long term causal effects from education to health, this study will soon evaluate the role of schooling in health promotion and education.

2.2 What is Health Promotion?

Health is a basic human right and is essential for social and economic development. An essential tool for health development is health promotion. Health promotion can be defined as the process of enabling people to increase control over, and to improve their health. The determinants of health, such as creating health gain for individuals, contributing to the reduction of inequalities in health and building human capital are affected from health promotion through investment and action. The ultimate goal of health promotion is to increase health status, and to close the gap in health expectancy between countries and groups. (Ottawa Charter, 1986)

2.2.1 Health

Health is a resource for everyday life, where they learn, work, play and love. It is not the objective of living. Because, to reach a state of complete social, mental and physical well-being, the society should identify and realize ambitions, fulfil needs, and modify or handle with the environment. Health is a positive concept emphasizing physical capacities and social and personal resources. Thus, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being (WHO, 1997a). The prerequisites for health are peace, shelter, education, social security, social relations, food, income, the empowerment of women, a stable eco-system,

sustainable resource use, social justice, respect for human rights, and equity. Above all, poverty is the greatest threat to health (Ottawa Charter, 1986).

2.2.2 Health Promotion

Health promotion supports personal and social development through providing information, education for health, and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health (WHO, 1995). Changing patterns of life, work and leisure have a significant impact on health. Work and leisure should be a source of health for people. The way society organizes work should help create a healthy society. Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable.

There are new problems influencing health status of citizens in countries such as, urbanization, increase in the number of older people and the high prevalence of chronic diseases. Resistance to antibiotics, drug abuse, and civil and domestic violence threaten the health and well-being of hundreds of millions of people in the world. Especially increasing percentages of mental health problems and new and re-emerging infectious diseases (such as, bird influenza etc.) require an urgent response. In that sense, health promotion activities should meet the changes in the determinants of health (Jakarta Charter, 1997).

The integration of the global economy, financial markets and trade, wide access to media and communications technology, and environmental degradation as a result of the irresponsible use of resources are the transnational changes that should be taken into consideration. These changes shape people's attitudes, values throughout the lifespan, and living conditions across the world. Some of these changes have great positive influences for health, such as the

development of communications technology, but others, such as international trade in tobacco, have a major negative impact (Jakarta Charter, 1997).

Equity in health is the main aspiration of health promotion. In order to enable all people to achieve their fullest health potential, health promotion activities are focused on reducing differences in current health status and ensuring equal opportunities and resources. A secure foundation in a healthy environment, easy access to information, gaining life skills and opportunities for making healthy choices are some of the actions taken for health promotion. People cannot achieve their fullest health potential unless they are able to take control the determinants of their health. Health promotion means much more than health care. The agenda of policy makers should be directed to be aware of the health consequences of their decisions and policy makers must be reminded of their responsibilities for health. Health promotion policy requires complementary approaches including legislation, fiscal measures, taxation and organizational change. It is a coordinated action that leads to health, income and social policies that foster greater equity. The contribution of this coordinated action is the insurance of safer and healthier goods and services, healthier public services, and cleaner, more enjoyable environments (Ottawa Charter, 1986).

Health promotion is not just the responsibility of the health sector. The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. A coordinated action, in which all concerned counterparts: governments, health and other social and economic sectors, nongovernmental and voluntary organizations, local authorities, industry and the media take part, is required to achieve health promotion. Individuals, families, communities, professional and social groups and health personnel have a major responsibility to mediate between differing needs in society for the pursuit of health. The different social, cultural and economic development draws on existing human and material resources in the community to enhance self-help and social

support, and to develop flexible systems for strengthening public participation in and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support. The systems of countries and regions should be taken into account for establishing health promotion strategies and programmes that meet the local needs (Ottawa Charter, 1986).

The World Health Organization explains that health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them. The aim should be to make the healthier choices easier for the easier policy makers as well.

Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities - their ownership and control of their own endeavours and destinies. Health is created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members.

Enabling people to learn, throughout life, to prepare them for all of its stages and to cope with chronic illness and injuries is essential. This has to be facilitated in school, home, work and community settings. Action is required through educational, professional, commercial and voluntary bodies, and within the institutions themselves. The health sector should give attention to move towards a health promoting pathway, beyond the providing clinical and curative services. New channels should be open between the health sector and the broader social, political, economic and physical environmental components to support the needs of individuals and communities for a healthier life. The health promotion conference met in Jakarta in 1997 says that reorienting health services also requires stronger attention to health research as well as changes in

professional education and training. The attitude and organization of health services have to change and refocus on the total needs of the individual as a whole person (Jakarta, 1997).

Caring, holism and ecology are essential issues in developing strategies for health promotion. Therefore, those involved should take as a guiding principle that, in each phase of planning, implementation and evaluation of health promotion activities, women and men should become equal partners (Jakarta, 1997).

Good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it. Health promotion action aims at making these conditions favourable through advocacy for health.

According to Jakarta Declaration the priorities for health promotion in the 21st Century are promoting social responsibility for health, increasing investments for health development, consolidating and expanding partnerships for health, increasing community capacity and empowering the individual, securing an infrastructure for health promotion.

Social responsibility must be a crucial concern for decision makers. Both the public and private sectors should promote health by pursuing policies and practices that: avoid harming the health of people, protect the environment and ensure careful use of resources, restrict production of and trade in inherently harmful goods and substances such as tobacco and armaments, as well as discourage unhealthy marketing practices, safeguard both the citizen in the marketplace and the individual in the workplace, include equity-focused health impact assessments as an integral part of policy development (Jakarta, 1997).

In many countries, health is not getting enough investments, and the current ones are inadequate. Especially in Turkey, the number of patients per doctor and the total expenditures as a percentage of Gross Domestic Product is

very inadequate. The OECD 2012 data says that in Turkey which stands at the bottom of the country list among all OECD countries, there are 1.4 doctors per a thousand patients, while this number is 2.9 on average in OECD countries. While the average of OECD countries spend 9.5 percentage of their gross domestic product on health on average, Turkey spends only 6.1 per cent, and this is the lowest percentage among all countries. Increasing investment for health development requires a truly multi sectorial approach including additional resources for education and housing as well as for the health sector. Significant advances can be achieved with the reorientation of existing investments and new investments that contribute to human development, health and quality of life. The interests of particular groups such as women, elderly, children and poor should be reflected while investing in health promotion.

Cooperation between different sectors is required for health improvement and social development of the whole society. Existing partnerships need to be strengthened and the opportunities for establishing new partnerships must be explored. Partnerships offer mutual benefit for health through the sharing of expertise, skills and resources. The partnerships should be ethical and transparent and include common understanding and respect.

“Health promotion is carried out by and with people, not on or to people.” (Jakarta, 1997). It improves both the ability of individuals to take action, and the capacity organizations or communities to influence the determinants of health. Increasing the capacity of communities for health promotion is something that can be achieved by practical education, leadership training, and access to resources.

An infrastructure available for promoting health is possible only when locally, nationally and globally funded new mechanisms are found. Health promotion can be maximized by confident governments, nongovernmental organizations, educational institutions and private sector that ensure the resource mobilization. There are "Settings for health" representing the organizational

base of the infrastructure required for health promotion. New health challenges mean that new and diverse networks need to be created to achieve intersectoral collaboration. Such networks should provide mutual assistance within and among countries and facilitate exchange of effective information and strategies. To improve planning, implementation and evaluation of health promotion programs, documentation of experiences should be enhanced. Reporting the researches and projects is an important tool for this enhancement. "All countries should develop the appropriate political, legal, educational, social and economic environments required to support health promotion" (Jakarta, 1997).

2.2.3 Health Promotion to World Health Organization

Health promotion is one of the main concerns of World Health Organization (WHO, 2009). The organization is arranging conferences focusing on health promotion since 1986. The first conference was held in Ottawa and still, the principles decided in Ottawa are used globally to promote health. The definition of health promotion and the pathways to spread health promotion studies across countries are discussed in these conferences since 1986. The fourth conference held in Jakarta in 1997 is seen very important as well, since in this conference a charter for new challenges of health is signed. The Jakarta Declaration on Health Promotion offers a vision and focus for health promotion into the next century and tries to express the pathways to tackle health determinants in the 21st century.

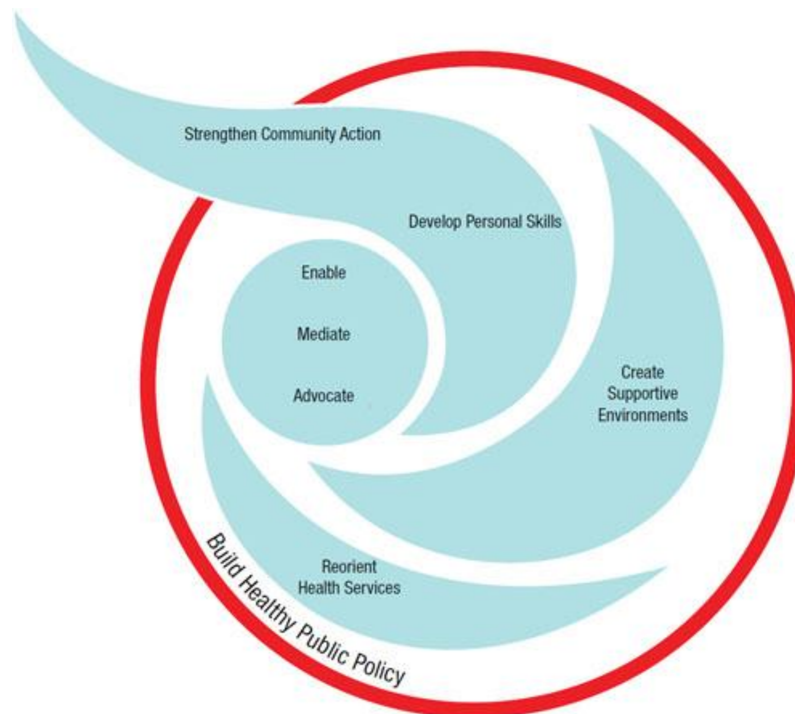
The participants in Jakarta Conference are committed to sharing the key messages of the Jakarta Declaration with their governments, institutions and communities, putting the actions proposed into practice. In order to speed progress towards global health promotion, the participants endorse the formation of a global health promotion alliance. The goal of this alliance is to advance the priorities for action in health promotion set out in this Declaration.

Priorities for the alliance include raising awareness of the changing determinants of health, supporting the development of collaboration and networks for health development, mobilizing resources for health promotion, accumulating knowledge on best practice, enabling shared learning, promoting solidarity in action, fostering transparency and public accountability in health promotion.

Between 10- 14 June 2013 the Eighth Global Conference on Health Promotion was held in Helsinki, Finland. The main heading of this conference was “health in all policies”. The draft conference definition for “health in all policies” was prepared in order to build common ground for understanding of the concept of Health in all policies. Health in all policies is an approach that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts, in order to improve population health and health equity. The approach is based on health-related rights and obligations and should improve the accountability of public policy makers for health impacts at all levels of policy making. Including an emphasis on the consequences of public policies on health systems, determinants of health, and well-being is very crucial.

Health Promotion Logo

The logo was created for the First International Conference on Health Promotion held in Ottawa, Canada, in 1986. At that conference, the Ottawa Charter for Health Promotion was launched. Since then, World Health Organization kept this symbol as the Health Promotion logo (HP logo), as it stands for the approach to health promotion as outlined in the Ottawa Charter (Figure 2.3).



Source: (Ottawa Charter,1986).

Figure 2.3 Health Promotion Logo

The logo constitutes a circle with three wings. It combines five key action areas in Health Promotion, which are building healthy public policy, creating supportive environments for health, strengthening community action for health, develop personal skills, and re-orienting health services, and three basic health promotion strategies: to enable, to mediate, and to advocate.

The outside circle is aiming to emphasize "Building Healthy Public Policies". The circle is closed to express that all policies should be kept together. There are three wings representing the five key action areas of health promotion determined in the Ottawa Charter.

The three basic strategies for health promotion (enabling, mediating, advocating) are standing in a round spot. The three wings represent (and contain the words of) the five key action areas for health promotion that were identified

in the Ottawa Charter for Health Promotion in 1986 and were reconfirmed in the Jakarta Declaration on Leading Health Promotion into the 21st Century in 1997.

Overall, the logo visualises the idea that Health Promotion is a comprehensive, multi-strategy approach. Health promotion applies diverse strategies and methods in an integrated manner - one of the preconditions "for Health Promotion to be effective" (Jakarta Declaration 1997). Health Promotion addresses the key action areas identified in the Ottawa Charter in an integrated and coherent way.

2.3 Why Promote Health at Schools?

The relationship between education and health is explained in detail in the previous sections. This relationship can be used to help create health promoting schools. The rationales for promoting health through schools are obvious. With more children than ever receiving a formal education, schools are rational places to reach school-age youth and their families in an organised way, and to ensure the personal development essential for national welfare. Schools are among the most important institutions and settings in which health can be created.

In almost every community, the school is a setting where students and staff spend a great deal of their time and many people learn and work, care for and respect each other. Schools are places where education and health programmes can be applied most effectively; because they influence students at important stages in their lives, from childhood to adolescence. For every society, children are the most important natural resources. Children should be placed at the centre of development. The power of the villages, cities and nations will be determined by these children’s wellbeing, skills, educational attainment and energy in the future. The capacity of healthy children who are lively, curious and ready for trying new things can be unbounded. In the past few decades,

many threats to the children's youngest children are defeated successfully in many countries. In today's world, children are healthier than in the past. They live longer, are better nourished, have more up-to-date immunisations. As a result, about 2.5 million fewer children die annually now than in 1990 (WHO, 2012). The number of children attending school is increasing as well. But still, weak health prevents children from attending regularly to school, so that these children do not get the knowledge and capabilities necessary for growing as productive and skilful citizens who can contribute to the growth and welfare of their countries. Any children should take part regularly in educational activities. To do this, they must be healthy, attentive and emotionally secure. Schools are places where the health of students, school staff, families and other community members can be promoted (WHO, 2012).

Schooling, alone, has been shown to be a powerful way to influence health, worldwide (WHO, 1999). Its influences may be clearly observed in benefits to maternal and child health. For example, the fertility rate and literacy rates are correlated in opposite directions. World Health Organization states that the fertility rates fall down as the literacy rates increase in developing countries. Women tend to marry later and more likely to use family planning methods as they have more educational attainment. Mothers are more able to take care of their babies as they get even one more year of education. The babies of these educated mothers are more likely to be immunized and to get medical care. Furthermore, all schools, with more or less resources, can contribute to the students' and staff' decisions to care for themselves and others and have more control over life's circumstances, and ensure better conditions that are conducive to health. These are the qualities through which health is created and they are either encouraged or discouraged by a school's policies, management practices and social conditions (WHO, 1999).

2.3.1 What is a Health Promoting School?

A Health promoting school views "health" as physical, social and emotional wellbeing (WHO, 1998a). It strives to build health into all aspects of life at school and in the community. Schools in different regions, in different countries have distinct strengths and needs. Improvement of health and reduction of health problems can be possible by building on those strengths and drawing on the imagination of students, parents, teachers and administrators. This is the heart of the process of becoming a Health-Promoting School.

The Ottawa Charter (1986) of WHO recognizes that, "Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to make decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members."

In the chapter below, some of the opportunities available in the school settings for improving health of young people and preventing the occurrence of health risk behaviours are described. School is a miraculous organization for improving the health of school personnel, families and members of the community, as well as students at the same time. It is a means to support the basic human rights of both education and health. It offers opportunities to achieve positive health and education outcomes with investments of scarce education and health resources. It also offers highly visible opportunities to demonstrate a commitment to equity and to raising the social status of women and girls. Primary school enrolments are increasing in nearly every part of the world. For example in Turkey, the net schooling ratio by educational year and level of education in 1997- 98 educational years was 84.7 per cent. In that year compulsory education was increased to 8 years. In 2012-13 educational years this ratio has increased to 98.7 per cent. The main exception of this situation in

the world is in Sub-Saharan Africa, where enrolments are stagnating or declining (UNICEF, 1999). However, worldwide, schools reach millions of students and, through them, their families and communities. Therefore, as articulated by UNICEF, the formal education system is "the developing world's broadest and deepest channel for putting information at the disposal of families, school personnel, and community members as well as students"(UNICEF, 1988).

There are six features of health promoting schools according to World Health Organization (WHO, 1996):

1. First of all, health promoting schools engage health and education officials, teachers and their representative organisations, students, parents, and community leaders in efforts to promote health, with families and community groups involved in the school, community services, businesses and organisations linked to the school**,** school/community projects and outreach**,** health promotion for school staff.

2. This kind of schools has sufficient sanitation and water. They are free from abuse and violence and they have a climate of care, trust and respect, social support and mental health promotion, safe school grounds, opportunities for physical education and recreation. With these qualifications health promoting schools endeavour to provide a safe and healthy environment.

3. Health promoting schools provide skills-based health education. The curricula of these schools improve students' approach of factors that have an impact on health and enable them to make healthy choices and adopt healthy behaviours throughout their lives**.** These curricula include critical health and life skills, that focus on promoting health and well-being, besides prevent important health problems, these schools give their students information and activities

appropriate to children's intellectual and emotional abilities and also training and education for teachers and parents.

4. Schools that promote health provide access to health services. These services are best provided in the school settings, such as screening, diagnosis, monitoring growth and development, vaccination, selected medications and procedures. It is obvious that establishment of these services depends on school resources and partnerships with local health agencies are required. These agencies will also provide healthy nutrition and food safety programmes.

5. Health-promoting policies and practices are implemented by health promoting schools. An overall policy supported by school administration as well as teaching practices that help create a healthy psychosocial environment for students and staff is appropriate for promoting health at schools. Equal treatment for all students, drug and alcohol use, tobacco use, first aid, nutrition, physical exercise and violence are policy areas that help prevent or reduce physical, social and emotional problems.

6. Health promoting schools strives to improve the health of the community by paying attention on community health concerns and participating in community health projects.

These measures are taken into consideration to constitute a base for questioning and analysing the current health promotion situation in the public primary school studied for this case study.

Fundamentally, a health promoting school uses its full organisational potential to promote health among students, staff, families and community members. A health promoting school starts with its own resources. It does not matter whether they are many or few (WHO, 1999).

2.3.2 Barriers to the Development of School Health Programmes

World Health Organization convened an expert committee on Comprehensive School Health Education and Promotion in Geneva, Switzerland, from 18 to 22 September 1995 in order to encourage educational and health institutions and agencies to coordinate their efforts to promote health through schools (WHO, 1995). The primary objective was to make recommendations for policy measures and actions that WHO (including its Regional Offices), other United Nations agencies, national governments and nongovernmental organisations could apply to enable schools to use their full potential to improve the health of children and young people, school staff, families and community members.

The expert committee surveyed how schools in the world affect health of children, families and community members and the global state of school health. Identifying the opportunities for and barriers to strengthening school health programmes at international, regional, district and local levels is a reference point for expert committee members.

After understanding the current situation and the reasons for problems the committee members are to make recommendations aimed at strengthening school health infrastructure and school health promotion activities. These activities have to maximize intersect oral action in support, assist policy makers and and decision makers in planning, implementing, and evaluating programmes and finally encourage the research needed to improve and fill gaps in professional knowledge.

There are significant reasons for designing school health programmes. The Expert Committee stated that that there is a rich base of knowledge on which to act to develop and improve school health programmes. Moreover, the research findings in both developing and developed countries demonstrates that school health programmes can simultaneously decrease common health

disparities, increase the efficiency of the education system and advance public health, education and social and economic development (WHO, 1997a).

The Expert Committee reviewed five barriers to the development of school health programmes as identified by national, district and local education and health workers (WHO, 1995):

1. There is a lack of clear vision of the potential benefits of school health programmes and how they might be realized. These visions motivate people to develop and implement solutions and to start a difficult process and see it through to the end. However, once a vision has been articulated, careful strategic planning is required. A vision without a plan is only a dream, whereas a plan divorced from a vision is lifeless and mechanical. Neither can yield any lasting, positive result without the other.

2. There is an inadequate understanding of the need for school health programmes and the new educational, medical and environmental technologies which they involve by decision-makers in influential international, national and local agencies, or by the public at large. Moreover, health promotion programmes can awake controversy, because they are intended not only to teach facts, but also to assist students, staff, parents and members of the community change in their behaviour. Even if the need for these changes is seen necessary, they are often seen as secondary to other priorities.

3. The lack of collaboration and coordination among responsible parties remains as a barrier. The progress in health promotion can occur when the ministries of health and education, as well as their representatives as the provincial, district and local levels, collaborate altogether, due to the fact that health and education are closely associated. Moreover, the ministries of planning, development, transport and others, all have interests, capacities and

responsibilities that can affect school health programmes. Additionally, the effective collaboration of nongovernmental organisations plays important roles in improving the health and education of young people.

4. The process of change has to be owned to convince participants to feel a sense of responsibility. Without a sense of ownership, responsibility and accountability school health programmes cannot be successful. The sense of responsibility is crucial to expect accountability. It is virtually impossible to know if success is being achieved or how to adapt what is being done without accountability. This relationship holds at every level and across levels. A barrier is created when national governments declare school health programmes to be the responsibility of schools, without giving them the necessary resources. The sense of ownership is prevented when school principals and head teachers place the responsibility for change but not allowing teachers to help determine the direction and processes for that change. Another barrier is created when the roles of participants are poorly defined and no one feels a legitimate part of the process in intersect oral collaborations.

5. The last barrier is the lack of resources (financial and human resources, materials and organisational infrastructure) and moreover little importance is given to the provision of these resources which undermines the achievement of educational and health outcomes, for the health and education of children and adolescents. Too few teachers and school personnel are educated and trained in the broad concepts of school health programmes. They are mostly not aware and do not have the skills to implement them. Materials for teaching about health, such as curriculum and training guides, are not available in many schools. Even minimum facilities for latrines and safe water are not available in many schools. This situation is rendering both health and education impossible.

2.4 Abraham Maslow’s Humanistic Theory

Humanistic theory is based upon the idea that everyone has the potential to make a contribution to society and be a good and likeable person – if their needs are fulfilled. Abraham Maslow (1968) led the humanistic theory movement and it was Maslow who developed the “pyramid of needs”. This theory is important to emphasize the importance of health promotion in schools, providing the fact that health promotion does not only improve the health status of children, but it also increases the ability and motivation of children to get education.

This theory in linked closely to the health and education concerns, because it is claimed that a child deprived of his basic health rights cannot show progress in educational life. Maslow (1943) believed that fulfilling the needs – in the correct order – would allow individuals to become self-actualized, fully able persons. So only after the basic physiological needs – such as food, shelter, warmth – are met can individuals move on to the next stages; the need to feel secure, to be loved and accepted etc.

Maslow developed his theory not by studying mentally ill patients, which is where much psychological knowledge had derived from up to that point, but by studying healthy, productive, creative individual’s lives and careers. He concluded that there were common characteristics which were shared by successful individuals – including self-acceptance, openness and respect for other individuals.

Abraham Maslow has been considered the **Father of Humanistic Psychology**. Maslow's theory is based on the notion that experience is the primary phenomenon in the study of human learning and behaviour. He placed emphasis on choice, creativity, values, self-realization, all distinctively human qualities, and believed that meaningfulness and subjectivity were more important than objectivity. For Maslow, development of human potential,

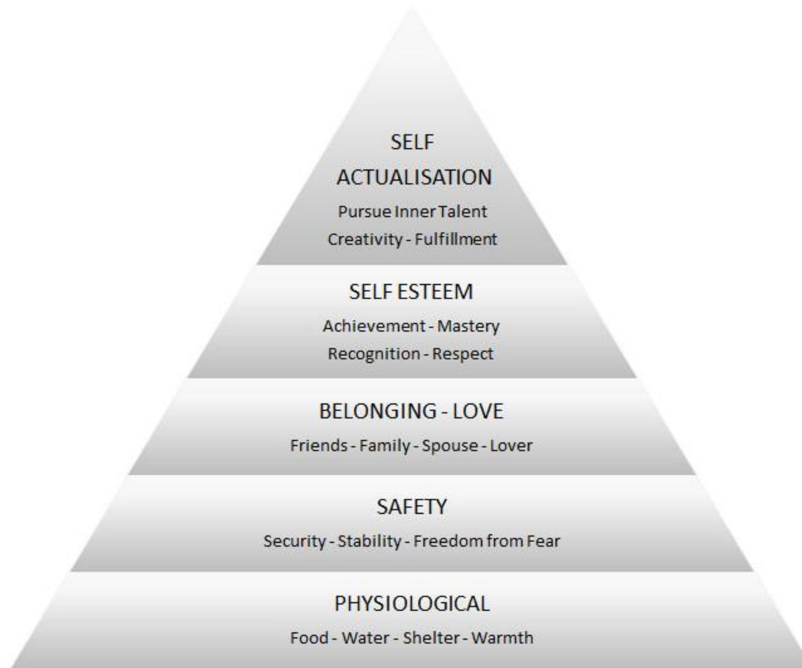
dignity and worth are ultimate concerns. Humanistic theory suggests that the achievement of happiness is frequently dependent upon achieving, or giving yourself the license to, investigate and pursue your own deepest interests and desires.

From Maslow's perspective, the drive to learn is intrinsic. The purpose of learning is to bring about self-actualization, and the goals of educators should include this process. Learning contributes to psychological health.

2.4.1 Maslow's Hierarchy of Needs

Maslow is famous for proposing that human motivation is based on a hierarchy of needs (Figure 2.4). The lowest level of needs is physiological and survival needs such as hunger and thirst. Further levels include belonging and love, self-esteem, and self-actualization (Maslow, 1943).

Physiological needs consist of needs for oxygen, food, water, and a relatively constant body temperature. They are the strongest needs because if a person were deprived of all needs, the physiological ones would come first in the person's search for satisfaction. We need these for basic survival. Maslow's theory said that you need to satisfy first the basic needs like physiological needs and safety needs to get motivation to truly attain the higher-level needs like social needs and esteem.



Source: (Maslow, 1943)

Figure 2.4 Maslow's Hierarchy of Needs Pyramid

When all physiological needs are satisfied and no longer dominating our thoughts and behaviours, we progress to safety needs. A person's attention turns to safety and security for himself/ herself to be free from the threat of physical and emotional harm. Such needs might be fulfilled by: living in a safe area, medical insurance, job security, financial reserves. These include the need for security. We often have little awareness of these, except in times of emergency and disorganization in social structure (war time, terrorist acts, domestic violence, and natural disasters). Maslow's hierarchy said that, if a person feels that he or she is in harm's way, higher needs would not be attained that quickly.

When a person has attained the lower level like Physiological and Safety needs, higher level needs become important, the first of which are social needs. Social needs are those related to interaction with other people like: need for friends, need for belonging, need to give and receive love. When safety and

physiological needs are met, we desire, to be loved by others and to belong. Maslow states that people seek to overcome feelings of loneliness and alienation. This involves both giving and receiving love, affection and the sense of belonging (family, friends, and social groups).

After the first 3 classes of needs are met, the needs for esteem can become dominant. These involve needs for both self-esteem and for the esteem a person gets from others. Esteem needs may be classified as internal or external. Self-respect and achievement are some examples of Internal esteem needs. Social status and recognition are some examples of External esteem needs. Some esteem needs are: self-respect, achievement, attention, recognition, reputation. Humans have a need for a stable, firmly based, high level of self-respect, and respect from others. When these needs are satisfied, the person feels self-confident and valuable as a person in the world. When these needs are frustrated, the person feels inferior, weak, helpless and worthless.

When all of the foregoing needs are satisfied, then and only then are the needs for self-actualization activated. The last necessity is the self-actualization or fulfilment needs. This includes purposed, personal growth, and the full realization of one's potentials. This is the point where people start becoming fully functional, acting purely on their own volition, and having a healthy personality. Maslow describes self-actualization as a person's need to be and do that which the person was "born to do." "A musician must make music, an artist must paint, and a poet must write." These needs make themselves felt in signs of restlessness (person feels edgy, tense, lacking something, restless.)

The person must be true to his or her own nature, be what you are meant to be. Maslow believed that very few people reach the state of self-actualization. Although we all have the need to move toward the goal of reaching our full potential, other needs may get in the way.

Maslow was interested in studying people who are psychologically healthy. These were people who had become self-actualized. He interviewed

these people to see how they were able to satisfy all of the needs on the hierarchy. He conducted what he called a "holistic analysis" in which he sought general impressions from his efforts to understand these people in depth.

Self-actualized people tend to accept themselves for what they are. They freely admit their weaknesses, but do make attempts to improve. They don't worry excessively over the mistakes they have made, but instead focus on improving. They respect and feel good about themselves. However, this self-love is healthy and not narcissistic. They are less restricted by cultural norms than the average person. They feel free to express their desires, even if contrary to the popular view. These people have frequent peak experiences, in which time and place are transcended, anxieties are lost, and a unity of self with the universe is obtained (birth of a child, marriage, deciding to go to school).

2.4.2 Importance of Maslow's Humanistic Theory to Education and Health

The most important educational goal is for students to learn. Another important goal is to make this newly gained knowledge and information purposeful and meaningful to the students so that it may be retained and useful throughout their lives. An essential factor involved in meeting these goals is motivation. If students are unmotivated in one way or another, it is likely that little learning will take place, or if by chance some learning should take place, it is probable that it will not be retained.

Maslow wanted to understand what motivates people. He believed that individuals possess a set of motivation systems unrelated to **rewards** or **unconscious desires.** Maslow (1943) stated that people are motivated to achieve certain needs. When one need is fulfilled a person seeks to fulfill the next one, and so on. The earliest and most widespread version of Maslow's (1943, 1954)

hierarchy of needs includes five motivational needs, often depicted as hierarchical levels within a pyramid.

Maslow’s theory has great impact on educational structure. In order to maximize on the effectiveness of school-wide and individual classroom teaching programs, administrators and teachers must consider student needs and their hierarchical order. This must be a top priority in the development of these programs so that students have the capability of reaching their highest levels of potential. For instance, if a student has not had her breakfast before she comes to school, she will not be concentrating on learning; she will be preoccupied with the need for food. Because there are many children who come to school without a proper breakfast, school systems must meet this need by providing breakfast programs so that these children will be more likely to learn effectively (Brickman, 2003).

Schools and government agencies have long realized that if students' basic needs are not met student performance will suffer. The advent of free breakfast and lunch programs was a direct result of such considerations. Unfortunately, these measures address only part of the first tier of Maslow's theory; physiological needs. Addressing basic physiological needs is still a key concern in today's classroom. Lack of proper nutrition, personal hygiene and even sleep affects many of today's students. In lower socioeconomic areas these concerns are further accentuated. These basic needs must be met before the student can reach the next level.

Student safety needs play a critical role in achieving student success. The need for a structured and safe classroom is essential for student growth and progression. A structured classroom provides psychological safety for the student. By having knowledge of clearly defined and established processes, procedures, rules and practices you eliminate students' fear of the unknown. By gaining knowledge of the expected dynamics of the classroom, the student gains more control of their environment simply by being aware of what is going to

happen before it happens. A safe environment is not limited to physical parameters. Students must not only feel safe in the classroom physically, but emotionally and psychologically as well. An environment must be provided and maintained where students feel free to take risks -- such as answering a question or sharing thoughts without concern for ridicule or teasing by other students. Additionally, students must trust that the teacher will not ridicule, use sarcasm, or otherwise berate the student when answering questions or addressing issues. The student must feel a degree of safety in all aspects of the classroom and school environment before progressing to the next step in Maslow's theory -- belongingness and love needs.

Robert Slavin (2012), in his book “Educational Psychological” notes, "The most important…needs, however, may be those for love and self-esteem." The student must feel that he/she is important as an individual -- that he/she is lovable and is deserving of being loved and cared about. Oftentimes the only time that these attributes are reinforced may be by the teacher at school. Students must be made aware that teachers value them as individuals as well as the work they perform. We as teachers must take advantage of each and every opportunity to reinforce each student's self-esteem in the manner in which we treat them in the classroom. This reinforcement of positive attributes of the student in turn aids in developing respect or a favourable impression of oneself.

Once these needs are met, the student may then move to the next level-need to know and understand. It is at this level that the student is most receptive to learning. Our challenge is to aid the student in achieving this level.

2.5 Teachers’ Role in Health Promotion

Teachers are a key factor in reforming education to educate and promote health. There is an important research explaining the social cognitive theory owned by Bandura in 1997 stating the belief that teachers influence the nutrition

and activity practices of students by health behaviour theories, such as the social ecological model and the social cognitive theory. These theories recognize that significant adults, such as teachers, influence youth behaviour through role modelling and social support. It has also been shown by Donnelly's study in 2009 that teachers' participation in a physical activity program has a significant effect on students' physical activity involvement (Snelling, Belson, and Young, 2012).

Snelling, Belson, and Young are revealing the fact that teachers are ideally suited to have a role in school health reforms, because teachers have direct and indirect impacts on student health outcomes. That exploratory study investigated teachers' beliefs and self-efficacy on the intersection of learning and health. The research is valuable for this study regarding the clues it gives about the beliefs and motivations of teachers. The findings demonstrate that there is a the need for a health promotion program for teachers in this school district, because, although schools may require innovation to deliver health promotion programs to teachers, the potential benefit is a healthier school workforce, which could translate to healthier students. The teachers surveyed appear to believe in the intersection of health and learning, which may be indicative why schools have to improve the health of students (Snelling, Belson, and Young, 2012).

The paper written by Yager and O'dea (2005) examines the important contribution that teachers and other educators have to offer in the prevention of eating disorders and child obesity. Schools have been recognized as an ideal setting for health promotion in prevention of eating disorders and child obesity due to the continual and concentrated access to a large number of individuals at a developmentally appropriate age. In addition to providing access to children and adolescents, school based programs offer the opportunity for curriculum support and reinforcement using a whole school approach to health promotion (Yager and O'dea, 2005). There are two systematic reviews in the literature concerning the effectiveness of the health promoting school pointing to the fact

of involvement of whole school, changes in psychosocial environment, personal skill development and parent and community involvement. Other studies show that properly implemented health promotion programmes are influenced by political and contextual factors that are necessary to develop projects (Jourdan, 2011). Much research has been devoted to contextual factors with less emphasis on teachers' classroom practises and perceptions such as their perceptions of efficacy of health promotion programmes, their own self efficacy beliefs.

The findings of Yager and O'dea show that teachers and school personnel are potential change agents to prevent eating disorders and child obesity but they are generally underutilized instead of their possible valuable contribution. This study perceives teachers and other school professionals as a factor for the success of treatment and prevention of obesity and other eating disorders. When the nutrition, dieting, weight control knowledge, values, attitudes, and behaviours of teachers and other school professionals involved in the treatment or prevention of obesity and eating disorders in schools fail to be sufficient these prevention programmes have limited positive outcomes. This may be due to the fact that school professionals are unknowledgeable about nutrition, prevention science, and appropriate methods of prevention for eating disorders and obesity. They also may be sensible to their own body image and weight-related problems, especially if they are young and female. Furthermore, the professional role and experience of these teachers and school staff may not necessarily protect them against having significant levels of anti-fat bias. These factors, all together, may have important influences on the success of prevention attempts, in particular, because of the potential for improper role modelling and transference of these attitudes and behaviours.

Another paper written about the role of classroom teachers in nutrition and physical education suggests that comprehensive school health education goes beyond the classroom, especially for the prevention of overweight and obesity (Prelip et al., 2006). The opinions of elementary school teachers on

nutrition education and physical education were gathered and their perceived roles and responsibilities, their institutional and community support, and their beliefs about the effects of nutrition and physical education on students' knowledge, attitudes, and behaviours were investigated (Prelip et al., 2006).

According to this study schools can become involved in nutrition education and physical education in there ways: direct health services, such as nutrition and physical activity counselling in a school-based health clinic, the school environment and school meals, and classroom-based nutrition education and physical education. Due to the given the multiple influences on health and health behaviours and the limited funds available for health promotion, previous research suggests that a comprehensive approach can be an effective way to improve the health of children and adolescents.

Prelip et al. (2006) says that from school principals to food service program managers, every staff member is responsible from comprehensive school health programs. With an increasing importance, classroom teachers are perceived to be responsible for health education, including nutrition education and physical education. There are some experts who have concerns about assigning additional responsibilities to classroom teachers. Prelip et al. (2006) takes attention to the fact that assignment of additional responsibilities to teachers without concomitant increases in pay or status can produce role ambiguity or work overload which can decrease program implementation. If classroom teachers will be expected to add health to their teaching repertoire, they must be adequately trained and motivated.

The results of Prelip et al.'s (2006) study examining the roles and perceptions of elementary school teachers regarding nutrition education and physical education showed that these teachers are aware of the problems among students at their schools like overweight, excess consumption of high-fat and high-sugar foods, and lack of physical activity. Teachers understand the multiple factors affecting student nutrition and exercise, including the family, the school

environment, and student knowledge, attitudes, and behaviours. Teachers participated in this study perceive their role in nutrition education primarily as an instructor who teach nutrition concepts in classroom. However, they also believe their role involves being a role model in healthy eating habits, defending the students, and motivating and facilitating the good nutrition habits of their students.

The elementary school teachers in Prelip et al.'s (2006) study are creatively combining nutrition education and present subject areas of an already impacted curriculum in the light of the fact that students are getting overweight and there are more pressures on students than ever to score well on standardized tests. Teachers use activities such as counting, graphing, art projects, stories, and gardening to accomplish this integration. This is important because integration of health education into other subject areas is a key component of effective health education. Integration is a strategy that helps teachers to efficiently use classroom time, while presenting new material in a familiar setting and context. Teachers in Prelip et al.'s (2006) study believe that nutrition education improves students' knowledge of nutrition and help them to make healthier food choices. Most teachers think that students eat healthier food less or more as a result of nutrition education. However, it is agreed that too little classroom time is spent on nutrition education. Time spent for other classes take too much time and teachers have limited training about nutrition education. Also, there is a lack of equipment and facilities to teach healthy eating. These barriers are preventing nutrition education according to this study.

The results of Prelip et al.'s (2006) study also indicate that physical education is a responsibility of classroom teachers. More than 80 per cent of teachers participating in this study declared that physical education is not taught a physical education teacher in their school. Physical education includes several types of activities, such as motor skill development, instruction in individual and group sport and dance activities and instruction about the benefits

of fitness. Physical education is reported to have a positive effect on both the school community and on student fitness. It teaches teamwork and sportsmanship and promotes a healthy lifestyle. Most teachers think that physical education improves student fitness either a lot or a little. Due to the lack of structure and lack of time in physical education class, the effect of physical education is remaining limited. The barriers among physical education are similar to the barriers of nutrition education. Other classes take too much time and there is limited teacher training. Moreover, schools lack the adequate equipment and facilities.

2.6 Factors and Barriers Affecting Teachers' Commitment to Promote Health

There are various factors and barriers affecting teachers' commitments and willingness to promote health in the literature. One of them is a study conducted by Jourdan, Stirling, Mannix, Mc Namara, and Pommier (2011) about the influence of professional factors in determining primary school teachers' commitment to health promotion. The objectives of the study were to identify the professional issues that teachers perceived as important in their commitment to a health promotion programme launched in their schools and to understand their perceptions of the impact of the programme on themselves as professionals, individuals, on students, on school staff and on the relationship with students' families. The school participation in a health promotion programme does not necessarily mean that all teachers' will engage with it. The beliefs of teachers about the programmes, the school's perceptions of student behaviour, the relationships with parents and the general school dynamic are the main factors that shape the perspectives and thus commitment of teachers towards health promotion programme. Teachers who believe that they have an impact on promoting healthy lifestyles and teachers who perceive their role as a

means of school improvement are more likely to implementing health promotion programmes (Jourdan et al., 2011). This is a key factor since teacher's views of their role in health promotion are closely linked to teacher's professional identity. However, the negative impact perceived by some teachers should not be underestimated.

Jourdan et al. (2011) says that implementing a health promotion programme requires a higher level of collective involvement than usual teacher practices. This is a difficulty for teachers and the challenges of collective work are heavy. When the negative effect of the implementation becomes too challenging, programme development may reduce and teacher motivation is decreased. Teachers can develop more integrated implementation when the development of training that integrates issues linked to the development of partnership, networking skills and sharing of experiences. There is a considerable body of evidence on educational change. There are three areas of significant influence affecting implementation: characteristics of change, local characteristics and external factors.

Jourdan et al. (2011) finds out that instead of general thought, local characteristics such as the school district and the headmaster and external factors such as government and other agencies, are not mentioned by teachers as being critical for their involvement. Involvement of teachers to the programme is mainly dependent on factors connected to the teacher himself or herself. The perception of the need of change, the clarity about goals and needs of the change, quality and practicality of the program and the complexity: the extent of change required to those responsible for implementation is areas for change process. In this initiative, most of the teachers perceive the relevance of the objectives of the programme, perception of the need for the programme, goal clarity, programme quality and practicality as important. The programme implementation created tension among staff according to majority of teachers. Thus, it can be claimed that the amount of change required from teachers was

posing a challenge to them. These tensions are linked to the fact that the health promotion approach is not shared by the whole staff. The attention to the school climate, collective work, relationship with the parents and accumulation of various programmes implanted in schools may be the challenges for them. Difficulties in establishment or lack of commitment is not simply a question of positive or negative teacher attitude to change but rather may be more related to the staff capacity to cope with change.

This study (Jourdan et al., 2011) concludes that the health promotion programmes have to be perceived as a central mission of the school setting: socialization and learning to be successful. Teachers have to find this mission meaningful and relevant to their educational understanding. They also need to be a response to a problem in their specific setting. In France, there is no mandatory health education, so teachers are often in initial states of adoption. They are more comfortable with the aspects linked to the curriculum than with society partnerships even if they have interest in health promotion.

Jourdan et al. (2011) claims that to build a common culture based on health promoting school approach, the development of comprehensive, both pre-service and in-service, professional development programmes are key issues. Since 2005, the French teacher training colleges' health education network includes more health promoting knowledge initial teacher education. The skills of the staff to implement change and to work collectively are crucial, so that the views of teachers in relation to health promotion have to be considered at the early stages of the implementation in order to shape and adjust the intervention programme.

There is another study conducted by Soultatou, Tzamalouka, and Kafatos, (2009) on fostering voluntary informal health mentoring in primary school in Greece. This research article aims to explore to what extent primary school teachers foster health-mentoring in their routine education practice on an informal and voluntary basis. Also it aims to identify the barriers school teachers

face in fostering informal voluntary health mentoring within routine educational practices in Greek public schools. In brief, the findings showed that Greek primary school teachers are willing to integrate informal health mentoring in their teaching activities. However there are barriers reported. First, subjective barriers and professional choices are the primary ones and are at the top of the barriers list, whereas organizational and structural characteristics are seen as less significant obstacles. External non-organizational factors are the least mentioned barriers in health mentoring. Individual professional choices are placed higher on the hierarchical pyramid of barriers for health mentoring. In-service and pre-service training are pointed on one hand and extrinsic motivation is kept on the other hand to interpret the barriers.

Soultatou et al. (2009) says that the insufficient extrinsic motivation was seen as an important barrier by teachers on the individual professional orientations agenda. Greek schoolteachers are permanent civil servants with minimal professional development prospects and they earn remarkably low salaries. In this context, an additional non-paid requirement, such as voluntary health mentoring, does not seem a favourable behaviour amongst the teachers who took part in this research. The teachers who are willing to implement health-mentoring practices to enrich their educational practice are the ones who neglect the existence of objective or subjective barriers. This is a quite apparent relationship which needs no further expanding.

Soultatou et al. (2009) finds out that when the commitment to the formal curriculum decreases, the teachers were more prone to indulge into informal health mentoring. The educational policies in Greece do encourage teachers to develop their own syllabus. Therefore, teachers are not confident yet to diverge from the traditional teaching practice that required strict attachment to the national curriculum.

Another surprising result of that study is that the teachers who reported less training in health-related subjects are more prone to assume informal health

mentoring. There are three possible explanations. Firstly, it may be difficult for teachers trained in health-related issues to translate theory into practice. Secondly, reluctance to do health mentoring may indicate that previous training in health-matters did not include an element of mentorship, so that mentorship is treated as an unfamiliar concept. Finally, teachers who are less familiar with the concept of mentorship may be more enthusiastic to include health mentoring in their practice as a positive challenge to their educational role. Senior teachers hold more enthusiasm than younger ones towards health-related teaching such as voluntary informal health mentoring. Senior people are more inclined to volunteer for peer-education in health education and they have a tendency to maintain a positive attitude towards health protection.

Despite teachers' overall positive attitudes towards health mentoring, certain problems were determined through Soultatou et al.'s study. The most important barrier is the teachers' insufficient in-service training in health-related content and the lack of innovative teaching methods to apply this content into practice. The traditional authoritarian teaching profession requires more support so that new elements, like health mentoring, could be effectively incorporated into shifting teaching practices.

Prelip et al. (2006) states that, besides training, the availability of resources like curricula, textbooks, equipment, and facilities are important because they affect the ability of teachers to implement health education. Curricula, books, and classroom materials are mentioned by teachers of this study as resources for nutrition education and physical education. According to the findings of this study, there are several organizations in the society to be potential resources, including grocery stores and other local businesses; hospitals, health care facilities, and health care providers; parks and recreation departments; local colleges and universities; and parents and families of students.

2.7 Impact of Curriculum in Health Promotion

A study by Herbert focuses on the effective health education curricula by exploring the relationship between instructional strategies and effective health education curricula. The curricula are shown to influence health promoting behaviour and have been found to share common characteristics. They are research-based, theory driven and culturally accurate and basic. They all depend on specific behaviours. Their learning activities engage students in interactive and experiential ways. Students are given opportunities to model and practice skills. They address social and media influences on behaviour. The individual values and group norms that support health-enhancing behaviours are strengthened and supported. They are of sufficient duration to allow students to gain the needed knowledge and skills; Teacher training that enhances effectiveness is included in these curricula.

In Herbert and Lohrmann's (2011) study, the characteristics of curriculum for effective health education programs are expressed as comprehensive and varied teaching methods, sufficient dosage, theory-driven, opportunities for positive relationships, appropriately timed, culturally relevant, included outcome evaluation, and delivered by trained teachers. The teaching methods found in effective programs are found to be stressed active, skill-based learning for students. Skills, rather than facts, were also found to be the major catalyst for behaviour change (Herbert and Lohrmann, 2011).

According to Herbert and Lohrmann (2011), teachers should combine 3 to 5 active learning strategies for teaching students the skills they need to make and sustain healthy decisions throughout life. These are role play, group cooperation, interactive technology, team games and small group discussion. Through role playing the student learns how to communicate, resolve conflicts, avoid and refuse health disturbing behaviours. Group cooperation is important for advocacy problem solving and again communication. Interactive technology

is an active learning strategy that enables the student to evaluate, solve problems and advocate. Critical analysis and communication is gained by playing team games. The last strategy is small group discussions that provide better communication skills, self-management, responsibility and critical analysis skills. These active learning strategies enable students to apply knowledge through practice. When active learning is taken away of education curricula, all learning process becomes didactic. It means that in the absence of active learning strategies, students only accumulate knowledge that includes facts about skills. Without these strategies, the majority of the other characteristics of effective health education become inconsiderable, because active learning strategies are the key to effectiveness. Role-play simulations, cooperative group work and small group discussions are the most outstanding strategies. These strategies are essential because they both focus on the individual student and help the student to learn and work with other peers. Thus, these strategies provide important by products for the learner.

Working in cooperative groups has been shown to have in a number of psychological benefits, such as higher self-esteem and self-confidence. This strategy also contributes to healthy social development by helping to establish and maintain friendships. Student-centred teaching methods are beneficial for bonding students to school. When the commitment of students to school increase, a reduce student violence, gang activity, substance use, delinquency, and dropout rates are reduced. Due to its positive and protective benefits, student commitment plays a major role in academic success across all subjects. Cooperative group activities that intentionally promote interpersonal and social skills should be employed regularly by teachers to make a major contribution to the mission of a school.

Use of technology in health education is desirable because of the explosion of technological advances that have potential for use in health education according to Herbert. The most commonly used form of technology

was video, then videotape and, now, on CD/DVD or even Internet Websites. In other words, the health education curricula generally use the proven technology of video and advanced technologies such as software-based interactive gaming and interactive simulations are neglected.

Herbert and Lohrmann (2011) states that the content analysis of select effective health education curricula identified 5 active learning strategies employed to teach health skills. To become an effective health education teacher, the teachers should combine a wide range of strategies and actively devote time for involving students in skills practise. It is important for teachers to compensate their deficiencies in professional practice as well as professional development. The most promising approach for all new health educators is to grip a wide variety of effective strategies that they practice during pedagogical courses to incorporate in their professional practice.

2.8 Significance of Teacher Training

Pre-service and in-service training are important health promotion tools for teachers. Several studies show that the success of health promotion programmes highly depends on the existence of these trainings for school professionals.

Teachers in Greece mentioned that they got inadequate pre-service or in-service training in health-related matters (Soultatou et al., 2009). In educational faculties' curricula only health education is recently included as a subject. This is the the only liable bodies for pre-service teacher training. In-service training in Greece has taken recently progressive steps but it is still not well-organized and unsystematic. Also, the formal teaching syllabus does not include mentoring, and teachers are therefore not accountable for this. The fact of mentoring health of students is the teachers' own accord.

Yager and O'dea (2005) put emphasis on the importance of in service and pre-service training of school professionals. The success of programmes focusing on the prevention of eating disorders and child obesity urgently depends on pre-service and on-going training for the various school professionals involved. This training has to develop their knowledge of nutrition, eating disorders, obesity, and preventive techniques. Teachers who have received health promotion training tend to be involved more frequently in health promotion projects and have a more comprehensive approach to health education. Given the low priority associated with health promotion and health education in teacher education, the effect of health promotion initiatives in schools is limited. Thus, precautions and new policies should be established in order to break the barriers of teachers to promote health more efficiently. A psycho-educational approach as a form of secondary prevention may improve the personal weight-related attitudes and behaviours of school professionals. Finally, the importance of building a healthy body image and addressing appropriate weight control practices should be stressed in teacher-training programs, in order to enable a role modelling and transference of these attitudes and behaviours to the many students in their care. In order to fully utilize schools as a setting for prevention initiatives, to improve the success of future prevention initiatives, and to promote the health of our young people, the actions that are told above should be implemented in coordination.

Teachers participated in Prelip et al.'s (2006) study reported lack of training as a barrier to both nutrition education and physical education. Other researchers have found that teacher training significantly affects the quality of health education. "Teachers who received nutrition education training used more resources and planned more activities than teachers with no training" In addition, another study found that "teachers in schools with fewer resources and lower institutional support for nutrition education and teachers with no training were less likely than other teachers to integrate nutrition education into other

subjects" (Celebuski and Farris, 2000). Similar to the findings of the study conducted by Yager and O'dea this study claims that additional teacher in-service training and additional resources should be made available to teachers to support nutrition education and physical education. In-service training improves health education and teachers feel more confident about health education.

2.9 Literature in Turkey

The academic writings on health promotion and health education in Turkey are very scarce. The development and the growth of the school children are highly effected by the adequate and balanced nutrition. There is scarce literature in Turkey focusing on the nutrition of school children. Şimşek, Yabancı and Turan (2009) has conducted a research in a primary school to evaluate the lunch boxes of the school children. The research questioned the frequency of bringing lunch box to school. 56 per cent of children sometimes bring lunch box and 27 per cent of children never bring lunch boxes at all. 33 per cent of the boys and 20 per cent of the girls never bring lunch boxes. 75 per cent of the children who do not bring lunch boxes state that they do not want to bring a lunch box and instead buy from the canteen, and the 25 per cent of of them tell that their mothers do not prepare a lunch box for them. An interesting observation is, during the observation study the number of children bringing lunch boxes increased. 15 per cent of the boys and 18 per cent of the girls frequently bring their lunch boxes with them to the school. This information shows that girls are a bit more conscious and sensitive about lunch boxes. In this study 79.2 per cent of children state that they get hungry during school hours. 56.9 per cent eat what they bring as lunch boxes with them and 43.1 per cent of them eat the food they buy from canteen when they get hungry.

When the ingredients of the lunch boxes are analysed, many lunch boxes have what the child likes to eat, not what is good for him/her. Chocolates, chips,

cokes, cakes, sausages etc. are the mostly brought foods with lunch boxes to the school. Children, who don't bring lunch boxes, buy their food from canteens and fast food restaurants around the school. A study in America shows that most of these fast-food restaurants are located close to the schools. (Austin et al., 2005) The canteen food (toast, hamburger, coke, processed fruit juices) are rich for calorie and fat and they lack healthy ingredients (vitamins, proteins etc.) Children buy concentrated fruit juice (42.8 per cent), simit[1] (32.9 per cent), toast and sandwich (30 per cent), chips (20 per cent). 69.9 of the students say they never but milk.

It is concluded that the teachers should observe and orient children about their nutrition habits. For this orientation both they and the families have to get the necessary education. The canteen personnel should be trained and the school environment and food at canteens have to be well organized. If it is possible a professional dietician may prepare a menu for the families. The lunch times can be made funny by organizing some games. This will encourage the children to earn lunch box habit. Also care should be taken to the materials lunch boxes are made of. They should be harmless for the children health. In addition Ministry of Education should define a Standard for the lunch boxes and this Standard can be audited by the teachers.

Childhood obesity is recognized as an an important problem in the world due to its increasing prevalence and being a precursor of adult obesity. In USA more than 50 per cent of adults and 25 per cent of children are overweight or obese. Today, it is known that 33 per cent of adolescent obesity starts from childhood ages. School-based interventions are used for reducing childhood obesity in the world effectively. School-based studies affect the eating habits of the students' parents as well as students, and these studies require a comprehensive training for teachers about nutrition and healthy living styles in

[1]A traditional Turkish savory roll covered with sesame seed.

order to transfer the necessary skills and knowledge to the children (Şimşek et al., 2009).

The positive effects of school based interventions demonstrate us that a primary school curriculum should include an education of healthy nutrition and physical health issues. Because primary education is obligatory and giving the chance to reach all children from each socioeconomic status, school-based interventions has an increasing importance. Gürel, Gemalmaz, and Dişçigil, (2004) has designed a study to determine the physical activity status and nutritional knowledge of primary school teachers. The study states that the role of teachers in nutrition and physical health education is very important. Besides, the knowledge and education of teachers on nutrition is one of the most important factors determining the effect of school on nutrition. The writers state that in order to start an implementation, the knowledge of teachers about this issue should be determined. In this study nutrition knowledge and its source, physical activity status of 143 teachers who are from 15 different cities of Turkey are determined by a self-report questionnaire. The nutritional knowledge of many (80.9 per cent) of the teachers was found to be inadequate whereas only 19.1 per cent of them had adequate knowledge. According to physical activity of the total, 77.9 per cent of the teachers were physically inactive. Eventually it can be concluded that primary school teachers need to be educated about healthy nutrition and they are physically inactive. These findings are in accordance with the findings of previous studies. The information resource of teachers participated the study is media. The study finds out that teachers need education about healthy nutrition. The information gathered through media is not enough, thus in-service trainings and additional education programmes in education faculties of universities are required.

An article that is written by Yabancı (2011) states that schools play an effective role in adopting and maintaining healthy eating and physical activity behaviours in children and adolescents. Chronic diseases such as childhood

obesity, coronary heart diseases, diabetes and cancer can be reduced by the efforts of schools. Besides, nutrition programs in schools can help children and adolescents participate in full educational potential; improve academic performance and health quality. As it is mentioned before this study again marks that to ensure a healthy future for our children, school-based nutrition education programs must become a national priority. Governments, community leaders, doctors, dieticians, nurses, teachers, and parents, all counterparts, must have commitment in implementing and sustaining nutrition education programs within the schools. This article summarizes School health and nutrition programs which are part of public health and education. School Health Programs are known as the studies to evaluate, protect and develop student health. Yabancı (2011) states that appropriate nutrition affects the school success, positively. Slight lack of nutrition may sometimes be ignored but generally results in learning disabilities. In developing countries, 40 per cent of the children are affected from growth problems which also effects mental development and school success. A study which took place in Kenya shows that the body weight and the school success are related. Another negative effect of improper nutrition is that it affects the attendance of the student to the lessons. Especially in the areas where the economic wealth is low, the execution of the breakfast and lunch programs increases the attendance and the school success.

According to Yabancı (2011) the schools cannot solve all the health related problems themselves but they have a strong effect to contribute positively with the school-based programs. Because of the fact that the children spend most of their time in school and have at least one of their meals there, they may gain a good nutrition habit in their school. Consequently the school nutrition programs prepared by a professional dietician have an important role. Nutrition education programs are important for children to gain a proper nutrition habit. Nutrition education should be integrated in other lessons. For example during Mathematics, the calorie requirement of a child may be

calculated; during reading lesson some texts about nutrition may be chosen. Some seminars may be organised in which the nutrition experts make presentations. The participation of the families and the society to these programs are important as well. The benchmarking of other countries about their nutrition programs will help to develop better programs in the schools. America and Chile have good program examples implemented before. Chile started their program after they recognized that the heart problems in the country create a huge cost for the country budget. After this diagnosis, the Chile government started a program to change the nutrition character of the children and the result was successful.

Meal skipping is a common problem among the school aged children. The mostly ignored meal is breakfast. In breakfast time the person is hungry and the body energy is low to feed the brain. If the breakfast is skipped, problem solving abilities reduce; on the other hand regular breakfast increases the school success and the academic point. In order to gain a regular breakfast habit the families and the children should be instructed about the subject. The children generally have to do their lunch in school according to Yabancı (2011). They generally prefer school canteen and the fast-food restaurants around the school. The education of the children for the healthy nutrition will also help them to choose the right food to buy. The American government implemented a program to give the children lunch in the schools and these lunches are generally free. By the help of this program the nutrition of the children are positively controlled.

Yabancı says that society participation should be encouraged and government politics should be developed for healthy nutrition and continued physical activities. To track the physical development the weight and the length of the students should be measured two times a year. Milk, breakfast and lunch programs should be started especially in low economic level schools. During the decision of the school meal menus the students should participate and take roles.

To increase the physical activities sportive areas should be constructed in the school campuses.

The academic writings on health promotion and health education in Turkey are very scarce. One of the leading studies in Turkish literature about health promotion is conducted by Taşdan and Memduhoğlu in 2008. The study states that, in Turkey, the school health services aiming to protect and improve the health of children are pretty deficient. There is almost no health personnel employed at public schools. The issues of health are included in the syllabus in a limited, dispersed and poor understanding way. There is an attempt to increase the number of health staff working at schools but an education programme to raise professional health service at schools is not present. However, private schools provide important services, especially to attract parents' attention.

Another study states that teachers are the main responsible to ensure students' security and health in the classroom (Aydın, 2003). Thus, they have to know how to build and manage a healthy school environment. The duties of classroom teachers with respect to the student health are: to provide health programmes pursued at the houses with the association of parents, to participate in health controls and give necessary information, to warn the family in case any symptoms showing health problems, to lecture health courses and support school health service activities, to record the physical developments of children regularly, to observe daily health situations of students, to control and arrange activities that is to develop habits from healthy behaviours and finally to be a role model in terms of health. Taşdan says that school administrators have to make strategic planning to provide school health. Teachers and administrators must satisfy their responsibilities by strategically planning their services to achieve teaching health.

According to Taşdan and Memduhoğlu's (2008) study, there are various factors affecting the children health in schools.Researches indicate that the

factors affecting school children health negatively, increases day by day. Some of these risky factors are:

Protection from diseases and care: Especially the children having infectious diseases should be determined and be kept out of the school until he/she is cured. For the determination process, frequent medical scanning can be planned.

Hygiene: The children should gain the habbit to clean their faces, hands and keep their clothes clean. School surfaces, gardens and toilets should be kept clean. A proper air conditioning is also a must for the students mental freshness.

Nutrition: Children spend 6 hours a day in their school. Thats why this period is important for a proper nutrition. The children should have breakfast or their lunch before coming school. The school nutrition programs are important. In 1941, USA started a nutrition program to give the students fruit and milk. In 1966 a breakfast program started and still free food distribution to poor family children is going on in USA. A fight against obesity is another important activity for school children. This sickness is spreading more and more and causes many diseases in later ages. Thats why giving consciousness to the families is important.

Insufficient and insecure playing areas: Games and sports are important for physical and mental health of children. Insufficient playing areas has a negative effect on the child's health. The ground profile of the school gardens like asphalt or concrete is risky for children when fall when they are playing. Children like to run, so that the children can also crash each other on small gardens and can be injured.

Accidents and Injuries: Insufficient teacher control and observation, running during breaks, crashes on the stairs may cause injuries. Improper usage of electrical machines and insufficient preventions for electricity may cause hazardous injuries as well.

Alcohol, smoking and drugs usage: It is a known fact that the starting age for smoking is decreasing, and the number of people using cigarette is increasing day by day. Drug usage is increasing, too. Depending upon a research in USA 82 per cent of the daily smokers are under 18. Another result shows that everyday more than 3000 young person starts smoking in USA. Therefore, public opinion about special programs against smoking and drug usage has arised all over the world. These special programs include informing the children about the negative affects of smoking on physics, health and psycology, preparing some special education programs for teachers and getting support from the families and the society. In 1988 the smoking rate of Turkey was 43.2 per cent. This rate was 47 per cent among teachers who has to be examples for the students. One third (32.8 per cent) of the smoking teachers declared that they smoke in front of their students. Majority (81.8 per cent) of the smoking students start smoking at the age of 13-15. It is a public issue that alcohol usage is harmful to human health. When education is taken into consideration alcohol triggers unwanted behaviour and increase the crime rates. Another research shows that drug usage decreases the communication in the school and decreases the support from the environment.

Heavy Bags: Heavy bags are risk factors for back-ache. The researches show that 70 per cent of the school children faces backaches. The children having backache in the earlyages continue to have the same ache when they grow up.

Physical Environment: In order to have children to move comfortably in a classroom, student per metersquare should be less than 1. If dressed suitably a room temperature around 20 centigrade degrees will be suitable. On the other hand, dressing and the physical conditions of the room changes the affect of the temperature. The school should not be close to noise sources. Researches on the schools near the streets show that students sitting beside the window has stress problems.

Transportation Vehicles: Due to the fact that students are using more transportation vehicle instead of walking, fatness, obeseness and some related sicknesses increase. If the school does not have a garden big enough than the students cannot complete daily physical activity requirements.

Annoying and violence: Thefts and annoyings result in psycological harms to students. Also violence results long term traumas. Distinctive talkings and symbols make a deep impact on children, results in emotional damage and creates hostile behaviours.

World Health Organization defines the age range of school health as 5-24 (WHO, 2012). In 2012 the population of the age range 5-24 in Turkey was over 25 million and covered33,3 per cent of the total population. More than 20 per cent of the total population is in relationship with the schools. Protecting the young population's physical and mental health plays a vital role for the future of the society. Taşdan explains the school and student health services in Turkey in his study. In this section, the findings of this researchare summarized as a critical literature review on Turkey.

Taşdan and Memduhoğlu (2008) mention that in Turkey, health education is given on different phases. In primary school program, health education is given during some lessons under subjects like traffic and first aid.

No health staff is working in most of the public schools. No protective activities are excuted in primary schools, so that infectious diseasas spread rapidly, and they can also effect the outside society.

The regular medical examinations in schools were the responisbility of Ministry of National Education until 2005. In 2005 this responsibility was transfered to The Ministry of Health of Turkey. A health commission has been established to execute health service activities in the cities. Another regulation for the school health is the primary school regulations. According to this regulation school and its environment health, ensuring a safe education, health examinations in schools are legally regulated (Taşdan and Memduhoğlu, 2008).

According to the statistics of the Ministry of National Education of Turkey, most of the schools do not employ a nurse or a doctor. In urgent issues, medical cupboard is used. In the education program list, the health related issues are dispersed and limited. Although lately some private schools started to employ health staff, a proper education is absent or insufficient for these people. In Turkey, although public schools dont have sufficient health services, the private schools have important health facilities (Taşdan and Memduhoğlu, 2008).

To conclude, the prior researches (both international and national) demonstrate a strong linkage between the health and education. Health education and promotion in schools is required to have a healthy and well-learning society. The teachers are significant in implementing health policies at schools due to their critical role at the education system. There are various factors affecting the success of health promotion programmes. However, the commitment of teachers is very important for getting the intended results. Unfortunately, there is a long path for Turkey to complete a social policy implementation promoting health in schools. The literature suggests that a national education policy that will direct all types of schools is needed to enhance the health education and promotion in Turkey.

2.10 Recent Health Promotion Regulations in Turkey

The regulations regarding school health are written by coordination of The Ministry of Health and The Ministry of National Education in Turkey. The Ministry of Health is kept responsible from protecting the school health in the Law of Public health (Umumi Hifzissihha Kanunu, 1593). The control of school buildings in terms of health conditions and protection from infectious diseases are left to this ministry. Within this legislator duty, The Ministry of Health has published a document in 2010 reminding these duties to the State Health Board. The board have to get in contact with other related institutions and have to audit the canteens of schools according to the related circular called “audit of school canteens and the hygiene rules to be obeyed” (Appendix F), prevent sales of food in open air, and promote sales of nutritional food at canteens and refectories (Milli Eğitim Bakanlığı, Sağlık İşleri Genel Müdürlüğü, Genelge 2011/41). The audit of school canteens is left to a commission established by presidency of the school administrator. The commission have to inspect the canteen at least once a month and the related control form (Appendix G) have to be filled. The audits conducted at the canteen of our case school have resulted to be consistent with the requirements of the circular.

The ministry of Health and the Ministry of National Education came together and signed a regulation in 2011 arranging the requirements of food served at schools (Appendix F). School period is seen as a period in which physical, cognitive and social development of children increases and foundations of healthy living is laid. Especially, the healthy eating habits gained in this period establish the basic way to protect from diseases related to nutrition such as obesity, cardiovascular diseases and diabetics. In most of the developed countries there are programmes and campaigns to promote balanced diet and correct nutrition habits. Breakfast/ meal programmes, nutrition friendly schools and healthy canteens are some of these projects. Also, the many European

Union countries the sales of junk food is prohibited or limited. In a policy document published by the Ministry of Health (Document number: B10.0.TSH.0.12.06/090-05) (Appendix F), it is stated that the increase in the consumption of food like carbonated drinks, chips, fried potatoes and candies, decreases the quality of the child's diet. The children are said to get 20 to 42 per cent of their energy from these food that are rich in energy, salt and oil but, poor in vitamins, calcium and fibres. These foods are mentioned to cause an unbalanced diet and related diseases such as obesity and diabetes. There is a circular published by the ministry of National Education in 2011 called "Sales of Food in School Canteens" (Okul Kantinlerindeki Gıda Satışı, 2011/41) (Appendix F). According to this circular the sales of junk food and drink such as chips, fried food and carbonated drinks are prohibited in all kinds of canteens, restaurants and cafes of primary and secondary schools including the boarding school refectories. These foods cannot be sold at automatic food machines. Instead, there have to be milk, ayran, yogurt, fruit juice, fresh fruit juice and fruits.

The presidency of Turkish Republic announced a circular in 2010 stating that the main aim of national health policies is to reach a healthy society consisted of healthy individuals (Türkiye Sağlıklı Beslenme ve Hareketli Hayat Programı, 2010/22). There is a need to develop policies that empowers the cooperation within sectors to reach a healthy society. The changes in daily lives of people due to the technological improvements, causes less physical activity and affects the nutrition habits negatively. Thus, obesity is becoming an important problem for especially developed countries. WHO states that obesity related diseases causes over 2.8 million deaths in a year (WHO Web Page). In Turkey the obesity rates are increasing too. Thus, struggling with obesity is significant for the future of our country.

The circular states that individual attempts are very important to defeat obesity. But, also the individual, family and society has to be informed about

adequate and balanced nutrition and physical activity. In order to establish a political decisiveness, a programme called “Turkey Healthy Nutrition and Active Life Program” is put into action in 2010. A strategic plan for this programme including the period between 2013 and 2017 is published by The Ministry of Health in 2010 (Sağlık Bakanlığı, 2010). This programme aims to struggle with obesity and decrease the percentage of obesity and related diseases in Turkey.

When the action plan of programme is analysed there are parts related to the promotion of health in schools. Within this programme, it is planned to spare a budget and take initiatives for establishing physical activity facilities at schools. It is aimed to alter the education programmes of education faculties to include nutrition, obesity and physical activity subjects in the curriculum. The preschool and school children, teachers and parents have to be informed about the struggle with obesity. In order to achieve this strategy, education materials have to be developed and interactive and entertaining practices have to be implemented in education programmes. There should be days and weeks dedicated to physical activity and adequate and balanced nutrition. Another activity is arranging organizations enabling children and youth love sports. Another policy is to arrange free breakfast and lunch programmes in schools especially in the poor regions of the country. The curriculum is to be improved by increasing the class hours dedicated to obesity, healthy nutrition and physical activity. Improving the physical activity opportunities at schools and universities is aimed by opening sports facilities to the students at weekends and increasing the number of sports facilities in schools. The School Milk programme is one of the activities planned in this action plan. Spreading the programme and including fruits in the programme is another activity that is planned to improve the health status of children.

This programme is very crucial for establishing health promotion in schools. But it lacks some basic points. First of all, although the programme

determines giving healthy eating and physical activity behaviours and habits to children as target, the strategies and actions related are mainly focused on improving the knowledge and awareness of children. The holistic perspective of health which includes mental and emotional wellbeing as well as physical wellbeing is ignored in this project. Also, this program again enforces knowledge and awareness, instead of developing behaviour and motivation for children to live healthily. The infrastructure of schools has to be renewed before implementing the called policies at schools. This renewal will require a noteworthy expenditure, which will challenge the government budget. There is not an attempt yet, to plan the budget and allocate the necessary monetary resources for this program.

2.11 The Basic Education Curriculum

In the 1739 numbered National Education Law, the Ministry of National Education states "to raise children having a balanced and healthy personality and character in physical, mental, moral, spiritual and emotional terms" as one of the main targets of national education system (Milli Eğitim Temel Kanunu, 1739). By reaching this target, the national education is to increase the welfare and happiness of Turkish citizens and Turkish society on one hand, and to support and fasten the economic, social and cultural development and finally to make Turkish nation a creative, constructive and elite partner of contemporary civilization, on the other. The course programs all of which are designed by "Talim ve Terbiye Kurulu" are following the general frame drawn by the ministry.

2.11.1 Knowledge of Life Course

Knowledge of Life (Hayat Bilgisi) is a main course for primary education and is composed for introducing the children themselves, as well as

the society and the world they live in. The students take five hours of knowledge of life course in a week. The current programme based on structured learning theory was admitted in 2012 after the approval of new basic education system (MEB, 2012a). The structural learning theory claims that students come to school with their own knowledge and beliefs. This theory locates the child in the centre. Because, each individual evaluates knowledge with respect to his/her previous skills, knowledge and experiences and forms the knowledge in his/her own mind. In this view, learning is evaluating and structuring our older knowledge with the enlightenment of new experiences. The knowledge of life course is designed based on structural learning theory. There are skills, personal features and sub-disciplines which this course is aiming to help the child to gain. The primary school curriculum is not the main focus of this thesis study, thus it is enough for now, to state and evaluate the acquisitions that the curriculum mention under health culture subject.

Although the curriculum writes health culture as one of the target acquisitions of the primary education system, living healthy or caring for health is not reported as a basic personal feature that the education system tries to create. The basic features of the child educated in the Turkish Primary Education are listed as: self- respect, self-confidence, socialization, patience, tolerance, love, respect, peace, solidarity, honesty, justice, openness to change, patriotism and improving cultural values. But, health culture is seen as a sub-discipline. The policy makers should take into account that a child who has not developed health awareness and who is not living healthy cannot feel self-confidence or openness to change. Thus, one of the first changes that can be done to develop the curriculum should be to consider health culture and awareness as one of the main targets of education system. Also, the curriculum should explain how to gain the aimed competences instead of listing them. Practises and actions should be placed at the hearth of primary education which the children learn by seeing and imitating in.

When the primary school curriculum is analysed health culture appears as one of the main sub-disciplines that the children should gain in the first three years of school life. In the curriculum, the expected health culture acquisitions in the first years of school are reported as: protecting and caring his/her own body, realising the individual differences in his/her body features, explaining the importance of nutrition for growing and being healthy, explaining the necessity of vaccination, determining the functions of sense organs, develops responsibility for building a healthy environment, determining the significance of daily living habits in being healthy, develops competence for handling negative emotions. In the second year of school the child is expected to gain regular nutrition habit, care to have a balanced diet, explain the significance of nutrition for growth and health, and learn the functions of different body parts. In the third class health culture is losing its weight in the curriculum. Balanced diet, regular nutrition and sensitivity for others emotions are the three acquisitions stated in the curriculum at third grade. At the fourth grade, the children are given science and social knowledge courses instead of the knowledge of life course. In the science course the children are expected to learn the benefits of doing sports for a healthy life, recognize the organs of the body. In the fourth grade the health culture is seen as introducing the systems of the body rather than building a healthy life philosophy. When the primary school curriculum is analysed, there are not specific techniques and practices mentioned in the curriculum to teach the health culture and provide the aimed acquisitions. In this respect the judgments of the teachers about the disadvantages and necessities of the curriculum are matching with the facts of the primary education programme.

2.11.2 Games and Physical Activity Course

The other primary education course that has implications on health promotion is Games and Physical Activity Course (Oyun ve Fiziki Etkinlikler Dersi) that is implemented in the primary education curriculum in 2012 after the change in the primary education system (MEB, 2012b). The primary education students take five hours of this course in a week.

The Ministry of National Education states that games and physical activities are important in the holistic view of education. The students have the opportunity to improve their physical, social and mental capabilities and promote their health as a result. Therefore, developing frequent participation habit starting from primary school is stated to be one of the most significant aims of general education. At primary school level, the participation in physical activities and games is expected to build an infrastructure for movement competency and active and healthy living.

The ministry mentions that the games and physical activity course aims to teach basic movement skills, basic movement concepts and game strategies and techniques for enhancing the movement competency of children, at first. Secondly, active and healthy living concepts and principles, active and healthy living practises and cultural accumulation and values are aimed to be given to children for teaching active and healthy living. Thirdly, the last aim the course is to develop individual, social and thinking skills. This course tries to develop personal skills such as self-knowledge and self-awareness, harmony, management and struggling, individual responsibility, self-confidence, time management and entertaining. The thinking skills in this course which are required to gather and use knowledge are observation, targeting, planning, practising, processing knowledge, evaluation and reflection. The social skills that is to be developed by this course is explained as communication skills,

cooperation, fair play, social responsibility, leadership, respect for others and environment.

The developers of this course curriculum are aware that games and physical activity are important for health promotion. The students must participate in games and physical activities at least one hour a day in order to protect their health according to academic studies (WHO, 2010). For frequent participation, the children have to feel entertained and observe the benefits of this participation. Therefore, it is important for students to understand the principles and benefits of active and healthy living.

This course has intended outcomes which seem appropriate for promoting the health of children. The children taking this course are expected to be able to explain the game and physical activity concepts for promoting health and being health. These children are expected to participate frequently and willingly in games and physical activities in order to be healthy and promote their health. The children are aimed to develop their skills of self-knowledge, struggling, individual responsibility self-confidence and time management which are important personal features for social and mental health. To sum it can be concluded that the Games and Physical Activity course is designed to assist health promotion of children in schools. There is a balance of knowledge and practise in this course.

CHAPTER 3

METHODOLOGY

In this chapter, the methods used to conduct this case study are explained. The overall study design, sampling, data collection instruments, data analysis and limitations of the study are described in detail.

3.1 Overall Study Design

There is a summary of the flow of research design in Figure 3.1 giving the details about the planning, instrumenting, data collection, data analysis and reporting processes.

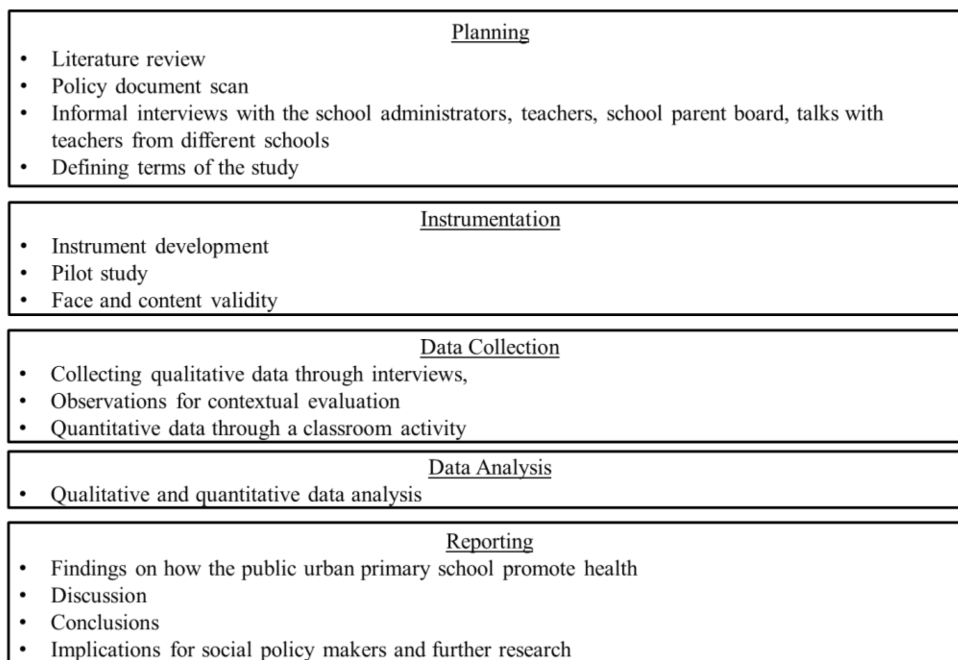


Figure 3.1 Flow of Study Design

This case study is aiming to figure out how Turkish urban public primary schools may promote health by examining an urban public primary school in Ankara, as a case. The term “primary schools” in this study is referring, in fact, public primary schools. A vast majority of primary school children (97 per cent of all primary school students) are attending public schools that are governed and managed by the state, in Turkey. In this study, the focus is on public schools rather than the private ones which differ a lot in terms of economic and social opportunities from the public schools.

The current situation of health promotion and education in primary schools in Turkey according to the views and perceptions of primary school teachers and their perceptions about the on-going health education and health promotion policies were investigated in this study. The awareness of teachers about the significance of health promotion and health education was questioned. The school environment and facilities were evaluated and the barriers in front of the teachers and the schools to reach a health promoting education system are investigated. Moreover, the opinions of the school administration and school-parent association about Turkey’s health education policies and related implementations at primary schools were gathered.

This thesis study is a case study which tries to describe the current health promotion situation in Turkish primary schools and to evaluate how primary schools promote health. Qualitative research methods; semi-structured interviews and observation were used in this case study. Also, a detailed description of school infrastructure was done and additional complementary data were collected through a quantitative classroom activity for measuring students’ breakfast habits to validate and triangulate the results of the interviews with teachers, administration, parents, and canteen staff.

In the planning phase of this study several talks with academicians and classroom teachers were made to frame the significance, research rationale and aim of this study. A strong literature review has been made for three months.

The policy documents and regulations about health promotion in Turkey were reviewed. The planning phase gave clues about the necessity of designing a qualitative study. This thesis study is aiming to see how health is promoted in urban public schools in depth, thus it is not adequate only to picture what is done in these schools or what the problems of these schools are. But indeed, how primary schools promote health and how the teachers, school administration, school-parent board and others act for promoting health and how they handle difficulties are more important for this research. Thus, as the method of this research, the researcher decided to conduct an in-depth qualitative case study.

This study tends to visualize the current situation in urban public primary schools in Turkey and the case school chosen is desired to be an average representative of the Turkish case. Thus, size, location, socio-economic background and welfare level of the school was taken into consideration as well as the convenience of the school for a case study while deciding which school to study on.

The data collection instruments, semi-structured interviews and student activity were designed by the researcher taking into consideration the findings and implications of the previous researches mentioned in the literature chapter. None of the questions were taken from a previous research, but rather the questions were prepared with the recommendations of two academicians interested in health promotion and two classroom teachers. A pilot study was conducted among three teachers and one parent who are not involved in the research. The questions measuring the health promotion activities and style of teachers and teachers' views on the curriculum and policies were detailed and some other questions about the current health status of teachers and parents were omitted after evaluating the results of the pilot interviews.

Qualitative data from the interviews and quantitative data gathered from the classroom activity were analysed meticulously to approach the true picture of health promotion in Turkish urban public primary schools.

The reporting part is written with enthusiasm because the results of the study gave important clues about the current situation in Turkish schools and for the development areas to promote health in public primary schools.

3.2 Participants

The school studied in this case study was chosen on purpose and representing the average size (745 students) (MEB, 2012) of Turkish urban public primary schools in Ankara with the population of 812 students (the number is including pre-school, primary school, and lower secondary schools students), located in a middle income town in Ankara in order to be a good starting point for further research attempts that can be generalized for the whole system. The primary section of the school has 262 students (N=262).

The school's availability and convenience to participate in the research was another criterion, because of the intentional participation principle applied in this study. Instead of the real names of the school and the participants, pseudonyms are used, so that the participants may feel more comfortable and reveal the truth more objectively and easily.

All, the classroom school teachers, administrators, canteen staff, school-parent board representatives were included in the data collection process. Fortunately, all of them admitted to participate in the study voluntarily. The students participated the classroom activity were chosen conveniently.

3.2.1 Characteristics of the School

The school that is subject to this case study is called as "the school" throughout this case study and is located in the Eastern part of Ankara, in Mamak district which is only 4 km far from the City Centre. In Turkey, families who are seeking for a public primary school for their children, have to send their children to the primary school that is located nearest to their accommodation address. The registration process is administrated through the "e-okul" (e-school) system automatically and parents register their children to this school formally. This system may lead to think that public primary schools in Turkey represent the socio-economic background of the town in which it is located. Thus, it can be said that the school studied has similar social and economic resources to the families living in that town in terms of monetary and moral support.

Until 2012, the compulsory primary education in Turkey was continuous and lasted till the eighth grade, and the case school studied was giving education as a public primary school. But, at the beginning of 2012-13 educational year the legislation has changed and the compulsory education in Turkey is divided in two parts: a first four years of primary education and a second four years of lower secondary education. Grades from one to four are named as primary school grades and from five to eight as lower secondary school grades. With this legislative change, the school that this study is conducted began to give education as a lower secondary school that includes grades bigger than four, but due to the infrastructural deficiencies, the school is still serving like a primary school of the old regulation, except for, there are no new first grade students enrolled in the school, in 2012-2013 educational year. Now, there are two nursery classes and three classes of every grade except for the first grade of primary education, getting education at this case school.

There are 812 students in total attending the school. In pre-school education there are 61 children, in primary school education there are 262 (N=262) students and in the lower secondary education, there are 489 students. There are nine classrooms in the primary part of the school: three second grade classrooms, three third grade classrooms and three fourth grade classrooms. Totally, there are nine primary school classrooms and nine classroom teachers (N=9) present at the school. There are two administrators (N=2): one is the principal and the other is the assistant principal. There are two canteen operators (N=2) and two cleaning staff (N=2) working at the school. The parent-teacher association is managed by a parent and a second parent is assisting her (N=2).

The education system has changed at the beginning of 2012-2013 educational year, and there are still confusions about the definition of school types. There are primary school students taking education at lower secondary schools, as it is the case in our study and there are lower secondary school students that are taking education in primary schools in 2012-2013 educational year. As a result the average sizes of average primary and lower secondary schools are not rational. So that, taking 2012 statistics instead of 2013 will give healthier estimations about the size of this study's case school. An average urban public primary school has 682 students on average in Turkey and 745 students in Ankara according to the 2012 statistics of the Ministry of National Education of Turkey (MEB, 2012). These numbers do not cover population of nursery classes. Thus, it can be concluded that the case school once named as a primary school is a middle-sized urban public school with a population of 751 primary and lower secondary school students. The average classroom size is 29 students in primary part of the school.

There are 16 separate rooms at the school serving as primary and lower secondary grade classroom. On average, an urban public primary school is serving with 20 classrooms in Ankara. There are no restaurants or refectories serving in the school. Only a canteen that is operated by the same family with an

area of 12 meter squares is present as eating facility. There is no sports hall, arts or music hall, either. There is a small library and a computer room, a teachers' room, two administrator rooms that can be mentioned as the facilities of the school. The school yard is nearly 2400 meter squares. Most of the playground is covered with asphalt and there is a small sand area in which only the nursery class students can play. There are two baskets for playing basketball, and a net for playing volleyball in the school yard in this asphalt ground. There are four restrooms and 16 cabinets in the restrooms at total. The teachers' restrooms are separated within students' restrooms.

3.2.2 Characteristics of Participants

In this case study, there were nine classroom teachers working at the school. All of these 9 primary school teachers are interviewed within this study (n=9). Also, the interviews with the 2 school administrators (n=2), 2 representative parents of the parent-teacher association (n=2) and 2 canteen staff (n=2) were conducted and used in this thesis study to have a complete point of view of the context necessary to define the current situation and suggest feasible social policy recommendations to improve the current system. In addition to the interviews, there is a classroom activity delivered in classrooms aiming to understand the breakfast habits of students at this school. Among 262 primary school children (N=262) attending this school, most of them (n=252) have participated in the classroom activity.

There were nine classroom teachers interviewed (Table 3.1). The classroom teachers participated this study were experienced in their profession. The least experienced teacher has been working as a classroom teacher since 15 years and the most experienced has two decades of experience. The average experience year of teachers is 17.8 years. These 9 teachers are working at this school at an average of 6.9 years. The longest working time is a decade and the

shortest is 3 years. Thus segmenting teachers according to their experience level is not meaningful, since all of the participants have at least 15 years of classroom teaching experience.

Table 3.1 *Participant Classroom Teachers' Profile*

	Year of Experience	Years worked at the case school	Age
Teacher A	19	7	40
Teacher B	19	8	42
Teacher D	20	7	43
Teacher E	17	7	40
Teacher F	15	10	55
Teacher G	18	3	39
Teacher H	18	6	49
Teacher I	17	7	43
Teacher K	17	7	45

Half of (4 out of 9) the teachers are graduated from classroom education faculties. 1 of them is graduated from ceramic education faculty, one another is graduated from arts education faculty. There are 2 classroom teachers who are graduated from other faculties. One of them is graduated from archaeology, one is from French language and literature and one is from chemistry faculty.

There are 6 female and 3 male classroom teachers working in this school. The participants' age range is between 39 and 55. The average age of teachers is 44.

The school principal is an experienced manager (Table 3.2). He has been working as an administrator for two decades, and he has 15 years of teaching experience in advance. He is in charge of this school for three years. He has been graduated from teachers' collage and education faculty. He declares he loves his occupation. The assistant principal is working for a decade at this school. In the last five years he is here as a manager.

Table 3.2 *Participant School Administrator Profile*

	Year of experience	Years worked at the case school	Age
School Principal	35	3	56
Assist. Principal	20	10	40

The first parent interviewed was the head of school-parent association and was graduated from high school. She has been working as head since three years. She has a daughter and a son attending this school. She is not working. They are living the the husband's mother due to economic problems. The second parent interviewed is also a mother, who is a housewife. She defines herself as a middle income household.

The canteen has been operated by the same person since 31 years. The operator was working with his wife and they were 60 and 57 years old.

The teachers described the socio-economic backgrounds and family structures of their children. The students' parents have generally migrated from other cities. Mamak is a central district of Ankara that is getting poorer as you go from centre to the outer parts of the town. The school is placed at one of the closest locations to the city centre. The households living in this part of Ankara are generally low-middle, middle income families who depend on a salary to survive. Also, there are high-income and low-income families in small percentages as mentioned by the school administrators. The fathers were mostly working as employees, and only some of them are officers. More than half of the mothers did not work. The most of the working mothers were employed at low-income jobs. The parents were generally graduated from high school or less. A small proportionate of the parents were university graduate, and these families had better income. The students generally had one or sometimes two siblings. In two of the classes the teachers expressed the density of separated families. Only one teacher mentions that the parents were well educated and

interested in the education and health of their children a lot. All other participants complain about the families' lack of interest in the academic success and health of their children.

3.3 Data Collection Instruments

In this case study, data was to be collected through multiple sources:

1. Semi-structured face-to-face interviews were conducted with primary school classroom teachers at different experience levels, school administrators, other school staff (cleaning staff), canteen workers, the representative parents of the school-board. The face-to-face interviews conducted with the primary school teachers were the main instrument of this study (Appendix A, Appendix B, Appendix C, and Appendix D).

2. The school environment and the facilities (sports and eating facilities, garden, classrooms, toilets) of the school were examined. The school and the environment were observed in general to taste the health atmosphere in and around the school.

3. A classroom activity was implemented in classrooms to determine the students' pre-school morning activities and breakfast habits during two weeks in order to gather data about their health and nutrition behaviours. A sheet was delivered to the students and they wrote down what they have eaten at breakfast and what they have done before coming to school (Appendix E).

4. Researcher gathered information and made observations at site to understand the school context in more details and define the current situation of the case school in more precisely.

All of the facilities and environment of the school were examined by observation. Classrooms, toilets, eating and sports facilities, teachers' room, school yard, school environment were observed in detail with respect to the standards required as a sign of a healthy school and environment. These standards were determined through international literature and Turkish Standards Institution. The observations of the environment and school facilities gave information about the hygiene factors, clean drinking water, cleaning equipment for classrooms, toilets, and other school facilities, the students' possibility of breathing, playing, learning and eating healthily during school-time. The examination of the curriculum was aiming to reveal the developments in policy makers' mentality towards the education of health at schools.

The contextual description and background information of the teachers and other participants was searched to explain the participants in detail. The participant teachers were studied according to their experience levels and professional education. Also the contextual description of the school was investigated in order to ensure that this school may represent the general situation in Turkey as much as possible. The socio-economic profiles of the students and their parents were tried to be indicated by interviews made with school administration. The policy documents related to health education and promotion were analysed in order not only to refine the findings but also to ensure the trustworthiness.

3.4 Instrumentation

In this section the development process of research instruments (interviews, observations and classroom activity) used in this case study are explained.

3.4.1 Development of Semi-Structured Interview-Schedule

The survey instruments in this study were four interviews and a classroom activity developed by the researcher. In this section the development process of the instruments is explained.

The interviews were prepared in the light of the literature written on health promotion. Databases such as Taylor and Francis Online Journals, EBSCOHOST, SAGE Journal Online, Oxford Journals Online, YÖK Thesis Bank, and METU Library Catalogue were searched to locate the relevant literature.

According to World Health Organization there are six features of a health promoting school.(1) These schools have teachers, students, parents and administrators that are engaged in promoting health.(2) They provide a healthy and safe environment both physical and psychosocial. (3) Their curricula provide skills based health education. (4) These schools provide access to health services. (5) They implement school policies and practises that support health. (6) Health promoting schools strive to improve health of the community. (WHO, 1996).The interview questions are designed in a way to question these six features to understand whether the school promote health and how.

The findings of studies conducted by the researches named in the literature review section are taken into consideration to design the questions of the interviews made with teachers, administrators, school-parent board and canteen staff. Bandura (1997) says that teachers influence the nutrition and activity practices of students by health behaviour theories. How significant is health for education and whether teachers are aware of their role for health promotion was questioned in the interviews. Their motivation and willingness towards teaching healthy living was examined. The findings of Yager and O’dea (2005) show that teachers and school personnel are potential change agents to prevent eating disorders and child obesity but they are generally underutilized

instead of their possible valuable contribution. This study perceives teachers and other school professionals as a factor for the success of treatment and prevention of obesity and other eating disorders. Thus, their efforts and willingness to promote health in their classroom was questioned carefully. The pre-service and in-service trainings they took about the health education and whether that was sufficient was questioned. Because Celebuski and Farris (2000) have found that teachers in schools with fewer resources and lower institutional support for nutrition education and teachers with no training were less likely than other teachers to integrate nutrition education into other subjects. The barriers that teachers and schools face were questioned. Prelip et al. (2006) states that besides training, the barriers like lack of an adequate curriculum, textbooks, equipment, and facilities are important because they affect the ability of teachers to implement health education.

Informal talks with two academicians working on health promotion and two classroom teachers helped to develop relevant instruments. Except informal talks, expert opinion was consulted while developing the data collection instruments. Items were mainly prepared to explore the current situation of promoting health in schools by asking questions like who, when, where to gain deeper insight of practises and situation. A university associate professor working on educational sciences provided continuous feedback for content and face validity during the development phase of the instruments. She has criticised the relevance of questions to the aim of the study and taught a lot about academic interviewing approach. According to her feedback, the instruments were revised so that they carry the desired parameters of the study. For example, the wordings of questions were corrected in order to be open and stay focused on the research questions. Some questions that seem to be irrelevant to the research questions were extracted from the interview forms. Moreover, questions were supported with sub explanations to remind what the question was about. For example, after asking the teachers their role in promoting health,

headings such as nutrition, physical development, and personal development was given concurrently, to gather related answers to the question asked. Also, a health professional is consulted to get knowledge about the importance of health awareness, healthy eating and healthy living habits for children's healthy progress. The information taken from the health professional is used to decide which questions are more suitable for this study.

Four pilot interviews were conducted with classroom teachers and a parent working at different primary schools in order to identify potential variables that could be included in or omitted from the interview and to obtain more detailed information for avoiding the researcher's bias before landing on the study field. The pilot study provided useful information to revise the inaccurately worded or unclear questions. Also this pilot study helped the researcher in writing the beginning part of the interviews. The beginning part is about the aim of the study and gives useful information to the participants on how the interview is conducted. The pilot study enabled the researcher to see what the participants find difficult to understand or doubt for volunteering this study. The beginning text is reworded and improved to be understood clearly. Moreover, face validity of the interviews are tested with this pilot study. The overall format of the questionnaire was revised to ensure face validity. The interview questions were more participant friendly after this revision.

Finally, as a requirement of ethical conduct, permission from the METU Ethics Committee is taken (see Appendix I). The committee evaluated the aim of the study and the study instruments and approved that this study is worthwhile and the instruments are ethical.

The interviews included both open ended and close ended questions. The language of the interviews was in Turkish. At the appendices section of this study, both the original Turkish interview questions and the translated English versions are available. The content of the interviews are explained below.

There were four parts in the interview conducted with teachers (see Appendix A). The interview starts with an introduction section where the participant can learn the aim of the study and the aim of the questionnaire. The beginning part also mentions that names of the participants were kept hidden and the interviews were tape recorded.

The first part of the interview was designed to gather data about the background of participants. Their graduation and experience in teaching is questioned. Also, the socioeconomic structure of students was asked to the teachers to understand the background of school population.

The second part was focused on the teachers' perceptions, practises recommendations and barriers to health promotion in public primary schools.

The third part of the interview was about the duties of and actions taken by the parents, school-parent board and school administration. Also, the condition of school in terms of healthy and safe school environment is questioned in this part. The six features of health promoting schools according to World Health Organization (1996) were searched to find out whether the school has a healthy environment.

In the last part, the opinions of teachers about the curriculum were gathered. A study by Herbert and Lohrmann (2011) shows that the curricula are shown to influence health promoting behaviour and have been found to share common characteristics. A health promoting curriculum has to be skills-based, theory driven and culturally accurate and basic. Also, the regulations of the ministries of health and national education and present policies implemented in schools were investigated. Taşdan and Memduhoğlu (2008) state that the school health services aiming to protect and improve the health of children are pretty deficient in Turkey. This study asked teachers their criticisms for the current policies and took their recommendations to improve the current system.

The interviews conducted with the school administration and school-parent board followed a similar path (see Appendix B, and Appendix C). The

questions were adapted to take their point of views and enlighten the happening in primary schools. The interviews with the canteen employers/ manager were focusing on the previous changes in their sales strategies and the consumption behaviours of students (see Appendix D).

3.4.2 Development of Contextual Evaluation Form

The observations of the school environment and facilities were made with another researcher to determine the current situation of the school's physical condition. The researchers examined cleanness, air conditioning, temperature, cleaning and teaching equipment, cleaning service, noise level of the school facilities, school yard and environment to understand the contextual design of the school studied. The observations and evaluations were made regarding the necessities of a health promoting school environment determined by World Health Organization and previous academic researches (Taşdan and Memduhoğlu, 2008). Also, the standards determined by Turkish Standards Institute and the Ministry of National Education were examined to understand the necessities of schools in details. The classroom sizes, equipment, general construction of the school, the restrooms and other facilities of the school, the school yard and finally environment were examined with respect to health promotion principles.

3.4.3 Development of Classroom Activity Form

According to Yabancı (2011), meal skipping is a common problem among the school aged children. The mostly ignored meal is breakfast. Unfortunately, the literature finds out that those children who are skipping breakfast live difficulties in learning and socializing. In this research, the students were directed to write down what they really do in the morning before

going to school. Also, they were said to write down whether they had breakfast before coming to school and what they have eaten at breakfast. The activity sheets were delivered and collected every day in classrooms by teachers and handled to the researcher at the end of the week.

3.5 Data Collection Procedure

The interviews were conducted at the spring semester of 2012-2013 educational year in Turkey. The observations and the classroom activity were conducted concurrently. The data collection process started at the beginning of April 2013 and lasted at the end of May 2013. There were 20 registered school visits done during this time period. The research was conducted in a spread time period to comprehend the situation of the school, completely.

The case study was conducted with the permission of Middle East Technical University Ethics Committee and The Ministry of National Education. Moreover, the written permissions of the interview participants declaring their will for voluntarily participating in the research and their allowance to use the findings of the interviews for this thesis study were taken (Appendix H). They were informed about the aim of the study and the ingredient of the interview.

The interviews were conducted at the school. An interview schedule was planned and the participants were invited to a convenient place such as the teachers' room or administrators' room on the agreed time and the interviews were conducted without interruptions. All of the interviews were conducted in Turkish by the researcher. The interview questions were asked verbally. The participants were allowed to see the interview forms. The interviews were taped, recorded and then transcribed. Moreover, the researcher took notes during the interviews. Each of the interviews took 25 to 40 minutes long. The response rate

was a hundred per cent. All the population subject to this research admitted to take part in this study, voluntarily.

The observations were gathered during the school time, the classrooms, toilets and other school areas were visited both at class hours and breaks to reach more detailed data. The observations were gathered with the permission of the school administration. The findings were written down by each researcher observing the school during the observation period. The notes taken by two researchers were compared with each other at the end of each school visit to validate the findings and ensure objectivity. The school context was observed at each school visit regularly to detect the changes and develop an objective and realistic contextual school evaluation.

The classroom activity forms questioning the breakfast and morning habits of students were delivered to the classroom teachers by the researcher. The forms were written in Turkish. It took 15 minutes each day for students to complete the forms. The teachers made the students to fill out the forms completely every day in class hours during 10 days (two weeks) (see Appendix E). The forms were collected from the classroom teachers by the researcher at the end of each week.

Starting from the end of May 2013, the data collected was analysed with qualitative and quantitative analysis methods.

3.6 Data analysis

Interim analysis was used to analyse the data gathered through this case-study in order to develop a deeper understanding of the research. The data gathered was tape-recoded and after the field study, the data was transcribed by documenting the records into a written format. Then the data was segmented into different parts: the opinions and perceptions of the interviewees were evaluated in different baskets according to their duties. The second segmentation

included the facts, implementations and regulations that could be observed in order to set the situation down clearly. The recommendations was analysed in a different segment, too. The observations and document examinations was also subject to segmentation to accurately abstract the findings. This study will be a case study so that, the statistical analysis was limited to determine the frequency of opinions and recommendations by counting the similar answers. After segmenting the data, the relationships were identified to see whether there are patterns within the answers of participants. These patterns were demonstrated through tables, graphs etc. This analysis was planned to give a chance for corroborating and validating the results precisely. The interviews were in Turkish so that, after analysing the data the results were translated in English to write this thesis study (see appendices A, B, C, D, and E).

The data analysis of the classroom activity was done with basic statistical measurements. The frequency of answers was recorded and the results were demonstrated in graphic to see the results in a comprehensive way. This classroom activity was subject to participant bias, so that the results only implicate a tendency instead of revealing a generalizable fact.

3.7 Trustworthiness

For the trustworthiness of this case study, various methods were implemented to ensure credibility, transferability, dependability and confirmability of the study (Lincoln and Guba, 1985).

In order to defeat any credibility threat the researcher spend extended time period (a month) to collect all the data available to objectively picture the happenings. This prolonged engagement enabled the researcher to deeply understand the context of the case school and environment. Moreover, the researcher knew the context of the school and its environment because she has lived for twelve years near the case school until 2007. This engagement helped

to explain the socioeconomic background of the school population more accurately. During the research phase, the researched spent plenty of time sitting in the school yard and observing the general atmosphere of the students, teachers, administrators and other community members.

Low-inference descriptors were used in reporting to provide trustworthiness. Direct quotations from the participants were used for the explanation of critical issues. Internal validity of this study is provided by data triangulation. The results of the interviews made with teachers were cross-checked with the results of interviews made with the administration and, school-parent board in order to ensure the findings. Triangulation allowed the enrichment of the information to understand the study context (Erlandson, Harris, Skipper, and Allen, 1993). Also, another technique, referential adequacy material, was used. For later utilization, all the data required prior to and during study was archived. Among these materials, there were voice records of interviews, interview question sheets (Appendices A, B, C, D, and E) classroom activity sheets (Appendix E), volunteer participation information sheets (Appendix G), recent policy and regulation documents (Appendix F).

The transferability of the research was gained by the demographic and contextual information in order to enable readers of this research making decisions about to whom the results may be generalized. The context of the study and the interpretation of the results were explained in details. The social context of the school and its environment and the families of students attending this school is explained in details to allow the transferability of the study to another context (Stufflebeam, Madaus, and Kellaghan, 2000). The findings of one study can be applied to other situations carrying the same context. The findings of previous qualitative and quantitative researches are compared with the results of this thesis study to verify the general atmosphere and parallel happenings. This comparison shows that the results of this study were similar to

the findings of previous researches and this similarity make transferability possible for this case study.

In order to address the dependability of this study, audit trial technique was used. An external auditor who is experienced on research conducting assessed the quality of the study and tried to assess the study process and study findings to see whether they were dependable and confirmable (Erlandson et al., 1993). The auditor was an associate professor in educational sciences and was an expert on educational research. All the data gathered and the data collection instruments were presented to the auditor for her determination of the trustworthiness of the research. The processes within the study were reported in the last chapter in detail, thereby enabling a future researcher to repeat the work, if not necessarily to gain the same results. The research design of this study may be viewed as a "prototype model". Such in-depth coverage also allows the reader to assess the extent to which proper research practices have been followed. Readers of the research report can develop a thorough understanding of the methods and their effectiveness, the research design and its implementation.

The study's findings were the result of the experiences and ideas of the informants, rather than the characteristics and preferences of the researcher. The role of triangulation in promoting conformability is recognized, in this context researcher bias was tried to be reduced. Once more, detailed methodological description in this study enables the reader to determine how far the data and constructs emerging from it may be accepted and this feature ensure a credible, transferable, dependable, and confirmable research.

For the quantitative part of the instruments, validity check was required to ensure that the data provided by the instrument could be used to draw accurate findings (Fraenkel and Wallen, 2006). Experts, that have the knowledge and ability to judge the relevance of the instrument to the purpose of the study judged the validity of the instrument. Two classroom teachers and an

academician in educational sciences checked the content validity of the classroom activity sheet. They were provided the aim and scope of study that are to be measured by this instrument. These validity checks were repeated until the final instrument is composed. Also, an external auditor who is an expert in educational sciences examined the face validity of the instrument to provide feedback on the overall format of the questions.

The reliability check was important for this instrument to see that consistent results can be gathered when used at different times at the same setting (Morris and Fitz-Gibbon, 1978). The traditional quantitative view of reliability is based on the assumption of replicability or repeatability. Almost all, 96 per cent (252 out of 262), of the primary school students participated in the activity, so that we can expect similar results when this study is conducted at any different time with the same population.

3.8 Limitations

Although, it will be misleading to generalize this study's findings for all primary schools in Turkey, the similarities with the previous findings and the socioeconomic background of the case school may lead to think that this case is conducted with an average sample of population that resembles the basic features of Turkish education system. This study aims to find out transferable results. None of the results gathered in this case study are standing away from the general situation of Turkish education system stated in the former studies. But, still there is need to make more comprehensive researches including larger samples of school contexts to generalize the findings to the whole system.

The change in the educational system at the beginning of 2012-2013 educational year created a notable limitation for this case study, as well as other studies conducted this year about primary or secondary education. Because, as mentioned earlier, most of the former primary schools are now continuing

education under the title of either primary or lower secondary school, and these school have students still from both levels. In this study, the case school did not accept first grade students of the primary school this year. But, there are second, third and fourth grade primary school children and even nursery classes under its roof. This situation may be thought as a problem for the credibility of this school. Because the absence of first grade means that the researcher could not interview with first grade classroom teachers. But, this is not a serious limitation for this case study, in fact. Hence, the classroom teachers answered the questions taking into consideration their experiences with the first grades. They were warned to mention any different activity or policy applied in the first grade level. It is stated by the participant teachers that there was not any different application or policy that they may add for the first year of school. Also, the classroom teachers of the second grade were with the same students one year before when they were in first grade. Thus, they were asked to answer the questions of the interview, considering the last year and this year together, to handle this limitation.

The participants were willing to answer the questions they were asked, except for a parent. This has eased the collection of data in a short time. The voluntary participation led to comfortable and apparent interview sessions.

The participant teachers of this case study were experienced at least for 15 years in education. Therefore, the health promotion approaches of newly graduated or little experienced teachers could be not examined with this case study.

The classroom activity was implemented in classrooms to determine the students' pre-school morning activities and breakfast habits were subject to limitations. Because the children tended to write down what they should have eaten, instead of what they exactly eat. Thus, the results of the classroom activity are only referable to see that the students know what they have to eat for a healthy breakfast. There is an interesting result in this classroom activity. The

percentage of students doing breakfast before coming to school increased day after day. This, can be due to the fact that the students write to tend down what is right, because they may have thought that the teachers were examining their behaviours. Thus, again, this classroom activity can be accepted as a supportive instrument sustaining complementary data rather than a main instrument conducted to conclude findings for this case study.

CHAPTER 4

FINDINGS

In this chapter the findings of the study is explained in detail to demonstrate how Turkish urban public primary schools promote health in a social policy context. The findings found can be categorized under 13 headings as can be seen in Table 4.1.

Table 4.1 *Themes Emerged*

1	Perceptions about the Importance of Health Promotion and Health Education in Schools
2	Teachers' Role in Health Promotion
3	Health Promotion Efforts and Activities
4	Barriers for Promoting Health
5	Evaluation of School Environment and Facilities
6	"School Milk" Project
7	Teachers' Views on Current Regulations and Policies
8	Teacher's Opinions about The Curriculum
9	School Administration's Role
10	Opinions of the School Administration
11	The Interviews Made With Parent-Teacher Association
12	The interview with the Canteen Staff
13	Classroom Activity

4.1 Perceptions about Importance of Health Promotion and Health Education in Schools

The participants were asked why health promotion and education in schools is important. Teachers thought that health promotion and education on schools is important for growing healthy future generations. Most of the teachers (8 out of 9) express that the families are not occupied and able enough to protect their children's health in terms of nutrition, physical and mental health. The parents sometimes do not have the necessary education to implement the right nutritional and physical behaviours. Another reason for the parents inefficiently in health promotion may be the economic problems. Low-income families cannot have a healthy diet. Also, the cultural accumulation can prevent parents from serving a nutritional diet and a health environment for emotional and physical development. The teachers say that the families are influenced by their children and their children's teachers. They tend to obey the advices given about nutrition and health as a whole more or less. The children are carrying what they have learned in classes to their home and forcing their parents to the rules and values they have learned about health as in any other issue.

The teachers also believe that the media and other communication channels can direct the youth to a single media- modelled appearance and health understanding. Thus, children should get adequate knowledge and gain habits at school in order to stay healthy now and then.

Teachers mention that health is very important because "healthy head belongs to healthy body". By healthy head they mean the students who are able to learn well and develop mentally. The school should be places where healthy living behaviours are given, but not just places where health is told in classes in words as reading texts in the curriculum.

The teachers stated that schools are important because health was both important for the society and the economy. Health problems are affecting the government budget. One of the teachers says that "preventing diseases is more important than curing them". Three of the teachers have taken attention to the cost of health expenditures on the state budget.

The school principal thought that health promotion at schools is very important. "In order to have a healthy society, health promotion and education is a must". He states that the education in school should be a complement to the education at home. The families, school and the child have to become together to promote health, otherwise the programmes cannot work. He mentions that the families are degenerated in terms of their children's education. They do not bother to be role models. Moreover, they are very likely to get angry with the school and behave impudently. The child observes these behaviours and she/he loses his/her respect, too.

When the answers of teachers and school administration were evaluated as a whole it is apparent that they all agree schools are places where health education and promotion should take place. But the reasons for this necessity are partially known. Their knowledge of the literature showing the importance of health promotion is limited to the economic and family related problems.

4.2 Teachers' Role in Health Promotion

The teachers were asked their role in health promotion. All believed that they had an important role in teaching healthy living behaviours and promoting health in schools. One of the teachers mentioned that "although teachers are key agents to health promotion in schools, the total quality management system perceives parents and students as customers and teachers are excluded from the teaching system every year more and more. Teachers are only seen as service providers who meet the science, maths and language needs of children. The

education dimension is losing blood in primary schools". All of the participant teachers mentioned that they had decreasing authority and thus teachers were less effective in health promotion likewise in other areas. In spite of this authority reduction, teachers were still called responsible from their students in every aspect. Any problem regarding health or academic progress in school was directly asked to the teacher. Teachers stated that the responsibility without the related empowerment created friction between the teacher, child and parents.

Teachers mentioned that health education and promotion was packed only in school books as reading materials by the curriculum. So that, the initiatives taken by classroom teachers about health was left to the personal interest of teacher. A teacher mentioned that "It is a chance, if the teacher has interest in health related issues. But, when you left health promotion to the personal interest of a teacher, a total social struggle to promote health is not possible. It is not possible to reach a certain stage by individual attempts; you can only affect your own students."

Most of the teachers (7 out of 9) told that health education was one of the main duties of teachers. Because, teachers were role models for primary school children. The participants declared that the classroom teachers were taking the places of mothers and fathers and were the main educators of children especially at the first three years of primary education. The children tend to imitate what their teacher do and make. A teacher said that "There are 64 cameras recording my appearance, behaviours, speech in the classroom now. They will try to imitate what I do in their daily lives. Thus, being a teacher means being a role model for my students." A teacher expressed that she gave up smoking and she quitted shopping from the canteen except for water. Another teacher said that "I try to have shower every day and come to class with clean clothes and shoes. Because my students pay care to observe if I look healthy and clean. Two teachers mentioned that they try to have lunch with the students in the classroom and bring food from home every day to be an example for the students. Three

teachers mentioned that they did not do anything special to be a role model, but rather they generally talked about the importance of healthy eating, cleaning and hygiene. None of the teachers declared an action they did, to be a good role model for emotional or mental health.

Schools are places where education rather than teaching is important. Anybody can show a child to sum and subtract or read and write. But educational function of primary schools is much more than that. Classroom teachers help children to gain behaviours, build a personality and determine their own values. This is also true for health promotion. One of the participants expressed that "healthy living and behaving is nothing that can be learned through seminars or lectures, but it is something which can be gained starting from the family by living, acting habits and generating values. Apart from genetic factors, health is gained through education and teachers have significant role here".

Teachers have mentioned that the children of wealthier families tended to be more immunized to diseases and they went to health controls more frequently than the low-income families. Half of the teachers took attention to the fact that promoting health in schools was especially important for poor children whose health was often not given the necessary importance by their families. In fact, schools and teachers were meant to be the only actors who cared about their health. The environment and houses in which these poor children live were thought to lack many of the conditions of healthy living, such as clean water and secure living areas.

4.3 Health Promotion Efforts and Activities

The teachers were asked how much time they spared for health promotion in a day or week and what they did to promote health. All of the participants agreed that they did not spare a certain time period to promote

health. But, rather they tried to integrate health promotion in class hours when there was an opportunity. For example, especially at the first year of school, four teachers mentioned that they took students altogether to the toilets themselves, to teach how to wash hands, use the toilets, and brush teeth. But, even this basic practice faced some difficulties. First of all, it was stated that the children were not allowed to go to toilets altogether in class hours, because the possible noise created at the school corridors may disturb the others doing lectures in the classrooms. Moreover, at the breaks, the toilets were said to be so crowded that teaching these basic cleaning behaviours to students was stated to be impossible. Besides, five teachers mentioned that the toilets were not hygienic and teaching how to do personal cleaning in that dirty area was not feasible. “I do not take my children to the toilets to teach how to wash their hands and brush their teeth. Because the wash bins and the tabs are dirty and there is a disgusting smell. A cleaning activity in those toilets cannot create a good impression in the child’s mind about cleaning. At first, the place and the equipment have to be clean to teach the benefits of cleaning”. Also, they tried to teach how to eat and drink at lunch pauses and they thought the importance of personal cleaning before and after eating meals. Three teachers mentioned that they made the children to bring their own soaps, brushes and towels in the classroom with them. The children were caring to obey the rules of the teachers about cleaning at the beginning of the school years, but they were stated to lose their interest in obeying these rules within time. The teachers said that due to the lack of parents’ commitment in health promotion and education, the children did not keep on practicing the same cleaning behaviours at home, and without repetitive action they could not build personal cleaning habits. Thus, after some time, the children, who could not set these behaviours regularly in their daily lives, were said to begin to get bored of the cleaning practises at school and to perceive these cleaning activities as useless.

In order to promote healthy nutrition in classrooms, eight of the teachers declared that they determined a diet list at the beginning of each year. They tried to develop a balanced diet list for students. Five teachers said that they composed the ingredients of the list in coordination with the parents. In the table below an example diet list is exhibited (Table 4.2).

Table 4.2 *Example of a Weekly Diet List*

Monday	Home-made cakes	Fruit juice	Fruits / vegetables
Tuesday	Bread	Cheese and olives	Fruits / vegetables
Wednesday	Sandwich	Milk / fruit juice	Fruits / vegetables
Thursday	Pasta	Milk / fruit juice	Fruits / vegetables
Friday	Toast	Milk / Ayran	Fruits / vegetables

When the list is analysed, carbon hydrates, fruits and vegetables take place every day in the list. Nutrients containing protein were not taking an appropriate part in the diet list, due to the lack of healthy food keeping conditions. Dried fruits such as walnut, hazelnut, almond and grapes were seen as necessary for the children's neural development by the teachers and the administration and it was made obligatory by the school to bring dried fruit to school every day. The physical and mental development of primary school children is directly related to what they eat and drink. Their diet should be rich of protein and calcium as well as carbon hydrates. But, as can be seen from the list, it can be thought that either the teachers are not very knowledgeable about nutritional requirements of child development or the physical and economic conditions prevent the teachers from applying a nutritional diet program in schools. All of the teachers mentioned that the conditions of classrooms were not feasible for keeping food fresh. The classrooms do not have any air

conditioning or refrigerators. Thus, they tried to choose from durable food alternatives when the list was developed.

The insufficient knowledge level of teachers and parents about healthy nutrition, physical and economic difficulties were admitted as obtacles that prevented healthy eating at schools by the teachers in this study. They mentioned that, they tried to improve their knowledge about nutrition by their own efforts. They tried to implement what they have learned from media or books in their classrooms. Moreover they agreed on the fact that they did not have the opportunity to improve physical condition of the classrooms or the school which requires managerial decisions and resources, such as establishing air conditioning, buying refrigerators or operating a fresh food serving eating facility.

The teachers' efforts to sustain a healthy lunch for children were often blocked by parents. It was stated that the pre-determined diet lists were not regularly pursued by parents. The majority of teachers (7 out of 9) claimed that the parents did not obey the diet list and put junk food in the lunch boxes. Furthermore, it was claimed that the parents often quitted preparing a lunch box, especially after the first grade. The teachers mentioned that when they warned the parents about the child's wrong eating habits and talked about the significance of healthy nutrition, the parents defended themselves and complained about the difficulties of preparing a lunch box. The parents are said to choose to give pocket money to their children to buy lunch from the canteen, instead of preparing the lunch themselves. But the canteen is inadequate in terms of meeting the healthy nutrition requirements of children as explained in the previous chapter.

The teachers participating in this study were seen to build health behaviours and give information about hygiene, personal cleaning, health eating and healthy living. But, their efforts remain as individual attempts, because there is not a complete school programme to promote health. Moreover, the physical

conditions of the school challenge the students, the teachers and the school administration. The toilets, the classrooms and the school building as a whole are insufficient for healthy learning, eating and cleaning.

The teachers were asked their methods to track the health status of their students. All of the participants replied that they were keeping a file in which they recorded the weight and height of students at the beginning of the school. They said that they also wrote down the chronic illnesses, medicines, and other information about the health status of their students. The teachers claimed that they controlled the height and weight of each child regularly at the first grade, but later in bigger grades they left the measurement to the students. Only one teacher mentioned that she controlled the teeth, hand and hair cleaning of her students weekly. Besides physical health problems, psychological health problems were also declared by the teachers to the parents, but the teachers did not feel themselves occupied enough or predominant to detect the problems in a timely manner. Teachers stated that they called the families and gave information about the health status of the child to the parents, when a child got ill in the classroom, was consistently unhappy or came to class with symptoms like fever and cough. None of the teachers reported the chronic illnesses or other severe health problems to the health authorities themselves; they leave the care of the disease to the parents. The school neither had a health professional employed nor an inner health service department. Moreover, there was not a communication link established between the school and the health authorities to cure or improve the health problems of students.

4.4 Barriers for Promoting Health

The teachers were asked the barriers in front of them to promote health. The most commonly mentioned barrier is the physical condition of the school. The school lacks appropriate facilities and conditions for promoting health.

There is a **small canteen** (12 meter squares) that has a service window looking in the playground of the school. The canteen is selling concentrated fruit juice, water, milk, ayran[2], ice cream, toast, chocolate and candies. There is not any warm food or hot meal cooked and served to be consumed as a lunch. There are not any sitting places to eat and drink, and when the weather is cold or rainy the children live difficulties in shopping from the canteen due to the fact that they have to wait in the open air to do shopping from the canteen. Other than the canteen there are not any eating facilities. The absence of restaurant, refectory or equipped canteen is not just a problem for the children, but it is also challenging for the teachers. The whole school population have to depend on their lunch boxes to get a lunch. As mentioned before, the school does not have an air conditioning system or refrigerators, thus the ingredients of the lunch boxes are limited to food that is durable, because it is impossible for the teachers and the students to keep their food cool and fresh especially when the weather temperature increases.

The participant teachers mentioned that **the playground** of the school was not sufficient for physical education. The ground is covered with asphalt. Teachers said that the optimal ground coverage for primary schools is sand or grass. The asphalt ground of the playground was claimed to cause injuries easily, when a child fell down. Moreover, the school do not have a sports hall. The children at primary school age have to be educated physically both for their mental and physical development. The sports halls have a critical importance for primary school children, because these places are play grounds which are secure and healthy for children. The students can play team games, socialize and be educated in these courts. Primary school children are very energetic and need to discharge their energy in some way; doing sports is one of the most precious ways to do this. The teachers said that the students were forced to sit in

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[2]A drink made of yogurt and water.

classroom for 6 hours, including the breaks, especially in the winter, because they did not have adequate facilities to play with their students.

The school is doing **binary education**, meaning that there students who attend school only in the mornings and there are others attending school only in the afternoon. The classes begin at 7:10 am for the students who are attending school in mornings. Every course is 40 minutes long. There are 6 courses in a day. The morning students leave school at 12 am and at 12:40 pm the afternoon classes begin. The classes are over at 17:30 pm. The breaks are very short, only 10 minutes long. The students do not have a separate lunch time. They eat their lunches in 20 minute time period which is taken from the class hours. This binary education system is criticized for not being feasible for students and teachers in terms of health promotion. Teachers declared that they had limited time to catch up with the curriculum that was already loaded with lots of different subjects. The teachers stated that they could not spare special time dedicated to promote health in class hours under these circumstances. This binary education is limiting the quality of lunch, as well. The children who do not have sufficient time to eat a complete meal said to be forced to feed on ready food like sandwiches or toasts at best. Provided the children had a separate lunch time, they might have taken the chance of going to their homes to eat home-made meals. Moreover, there is almost no time left to students for playing and interacting with friends after having lunch. Physical activity and socialization were claimed to be ignored due to the short breaks and school time.

The **difficulties in hygiene and cleaning** are mentioned as other severe problems. The toilets and the classrooms are not clean enough. Moreover, there is a sewage problem in one of the two school buildings and due to the old infrastructure; this problem cannot be solved permanently. The corridors smell disgusting because of the sewage problem and the children have to use that toilet unfortunately. There are only two cleaning staff employed for the whole school which has two separate buildings. Each cleaning staff is responsible from one

building. The participants of this study all stated that the demand was not met by this limited supply. The school is making binary education. Half of the classes attend the school in the morning and leave the school at noon. The rest of the students come to school at noon and leave in the evening. There is not enough time left between the classes in the morning and the classes evening to clean the classrooms. Thus, the classrooms are mopped up once a day in the morning or evening. Thus, the primary school students who come to school at noon are sitting in classrooms that are desecrated by bigger classes in the morning. Cleaning of these classrooms is sometimes said to be done by mothers of the students. A teacher stated: “Every day a parent comes to the classroom before the lessons start. The bigger classes leave the classrooms really dusty and messy. We have to clean the classroom with our own efforts. The cleaning personnel cannot mop up the classroom in the midday. He has lot to do. I try to keep the classroom clean during classes, but it is not enough. Primary school children can easily get ill due to dust or pollution. Hence, we try to keep the classroom clean with our own efforts”.

All of the teachers and administrators thought that **families** were barriers to promote health, too. The parents were said to not care enough for the child’s daily cleaning and sleeping hours or they did not give importance to their nutrition enough. Most of the families were believed to be really irrelevant to the health education and promotion. The teachers thought that some families could be aware of the importance of healthy living, but this time they might lack the economic and physical conditions to provide a healthy environment to their children. The teachers mentioned that some children were abused and subject to violence and they did not have a climate of care, trust and respect, social support and mental health promotion. It is not only parents, who are responsible from child abuse and violence. A small proportion of teachers and children were observed to abuse and assault children during class hours or breaks while conducting this study.

Seven of the teachers complained about the **procedures of the ministry** in front of applied education. The teachers stated that they had to handle with a lot of procedure when they wanted to take the children to a trip for educational purposes. The students learn by practising and seeing. However, the teachers told that they were forbidden to take their students to a place like a zoo, a museum or a health facility during class hours. Also, they had to take permission from the Ministry of Education, in advance. The expenditures like transportation or entrance fees were paid by the families. Under these circumstances the teachers said that they were generally discouraged to take the students to an educational trip.

Seven teachers claimed that **absence of professional health personnel** working at the school is another barrier in front of teachers to promote health in schools. The teachers did not feel qualified enough to interfere in health problems. A professional aid should be beneficial not only for curing diseases or injuries but also for promoting healthy eating and living in schools.

When the **teachers' level of qualification** was questioned to promote health in schools, seven teachers mentioned that they felt not qualified enough to promote health. They declared that they required in-service trainings to promote health. They did not get any per-service training during their university education about health promotion, either. Only two teachers said that they felt qualified enough to promote health, due to their personal interest in health related issues. It was understood that these two teachers who felt themselves qualified to promote health, seemed to perceive health promotion rather only as health education. The answers of these two teachers to the other questions revealed the fact that they only gave information about health to their students but did nothing to develop behaviours or habits for healthy living.

The assistant school principal stated similar problems to those mentioned by the teachers. He thought that there were severe problems with the nutrition of children. The canteen of the school was too inadequate to meet the needs of

children. They did not have a table to sit and eat their food. Also, he mentioned that families and the media played the main role in the child's attributes towards healthy living. He claimed that they had limited resources as the school administration and they could not interfere in the health education and promotion of children. He took attention to the fact that children were perceiving spending money as something prestigious. The school canteen was the only place where they could spend money in front of their friends. Thus, the students were thought to like to buy things from the canteen. Unfortunately, in spite of the recent regulations on food sales at school canteens, canteens were still not seen as healthy eating facilities by the school administration. The children can still buy chocolate, candies, and other kind of packaged snacks from the school canteen. The students prefer to consume these as lunch in spite of bringing lunch boxes to the school.

The school principal criticized the education policy as not being national. He thought that the policies were taken from different resources and the education system limped in various aspects. The school principal claimed that in the past the authority was in the hands of the teachers and the school administration, but now it was given to students. The parents tended to complain about teachers very easily. The school principal stated that this structure demotivated the teachers and they refused to do more than the curriculum. He claimed that the teachers taught what they have to teach and leave the classroom behind them after last the ring belled. He complained that any policy change should be done with the attendance and commitment of teachers. The teachers were claimed to be a chain ring that linked education policies and the society.

4.5 Evaluation of School Environment and Facilities

When the teachers were asked to evaluate the health conditions of the school and school environment, they repeated the previous complaints

mentioned in the previous section. The canteen, toilets, classrooms and the playground were said to lack important features of a healthy environment. There is a noteworthy service and infrastructure problem in cleaning and sanitation. Also, the children cannot use the tap water for drinking. They have to buy their drinking water from canteen or bring from home.

Eating healthy food and playing in a healthy environment can be thought as the basic feature of any school, since schools should be places to raise healthy children. But, in this school even these most basic needs could not be met. There is no eating facility that serves daily and nutritional food, and there is not a sports hall or a healthy playground for physical activity. The teachers could not mention any health disparities directly related to the absence of these facilities, but they said they did not have any opportunity to compare how the health of children may improve with the presence of these opportunities. Because, that mentioned that these problems were the common troubles for most of the primary public schools in Turkey.

Moreover, it was claimed that the school was not located securely. The walls surrounding the school area is not built properly. There are not any security personnel controlling the entries. Three teachers were worried about the security of the school, while others did not mention any complaint. A teacher declared: "The location of the school is not healthy and that is valid for most of the primary schools in Ankara. The schools are generally near the highway or within roads and the schools are built on uphill roads. The primary school students have difficulties in reaching the school especially in the winter. The location is not inspected by the ministry in terms of its feasibility to be a school. If the land is empty and cheap then it is seen as feasible".

The principal agreed that the toilets were not hygienic. There are 18 toilets cabins in total at the two school buildings, and these toilets are cleaned by only two people. Also, there are 24 classrooms and other administrative and service rooms that have to be cleaned every day. The principal said that the

schools could outsource the cleaning service, but the state did not spare a budget for schools to pay for the services outsourced. He stated that it was necessary to clean the toilets at every break, but it was impossible to clean so frequently with limited staff and monetary source.

The teachers agreed that the classrooms were infeasible for sustaining a healthy environment. The classroom should have washbasins that can be used by the students before or after lunches or whenever necessary. The hygiene of these washbasins can be controlled by the teachers easily. The rows that the children sit are not ergonomic. They are made up of wood, are very heavy and impractical to use.

The last and may be the most important problem of schools is the limited monetary resources of the school. All of the teachers take attention to this problem. The state pays the salaries of teachers, water, bills (water, electricity, natural gas) but, do not give a separate budget to schools for any other expenditure. In the past the schools were free to collect donations from parents, but since a few years, collecting donations have been forbidden. The only income resource for the school is the budget of school parent association. They hire cleaning personnel and buy cleaning materials from this budget. The school parent association collect rent from the canteen and accept voluntary donations from parents. This budget is very limited so that, only two people can be hired for cleaning the whole school.

The assistant school principal was asked his opinions about the conditions of the school in terms of health promotion. He mentioned that the school was well equipped compared with the schools around. "The wellness of the school is directly correlated to the income level of the town that it is located in". Although collecting donations was forbidden, the conditions of schools that are located in richer towns tend to be better. This may be due to the fact that the children coming from higher income families protect and maintain the school facilities better. Also, the reason may be that the state builds better school

facilities in towns with higher income. The general wellbeing of school affects the outcomes of attempts to promote health at schools. Thus, improving the physical conditions of the school will directly improve the health status of children.

4.6 “School Milk” Project

Besides the barriers explained above, there is a new policy implemented in schools what contributes to the health of school children. The state delivers packaged milk to primary schools there days a week since 2011. The permissions of parents are taken to allow the child to drink the delivered milk. The teachers mentioned that out of 262 students attending, second, third and fourth grades, 40 students do not take milk. The ones that do not drink the milk generally do not feel confident about the ingredient of the milk. There are 10 students which are reported as allergenic to milk. Seven teachers agree that milk distribution is beneficial for children more or less. They have witnesses who begin drinking milk after this policy. The children like to imitate their friends as well as their teachers. The participant teachers observed that children influence each other positively in milk consuming. Only two of the teachers mentioned that they did not feel safe to recommend the consumption of school delivered milk to their students. In the classroom of these teachers the milk consumption was less than the other classrooms. On average 12 per cent of students did not take milk in the classrooms of these seven teachers who supported milk distribution. But, in the classroom of the other two teachers the rate of students who did not consume that milk was 40 per cent. It is clear that the choices of teachers directly affect the choice of students. This is a very critical parameter demonstrating the significance of teachers on children for health promotion.

4.7 Teachers' Views on Current Regulations and Policies

A brief explanation of what is going on Turkish Politics about health promotion and education was summarized in the literature review section before stating the results of the interviews in terms of the views about current policies, regulations and present happenings going on about health promotion under the umbrella of Turkish political atmosphere.

The teachers of this case study were totally unaware of the "Turkey Healthy Nutrition and Active Life Program" program. None of them have mentioned that they were informed about the program or the targets of the program, although as stated in the previous chapter there are certain activities that have to be implemented by schools and teachers.

The teacher and the administration declared that the health services provided by the state were very rare and not functional. The health services delivered in schools were limited to immunization and controls of eye-sight and teeth health. All of the teachers agreed that there were not any problems about the vaccination programmes. But, the services for health controls did not work appropriately. Eight teachers said that the regular teeth and eye-sight controls were ignored by the health authorities in the last two years. Even when they came to the school, their controls do not go further from determining the cavities or myopias. A teacher announced: "The doctors come and examine the mouth of children in seconds. They said the child how many cavities he/she has. They did not record the problems or do not direct the child and the family to a hospital or do not recommend any treatment to cure the problem. This is only a waste of time for the doctor and for the child." However, there are lots of actions the doctors can take. The doctors or other health professionals can take the children to the hospital after the check-ups and give free medical assistance. A health report for the families can be prepared in order to give information to the families after controlling all critical systems of the child containing both

physical and emotional wellbeing. Turkey is a social state and the children are the future of this state. Thus, students should get a functional health service in schools.

4.8 Teacher's Opinions about The Curriculum

The teachers were asked their opinions about the curriculum in terms of health promotion. All of the teachers agreed that the curriculum was not comprehensive and practical. The primary school curriculum included reading texts about the cleaning, diseases and health but these texts were only informative. It did not teach children how to live and behave healthy. The curriculum did not aim to develop behaviours and values in health promotion but rather give information and teach what is good or not for health. It did not show how to stay mentally and emotional well and how to gain habits for healthy eating. The teachers desired practise and application in every educational aspect as well as in health promotion. One teacher suggested that professionals could be invited to teach health living behaviours in the classrooms. Six teachers expressed the load of subjects that were concentrated in the curriculum. A teacher said:

> There are a bundle of subjects that we are expected to finish throughout each semester. Some of these subjects are very important but some others are really ignorable. Primary schools are places where the children structure his/her personal values and beliefs. Thus, the important subjects should take more time in the curriculum. We get exhausted to finish the programme but, however, we miss educating our students in vital subjects like health promotion.

Another problem with the curriculum was the absence of a professional physical education lesson given by a physical education teacher. The classroom teachers took their students to the playground themselves and leave them to play as they like. But, four teachers mentioned that a physical education class that

was directed by a physical education teacher is more beneficial to the physical development of children. The students had to learn how to train their bodies correctly. But, the classroom teachers had no professional knowledge about training the child's body adequately and without injuries. The children who were educated by a physical education teacher may be more tend to participate in sports activities and team work than the others.

4.9 School Administration's Role

When their opinions about the role of the administration in health promotion was asked, the teachers agreed that there was nothing much to do. The school principal was perceived as a responsible and interested manager, but his resources were too scarce to create a difference. A teacher mentioned:

> The administration has no resource or authority to promote health in schools. They have bigger problems than health. They were forbidden to collect donations, thus the budget of the school is very limited. Also, the current changes (4+4+4 system) in the education system created new attainment problems. Thus, the principal cannot spare time to improve the health conditions now.

At the end of the interview the teachers are asked their opinions which they want to express as an addition. They are generally living difficulties due to the problems of physical school conditions and curriculum. These factors have to be designed at first in order to build a health promoting school system.

A teacher believed that building health teams in schools and developing the physical conditions of the school may be seen expensive, but it was more expensive to cure the health problems related to the current system. Half of the expenditures made for curing diseases may be prevented through promoting health in primary schools. Teachers added that:

Health means wellbeing. Thus taking children in the nature is very important. Doing sports and walking in the nature are important for their development. Teachers should be given their authority to take the children to these places and should be able to do this within class hours because this is more educative than only talking or sitting in classrooms

The curriculum is information intensive, but rather it should be practice intensive. Now, schools are not seen as a part of life. Children place schools apart from their daily lives. They feel that they leave their daily life and come to school, and after the classes end they rush to turn their daily lives. We should integrate school life into daily life in primary schools. Then we can expect that the children practise what they have learned at school in their lives. This is all about the mental, physical, emotional health of the child. The child, who is committed to the school, is more likely to achieve academically and be healthy.

4.10 Opinions of the School Administration

The principal mentioned that the new education system has brought severe infrastructure problems with itself. The fifth grades were included in the secondary education now. The school has changed its category from primary school in which students from first grade to eight grade took education, now to secondary school which is expected to educate students from fifth grade to eight grade. But, since it is the first year of the new system except for the first grade, the school still has students from all the other classes. The main problem with the new system was the size of the classes in the second education. There were 28 students on average at the primary level. But, due to the new registrations coming from other schools the average student number has increased to 45 in the second level. The fifth, sixth, seventh and eighth grades are living difficulties in committing to the school. The capacities of the classrooms are 30 students, but there are 45 children now sitting tightly in rows. In such a condition, health disparities are one of the first troubles the students face. In these classrooms the infectious diseases spread very quickly. These crowded classrooms are suitable for getting ill, because of the inadequate air conditioning and hygiene problems. Psychological problems related with the stress, depression and anxiety occurring in crowded living places may arise.

He was asked what can be done to improve the conditions of the school. He said that the school has to be rebuilt. The classrooms and teacher's room were insufficient. The toilets were not steady and the school does not have a sports hall and restaurant. The buildings have to be designed to attract students and teachers to come and study comfortably.

He believed that schools are complementary in health promotion. Without initiatives taken by the families, the child's health status cannot improve much. "Think of a father who is unaware of washing hands after using the toilet at home. You cannot keep this child healthy with your attempts at school by teaching cleaning principles".

Although there existed severe barriers in front of health promotion, there are good practises at school, the principal expressed. Milk distribution is one of the recent policies that are very crucial for the children's development. Also, the children of this era are very alert to reach new information. They are the children of World Wide Web. They are in front of their teachers and parents in terms of access to knowledge. Of course, this has some certain disadvantages. But, it is admitted that the children can learn knowledge quickly from internet. Thus, schools should be places to learn how to use knowledge instead of giving knowledge.

4.11 Interviews Made With Parent-Teacher Association

Interviews were made with two parents who were members of parent-teacher association. The participant parents mentioned that the parents do not support the school economically. Collecting donations from the parents is forbidden since three years. Since then, it is difficult for the school to sustain even the most basic services, such as, clean classrooms and toilets. Moreover, they cannot buy adequate amount of toilet papers, detergents and other cleaning

staff. The personnel employed cannot handle with the whole school with limited workforce, appropriately.

The head of parent-teacher association believed that the teachers were doing their duties well in terms of health promotion under these circumstances. The teachers were believed to work with limited sources and their work load was perceived as heavy. After the third grade the teachers cannot control the child very much. At that point, the students begin to walk on their own ways. A sports hall and an eating facility are the main necessities of this school according to the head of parent-teacher association. There have to be better security and cleaning capabilities.

The policy makers had to be careful about the personnel hired for working at schools. “Once there was a project of the government spoken in the school about hiring cleaning staff. There was told to be a law suggestion to hire ex-convicts at schools as cleaning staff. This project is reacted fiercely by educators and parents, a lot, because schools are places in which the families give the duty of their children’s safety to the school”. Hiring ex-convicts can disturb the students and parents and may affect the commitment of children to the school negatively.

In order to provide income to the school, the parent-teacher association collects the rental income of the canteen and organizes a “kermes”[3] every year. Sometimes, parents or municipality can donate equipment such as benches, computers, books or sports equipment etc. This is how the budget of the school is formed.

She mentioned that health education is the responsibility of the family. A mother should teach the child how to clean his/her body. When she was asked about the duties of the school about health promotion, she said that her children do not use the toilets of the school due to hygiene reasons.

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[3] A charity market or fair

She tried to organize meetings with the parents about the problems of school and the children. The school-parent board tried to express their opinions and find a way to solve the disturbances. But, the parents were incurious towards the problems of their children's education. This finding of the interview was parallel with the findings of the interview made with teachers (n=9) and school administration (n=2).

She felt herself occupied about nutrition due to her personal interest. But, when physical or mental health is the concern she tried to ask for advice. Moreover, she mentioned buying books regularly to her children and she mentions that she reads a lot too.

The second parent interviewed seemed to support the opinions of the school-parent association. She complains about the lack of practise in classrooms and the school generally.

4.12 Interviews with the Canteen Staff

The canteen operator perceived healthy nutrition as an important concern because, the ones who come to school without having breakfast cannot learn well and can develop physical problems.

He supported the recent regulations that limit the sales of junk food at school canteens. But, he adds that the student gets out of the school and goes to the market close to the school yard, at breaks to buy coke and chips. The ministry should bring similar regulations to the markets that are close to schools. The consumption of fruit juice and milk has increased after the new regulation. He has tried to sell fresh fruits in the past but it did not work, because the students bring their own fruit with themselves.

The operator mentioned that children are conscious about that they consume, they have the habit of controlling the exposure date of products they buy from the canteen.

The canteen was a small room (12 meters square) that was linked to one of the main school buildings and there is only one small window that looks in the playground of the school. The children waited in front of that window, in open air to pay for and get their orders. There are no tables for students to have a sit. The door of this room was inside the school building and it is opened for the canteen operator only. There are two refrigerators, one for ice-cream, and one other for drinks. The rest of the equipment was a toaster and a tea machine. He said they try very hard to clean the canteen regularly, but the physical conditions were not suitable for serving better food such as fresh sandwiches or hot meal. The canteen operator stated that he uses the best products in the canteen because the health of children is important to him. He thought his service was satisfying, so that he was able to have 31 year of experience at this school.

4.13 Classroom Activity

Among 262 students (N=262), the classroom activity that was conducted with 252 (n=252) primary school students for ten days. In the first part of the activity the children were asked what activities they did before coming to school (Appendix E).

The students participating in the classroom activity were given alternatives and made to choose the activities they did. There is a graphic below to show the distribution of their answers (Figure 4.1). As mentioned before, this activity was designed to give a broad perspective of the tendencies of children to give importance to healthy eating habits.

The children were washing their hands and face (n=183), and watching TV (n=173), usually. Nearly half of them (n=142) were playing games before coming to school. Nearly one third of them have mentioned that they were studying (n=82) and brushing their teeth (n=98) before coming to school.

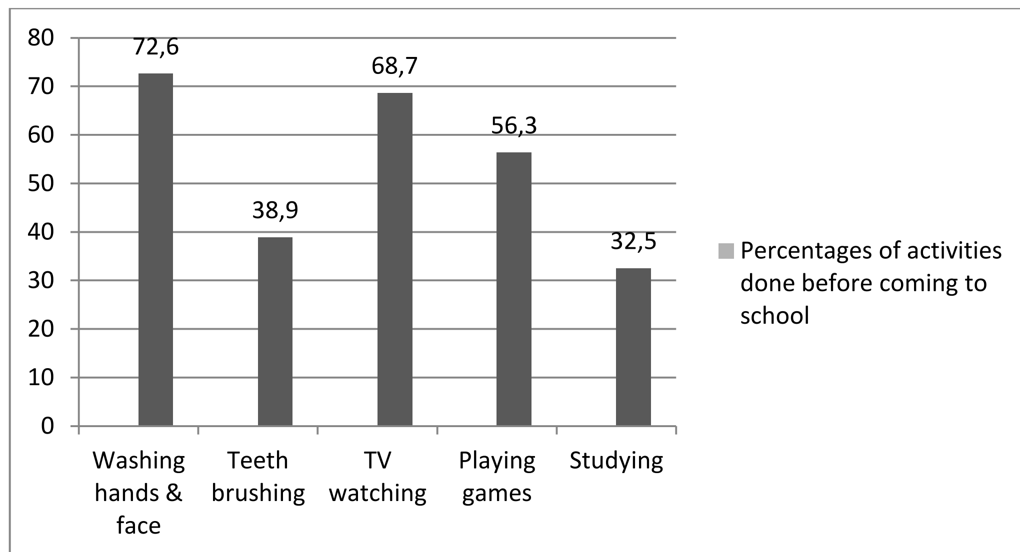

Figure 4.1 Activities Done Before Coming to School

In the second part of the activity the children were asked whether they did breakfast and where they did their breakfast: at home or at school. Most of the children (n=230) said they did their breakfast before coming school at home (91.3 per cent). However, when it is considered that all of the primary school children were coming to school after lunch time it is critical to see that 8.7 per cent of these children (n=22) do not have breakfast before coming to school (Figure 4.2).

As the last question the children were asked about the ingredients of their breakfast. Two third of the students (n=167) eat nutritional food at breakfast (66.3 per cent). There are still a big percentage of children eating junk of unnecessary food at breakfast (Figure 4.3).

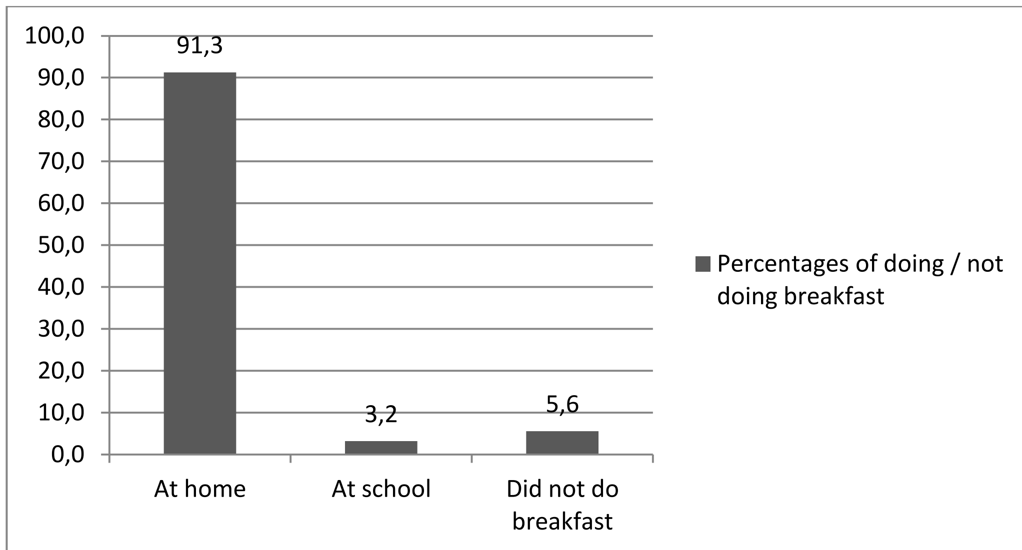

Figure 4.2 Students Having / Not Having Breakfast

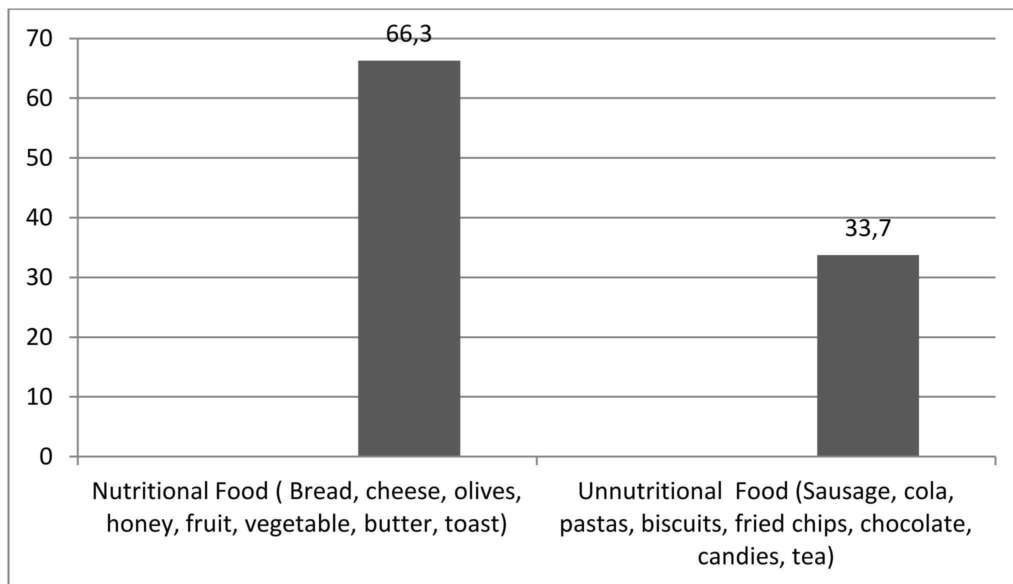

Figure 4.3 Ingredients of Breakfast

This activity can be subject to answering bias, because some children (n=22) tend to write down what was desired to happen instead of what they actually did. This may be due to the fact that the teachers delivered the forms, so that the students could think that the forms were evaluated by the teacher. However, due to the socio-economic background of the school and the school starting time (primary school starts at noon), doing breakfast at home before coming to school was an expected activity.

4.14 Summary of Findings

The participants of this case study are found to be aware of the significance of health promotion in schools. However, they perceive health promotion as a concern of physical health rather than a combination of mental and emotional health. The teachers are found to feel responsible from their students' in terms of promoting their health, because they know that they are role models for the children.

The teachers are found to teach the personal care and basic cleaning behaviours in the classrooms. Moreover, they try to monitor the health status of their children regularly, but their efforts remain individualistic and there is lack family of support to enhance the health status of students.

There are several barriers the teachers, the school administration and the parent-teacher association is dealing with. The small canteen, the unhealthy playground, lack of health services in school, binary education, difficulties in hygiene and cleaning, monetary problems, families, procedures of the ministry of education, absence of professional health personnel, insufficient teacher qualification, old school infrastructure, curriculum workload are found to cause problems and deficiencies in health promotion practises.

Besides, these barriers there is found to be a health promoting project named "school milk" conducted in primary schools. Free milk is delivered three times a week to the primary school students.

The teachers and administrators are living difficulties due to the curriculum and regulations to promote health of children. Because, there is claimed to be absence of a health promotion program in primary schools and the curriculum workload is heavy and not skills-based.

The school lacks the physical conditions like eating and sports facilities. Moreover, the cleaning and health service delivered at the school was inadequate. The administration is living severe financial problems. Moreover, the families are not supporting the school financially or personally. Thus, it is found that the school has apparent problems in promoting the health of school children and even the school staff.

CHAPTER 5

DISCUSSION AND IMPLICATIONS

In this chapter, firstly, the findings are discussed with respect to the research questions of this thesis study and then the conclusions are stated, accordingly. Afterwards, the researcher's implications for practise are stated. In the last part of the chapter, implications gathered for further social policy and educational studies are written, in details.

5.1 Discussion

In order to maximize on the effectiveness of school-wide and individual classroom teaching programs, administrators and teachers must consider student needs and their hierarchical order according to Maslow's theory (Maslow, 1943). This must be a top priority in the development of programs so that students have the capability of reaching their highest levels of potential. Schools and government agencies are aware that if students' basic needs are not met student performance will suffer. Addressing basic physiological needs is still a key concern in today's classroom. Lack of proper nutrition, personal hygiene and even sleep affects many of today's students. In lower socioeconomic areas these concerns are further accentuated. These basic needs must be met before the student can reach the next level (Maslow, 1943). According to Maslow's hierarch of needs, the need for a structured and safe classroom has to be essential for student growth and progression. A structured classroom provides psychological safety for the student. A safe environment is not limited to physical parameters. Students must not only feel safe in the classroom physically, but emotionally and psychologically, as well. The student must feel a

degree of safety in all aspects of the classroom and school environment before progressing to the next step in Maslow's theory -belongingness and love needs. Robert Slavin (2012) notes, "The most important…needs, however, may be those for love and self-esteem." The student must feel that he/she is important as an individual - that he/she is lovable and is deserving of being loved and cared about. Once these needs are met, the student may then move to the next level- need to know and understand. It is at the last level called "self-actualization" that the student is most receptive to learning.

From Maslow's (1943) perspective, the drive to learn is intrinsic. Learning contributes to psychological health. Self-actualized people tend to accept themselves for what they are. They freely admit their weaknesses, but do make attempts to improve. They don't worry excessively over the mistakes they have made, but instead focus on improving. They respect and feel good about themselves. However, this self-love is healthy and not narcissistic. They are less restricted by cultural norms than the average person. They feel free to express their desires, even if contrary to the popular view. These people have frequent peak experiences, in which time and place are transcended, anxieties are lost, and a unity of self with the universe is obtained (birth of a child, marriage, deciding to go to school). The challenge of teachers is to aid the student in achieving this level. As it is discussed below this case study reveals that this case school has difficulties even in meeting the most basic needs stated in the hierarchy of need pyramid developed by Maslow. Thus, it can be concluded what a child who deprives some of his/her basic needs, cannot be able and motivated to learn and attend school for completing his-her self-actualization. In the upcoming parts of this chapter the problems in meeting each level of these needs is discussed with respect to the research concerns of this study.

The findings of this study support the previous findings about the situation of health promotion and education in Turkish primary schools. The service and practises that is expected to be enforced in order to promote and

protect health of school children is inadequate in Turkey (Taşdan and Memduhoğlu, 2008). Also, Turkish primary schools do not meet the healthy environment standards (Canbaz, 2011). Moreover, the classroom teachers lack adequate training and qualifications to educate the children in terms of health promotion. There have just been new regulations and programmes written by various policy makers (Ministry of Health, Ministry of National Education) to promote health in schools, but most of these initiatives are not put into action, yet. There are still several problems in promoting health in public primary schools. In fact, it can be concluded that there is little evidence to state that the school studied promote health properly.

The findings of this study are discussed below in relation with the research questions developed for this case study to understand how Turkish public primary schools promote health. The findings stated in the previous section are grouped to answer each research question in depth. The research questions discussed in the next part are:

1. What is the current situation of health promotion in public primary schools in Turkey according to the perceptions of primary school teachers with respect to the on-going health education and health promotion policies?

2. What are the attitudes of primary school classroom teachers towards health promotion and health education?

3. What are the barriers in front of the teachers and the school to reach a health promoting education system?

4. How appropriate are the school environment and facilities designed for students to become and survive as healthy individuals?

5. What does the school population think about Turkey's health education policies and related implementations at urban public primary schools?

6. What are the teachers', the school administrators' and the parent-teacher association's recommendations for developing the current health promotion policies in public primary schools?

5.1.1 Discussion for Research Question 1

Providing that this case study has a saying on the Turkish public primary schools, this study finds out that Turkish public primary schools have serious challenges in promoting health in schools. Moreover, the teachers and the school as a whole think that there is not an expectation declared by the state for health promotion in schools. The teachers are struggling to teach the significance of health and build health promoting behaviours by their own efforts. There is not a school program established to promote health at this urban public primary school. Individual efforts of the teachers and the school administrators cannot go beyond teaching basic personal care, cleaning and healthy eating behaviours. The participants do not have the education or qualification to imagine a health promoting school as a school that is strengthening its capacity as a healthy setting for living, learning and working (WHO, 1997).

A health promoting school views "health" as physical, social and emotional wellbeing (WHO, 1998a). But, the case study reveals the fact that there are gaps to build health into any of these aspects of life at the school and in the community. The school mentioned several barriers to promote physical health in the school and worse than that the participants of this study are almost unaware of their role in social and emotional health. However, health promotion in schools have to be very important for Turkey, because the research findings in both developing and developed countries demonstrates that "school health

programmes can simultaneously reduce common health problems, increase the efficiency of the education system and advance public health, education and social and economic development in each WHO Member State" (WHO, 1997a). Therefore, improvement of health and reduction of health problems have to be achieved by building on the strengths of the schools and drawing on the imagination of students, parents, teachers and administrators. In the two sections below the current situation of health promotion is discussed in more detail.

Perceptions about Health Promotion in Schools

When the answers of teachers and administrators are evaluated as a whole it is apparent that they all agree schools are places where health education and promotion should take place.

Any children should take part regularly in educational activities. To do this, they must be healthy, attentive and emotionally secure (WHO, 2012). The World Health Organization states that schools are places where the health of students, school staff, families and other community members can be promoted. All of the participants (teachers, administrators, canteen staff and parents) agreed that schools had an important duty in promoting the health of children and others. But, this study demonstrates that there are barriers that are explained in detail in the previous section in front of teachers and schools to promote health in public schools, according to the teachers. The physical and humanitarian difficulties make it challenging to promote health in this school.

By creating schools that are health promoting, schools can promote education, as well (Bach, 2010). A child who is living with health disparities is easy to leave school because she/he loses the required ability and motivation to attain in education when his/her health is improperly functioning. The results of the study showed that teachers agreed on the fact that any health problem, flu or even a headache could discourage children to attend school and the ill students

lose their concentration and energy to learn new things properly and quickly. However, this study demonstrates that the health problems of students are not regularly monitored and recorded by the school or health professionals. The students and the school do not have direct access to health services. The families are found to be seen responsible from protecting the health of their children by the participants. Moreover, the decision of taking children with health problems to hospitals is left to the families by the teachers and the school. This finding supports that the school lacks an important feature of health promoting schools determined by the World Health Organization saying that health promoting schools have access to health services.

Mothers are more able to take care of their babies as they get even one more year of education (WHO, 1999). The babies of these educated mothers are more likely to be immunized and to get medical care. This finding of World Health Organization is supported by the views of participant teachers. In this case study, the health status of wealthier children are claimed to be better than the children with lower income. Therefore, schools are important for closing the inequalities between children with different economic backgrounds. This case study reveals the fact that the parents with less income are more likely to ignore health of their children due to reasons such as economic difficulties or inadequate parent education. The children imitate their teachers and learn basic personal care or healthy living behaviours from them. Therefore, health promotion in schools is a must to ensure raising a health aware generation.

The results of a study by Jourdan (2011) suggest that school participation in a health promotion programme does not necessarily mean that all teachers' will engage with it. The beliefs of teachers about the programmes, the school's perceptions of student behaviour, the relationships with parents and the general school dynamic are the main factors that shape the perspectives and thus commitment of teachers towards health promotion programme. In this respect, it can be concluded that the teachers in this case study are not engaged with

promoting health, deeply. Because, the relationship with parents are not strong and they felt that the general school dynamic prevented them to educate and promote health properly. They all complained about the deficiencies of the school, irrelevance of parents and their burden of duties in other educational outcomes. In this respect, a health promotion programme can face difficulties in gathering intended outcomes in this primary school. All of the teachers and administrators agreed that the parents were irrelevant to teachers' implications about healthy nutrition and healthy living. Besides, the physical conditions of the primary school are not appropriate to establish a comprehensive health promotion programme. The absence of eating and sports facilities, the lack of sufficient cleaning service, the binary education system, defective sewage system and unfeasible classroom organization and equipment (seats, air conditioning etc.) made it difficult for teachers to engage with a possible programme.

The teachers and administrators also believed that the media and can direct the youth to a single media-modelled physical appearance and health understanding. This belief was previously declared at the International School Health Network Position paper. In an increasingly media driven society where the importance of appearance is becoming more pronounced, where many consider a perfect body and perfect health to be the ultimate aim, schools are under increasing pressure to contribute to the promotion of a single healthy mode of living or a body cult (IUHPE, 2009).

Importance of Pre-Service and In-Service Trainings

All of the participant teachers mentioned that they had decreasing authority in the education system and thus they were forced to be less effective in health promotion likewise in other educational areas. This feeling may be due to the fact that, the teachers lack the necessary in-service and pre-service

trainings that is important to be in command of the students. They did not feel qualified to promote health adequately. To build a common culture based on health promoting school approach, the development of comprehensive, both pre-service and in-service, professional development programmes are key issues (Jourdan, 2011). The teachers' and the administrators' health promotion knowledge is generally limited and just about nutrition, hygiene and personal care. The study conducted by Yager and O'dea (2005) puts emphasis on the importance of in-service and pre-service trainings of school professionals. The success of programmes focusing on the prevention of eating disorders and child obesity urgently depends on pre-service and on-going training for the various school professionals involved. In-service training improves health education and teachers feel more confident about health education (Jacobs and Wylie, 1995).Teachers in Prelip et al.'s (2006) study reported lack of training as a barrier to both nutrition education and physical education.

This case study found out the same result. All of the participants explained that they did not get pre-service academic education or in-service health promotion trainings to establish a skills-based behaviour building education system in their classrooms. The current university education in educational faculties is insignificant for these experienced teachers who have been graduated from university years ago. They should be given comprehensive in-service trainings to improve their knowledge, awareness and motivation to promote health in schools. However, they mentioned that they did not get in-service trainings about health promotion. Most of the teachers could not name any in-service training they took about health related issues. Only one of them stated that he attended a seminar about the harms of smoking and only one teacher said that she attended a seminar on first aid. The teachers who attended in-service trainings about health related issues claimed that the trainings were full of information and there was nothing told about how to protect the health of children or to integrate the information told in practise. The trainings were said

to be unprofessional and careless. The teachers all complained about the lack of professional and comprehensive in-service trainings that is crucial for health promotion in schools. Providing the fact that lack of training is barrier to both nutrition education and physical education, Turkish public primary schools have to sustain in-service trainings that offer applicable and comprehensive practises for health promotion in schools.

5.1.2 Discussion for Research Question 2

Teachers participating in this study all felt that they were responsible from teaching healthy living to their students and they should try to promote their health. Jourdan suggests that teachers who believe that they have an impact on promoting healthy lifestyles and teachers who perceive their role as a means of school improvement are more likely to implementing health promotion programmes. This is a key factor since teacher's views of their role in health promotion are closely linked to teacher's professional identity (Jourdan, 2010). Within this respect, this study concludes that the teachers face serious difficulties in promoting health and they do not feel qualified enough for health promotion, but they believe in their impact on the health of children and are willing to teach and promote health to their students. Therefore, improving the other factors like physical school conditions or parent relationships are expected to be effective to implement a successful health promotion program at this school. In the section below, the efforts and activities that are done to promote health in the school is discussed in details.

The teachers participating in this study try to educate the students about cleaning and personal care. They try to set values in their minds about healthy eating. The teachers' efforts remain as individual attempts, which contribute only to their own students. These initiatives are important but not sufficient for health promotion, because health promotion requires practises, equipment,

physical facilities and family and state engagement as a comprehensive policy approach (WHO, 1999). Equal treatment for all students, drug and alcohol use, tobacco use, first aid, nutrition, physical exercise and violence are policy areas that help prevent or reduce physical, social and emotional problems (WHO, 1996). Drug and alcohol use, tobacco use, first aid, nutrition, physical exercise were the areas in which the teachers spare time to teach and practise in their classrooms. But, the teachers and administrators did not mention any efforts to prevent social or emotional problems as a health promoting activity. This may be due to the fact that they perceived health promotion only as a kind of hygiene or healthy eating issue. Here, it can be agreed that although teachers were aware of the importance of health promotion in schools, they did not have the holistic approach to define and apply health promotion in a complete way.

The teachers participating in this study seem not to have adequate knowledge about the programs of primary education courses like Games and Physical Activity course and Knowledge of Life course that aim to practise and teach healthy living. The Ministry of National Education (2012b) states that games and physical activities are important for students to have the opportunity to improve their physical, social and mental capabilities and promote their health as a result. Therefore, developing frequent participation habit starting from primary school is stated to be one of the most significant aims of general education. This course has intended outcomes which seem appropriate for promoting the health of children. But, the teachers and the administrators all agreed that the curriculum ignores health promotion and education. It can be concluded that there is a severe gap between the policy makers and the implementers. The curriculum was not successfully put into practise.

Students can access to health services easily in health promoting schools (WHO, 1996). These services such as screening, diagnosis, monitoring growth and development, vaccination, selected medications and procedures are best provided in the school settings. But, this study reveals the fact that professional

health controls like teeth or eye-sight were not done regularly by the state health service providers. Moreover, the teachers can only warn the parents about the children's illness but not take further action like providing a health service for the children. IUHPE states that healthy school policies, school environment (physical and social), individual health skills and action competencies, community links, and health services are essential to establish health promoting schools (IUHPE, 2008). In that sense, the case school is lacking another feature of a health promoting school definition.

5.1.3 Discussion for Research Question 3

The barriers in front of promoting health in the school mentioned by the participants of this study are the small canteen, the unhealthy playground, binary education, difficulties in hygiene and cleaning, irrelevant families, procedures of the ministry, absence of professional health personnel, curriculum and the teachers' level of qualification. These barriers reveal the fact that the school is not carrying the most six basic features of a health promoting school according to World Health Organization (WHO, 1996). The teachers, students, parents and administrators are not fully engaged in promoting health. The school do not provide a healthy and safe environment both physical and psychosocial. The curriculum does not provide skills based health education. The school does not provide access to health services. School policies and practises that support health are not implemented in this school. Health promoting schools strive to improve health of the community, but this school has no efforts to do so. In the section below these barriers are discussed in detail.

Taşdan and Memduhoğlu (2008) say that in Turkey, health education is given during some lessons under subjects like traffic and first aid. This study finds out that the physical education courses (or Games and Physical Activity courses) are delivered by classroom teachers instead of a physical education

teachers. No health staff is working in most of the public schools. No protective activities are executed in primary schools, so that infectious diseasas spread rapidly, and they can also effect the outside society. Also, the schools are not physically well built. Soultatou et al. (2009) mention that those teachers' taking insufficient in-service trainings in health-related content and the lack of innovative teaching methods prevent teachers from applying health promotion content into practice.

Teachers and school principal of this study reported various barriers in front of health promotion. Teachers have limited training about nutrition education. The physical condition of school, binary education system, limited cleaning services, scarce monetary resources, weak family (parent) support, and long procedures in front of practical education, curriculum workload and limited teacher qualification are the barriers that the participants of this study declared as barriers that prevent the promotion of health in schools. As findings of other researches in Turkey reveal similar facts, it can be concluded that these barriers are valid for Turkish primary education system that have to be solved quickly in order to achieve health promotion in primary schools.

This study concludes that parents are not actively participating in their children's educational voyage. The teachers, the administration and the school-parent association believed that families are uneducated or irrelevant about health promotion. Their attitudes towards preparing lunch boxes, encouraging the child to do sports, caring for his/her personal care and their interaction with the teacher or the administration was claimed to be weak by the participants of this study. Other researches support that parents are not caring for their children's nutrition at school (Şimşek, 2009). The families have to get the necessary education according to Şimşek and the participants of this study.

All of the teachers and the principal in this study agreed that the primary school curriculum was not comprehensive and practical. Herbert and Lohrmann find 9 common characteristics of successful health education curricula:

comprehensive and varied teaching methods, sufficient dosage, theory-driven, opportunities for positive relationships, appropriately timed, culturally relevant, included outcome evaluation, and delivered by trained teachers (Herbert and Lohrmann, 2011). However, the curriculum was mentioned not to be skills-based. The curriculum aims to build behaviours in many fields including health but, the classroom programmes lack to show the necessary actions to develop skills. The teachers desired more practise and application in every educational aspect as well as in health promotion. The time schedule for giving promoting health was not spread all over the educational year. The curriculum was claimed only to put emphasis on health when there were relevant reading texts in courses like Turkish or Knowledge of Life. The health promotion is stated not to be present in other courses like mathematics or language skills. However, for successful health promotion, health should be integrated in all aspects of the school and courses. There is a course called Games and Physical Activity included in the basic education curriculum last year but the participants seemed to be ignoring or unaware of the intentions of this course focusing on health promotion.

The teaching methods found in effective health promotion programs stressed active, skill-based learning for students (Herbert and Lohrmann, 2011). For behaviour change, skills, rather than facts, were found to be the major catalyst. But, in the school, all the teachers agree that the curriculum and education system was based on giving knowledge and facts. Although, the current curriculum established in 2012 writes health culture as one of the target acquisitions of the primary education system, living healthy or caring for health is not reported as a basic personal feature that the education system tries to create. Health culture is seen as a sub-discipline rather than a skill of competence in Turkish education system. The policy makers should take into account that a child who has not developed health awareness and who is not living healthy cannot feel self-confident or not be open to change. The

curriculum is now based on structural learning. However, active learning should be the main method to implement health promotion in schools. Without active learning strategies; the majority of the other characteristics of effective health education become inconsiderable, because active learning strategies are the key to effectiveness.

An overall policy supported by school administration as well as by teaching practices that help to create a healthy psychosocial environment for students and staff is appropriate for promoting health at schools (WHO, 1998b). The teachers of this case study were totally unaware of the "Turkey Healthy Nutrition and Active Life Program" program established by the ministry of health in 2010. They were not informed about responsibilities of schools and teachers. Moreover, the school parent board was not aware of the program, either. However, as well as the school engagement, the participation of the families and the society in health promotion policies and programs are important to achieve the intended improvements in health status and wellbeing of children (Yabancı, 2011). All of the participants (teachers, administrators and school-parent board) told that the policies and programs employed to promote health could not get the support of families and other community groups like health professionals, civil society organizations or other state institutions. Thus, it can be concluded that besides policies and programs to promote health in schools, social polices engaging the whole society in health promotion is required for enhancing the wellbeing of the children, families and thus society.

5.1.4 Discussion for Research Question 4

The school environment and facilities are criticized by the participants of this study in terms of lacking the desired features for promoting health and sustaining a healthy environment for children and school personnel to live, learn

and work. The section below gives detailed discussion about the general condition of the school environment and facilities.

Even minimum facilities for latrines and safe water are not available in many schools (WHO, 1995). But the schools that are health promoting should have sufficient sanitation and water. They should be free from abuse and violence and they must have a climate of care, trust and respect, social support and mental health promotion, safe school grounds, opportunities for physical education and recreation. With these qualifications health promoting schools endeavour to provide a safe and healthy environment (WHO, 1996). When the case school and its facilities are evaluated, it can be easily concluded that, most of these requirements are not met. A proper sanitation and access to clean free drinking water is not available. Teachers mentioned that the children are subject to abuse and violence by their families or environment. The findings reveal that the students did not have a safe playground or social support. Moreover, the school lacks opportunity both for healthy nutrition and physical activity, because there were no sports halls or equipped eating facilities (except for an inadequate canteen serving almost packaged food). The physical education courses are delivered by classroom teachers instead of physical education teachers.

Anybody, who is asked to state the possible basic requirements of a primary school where children spend most of their daily lives, may answer that a primary school should be a place that the children can eat and play healthily to learn and grow up properly. But, unfortunately the school lacked these basic functions. Even, the deficiencies of healthy nutrition and physical activity opportunities throw the school far apart from the league of health promoting schools. A child, who cannot eat healthy food, nor play or do sports in a healthy environment, cannot build healthy behaviours, cannot develop healthily, cannot learn properly and cannot achieve well, academically.

5.1.5 Discussion for Research Question 5

The school administration shared the opinions of the teachers in almost every aspect on health promotion. The administration is aware of the the importance of health promotion in schools as well as the barriers in front of promoting health. Especially, the school principal stated that the education policy in Turkey is not adequate for promoting health in schools. This consistency in the views of the teachers and the administration is strengthening the validity of this study that the public primary school tries individually to promote health but there are radical changes required both in the physical conditions of the school and minds and qualifications of teachers, administrators, parents and students to achieve the intended health promotion. In the section below the discussion about school administration's views is given.

Instead of general thought, local characteristics such as the school district and the headmaster and external factors such as government and other agencies, are not mentioned by teachers participating in a previous study as being critical for their involvement in health promotion (Jourdan and Stirling, 2011). The results of this study reveal similar findings. Teachers agreed that the administration had no resource or authority to promote health in schools. The changes in the education system (4+4+4 System), monetary problems and other administrative problems were the main concerns of the administration. The principle himself agreed that health promotion was very important but the burden of other problems and lack of monetary resources limited his play ground. He wanted to hire more cleaning personnel and equipment but, the budget of the school was even not enough for meeting these needs. The school administration perceived teachers as important agents for health promotion. Both of the administrators thought of their role in health promotion as improving the physical conditions of the school. But, they have mentioned nothing about implementing projects or practices to promote health in this

school. They were unaware of the fact that the school administration can change the understanding of the whole school participants about health promotion by implementing projects or policies.

The World Health Organization states the lack of resources (financial and human resources, materials and organisational infrastructure) and moreover little importance given to the provision of these resources which undermines the achievement of educational and health outcomes, as a barrier for the health and education of children and adolescents (WHO, 1995). This study demonstrates that the school has another challenge here, to promote health. The principal of the school agreed that materials and equipment for teaching health, even minimum facilities as latrines and safe water were not available in many public primary schools. The school principal complained about the ignorance of the state and the ministry about the problems of primary schools. He mentioned that Turkey does not have an intrinsic national education system, so that the country cannot solve the educational problems and raise healthy generations. It can be concluded that the administrative difficulties are rendering both health and education impossible.

5.1.6 Discussion for Research Question 6

The participants of this study agreed that improved and expanded investment in this school is required to enable comprehensive health promotion. As globally admitted, education is a fundamental human right. All the children, including the ones with impairments, have the right of accessing education in schools that meets the full range of children's learning and developmental needs (WHO, 1998b). To ensure this right this school have to be rebuilt according to the school principal. Because, the old school buildings and court have permanent structural problems such as sanitation, air conditioning and size of classrooms.

Safety is an important factor of a learning environment. Thus, every school must provide a safe learning environment for students and a safe workplace for staff according to World Health Organization (WHO, 1998b). The physical and emotional health of children can be threatened by the school environment. Schools should protect children from diseases, discrimination, harassment, abuse, and violence; and reject the use of tobacco, alcohol and illicit drugs. The entrance to the school yard is not controlled and students can leave the school area easily without tackling any barriers. The teachers and administrators have different recommendations for the safety of the school. Security personnel should be employed at the entrance of the school according to two of the teachers. The walls surrounding the school yard have to be raised according to the assistant school administrator. But, the participants all agreed that apart from the security problem related with the outside, the school have more significant problems inside the school borders. All of the participants agreed that the playground have to be rebuilt to become a healthy and secure area to prevent injuries. Also, the classrooms, doors, stairs and other school facilities have to be reviewed to ensure security. The participants did not mention any recommendation for preventing violence or discrimination, not because there exists none, but more likely because they are unable to create solutions for these problems. This finding supports the fact that the teachers and the administrators are unaware of the significance of emotional and social wellbeing of children for health promotion. They are basically focused on the physical health of the students.

The World Health Organization mentions that every school must enable children and adolescents at all levels to learn critical health and life skills (WHO, 1998b). The teachers all agreed that the health education in schools should teach life skills that can enable children to make healthy choices and adopt healthy behaviour throughout their lives. The health education should be

skills-based and focused. The teachers recommended that the education system had to be based on practise and develop skills, instead of sole information.

Schools have to provide nutritious and healthy food that is needed to foster the growth and development of children, to prevent diseases and to reduce hunger according to the teachers of this study. The participants and the children live difficulties in having nutritious ad healthy meals at school. The participants all agreed that primary school should have equipped eating facilities that served food for the whole school population.

The World Health Organization suggests that oral, vision and hearing health problems should be identified by school and these problems have to be treated when possible. Besides these physical precautions, psychological problems have to be recognized and those children should be directed to take appropriate treatment (WHO, 1998b). The same recommendations are declared by the teachers participated this study. The health problems of children are not identified nor treated by the school. The families are dealing with the children's health problems, but taking into account that these families are seen as irrelevant, the schools should provide the necessary health services to take care of the students.

Policies, legislation, and guidelines must be developed to ensure the identification, allocation, mobilization and coordination of resources at the local, national and international levels to support school health (WHO, 1998b). The teachers were complaining about the lack of a comprehensive policy or program to promote school health. They were also worried about the increasing responsibility and decreasing authority they were given. The frames of responsibility and accountability must be drawn clearly for comprehensive school health programmes. The teachers and the school principal stated that they should have a balance of responsibility and accountability. They want to be empowered to have the adequate time and tools to promote health of their students.

The teachers and other school staff must be supported properly to enable them promote health. Teachers, school staff and school administrators should be given the resources that will train them about the health and educational needs of children. The participants declared that there should be adequate and professional in-service trainings for health promotion and university education of teachers had to be regulated to include health promotion in their curriculum.

All of the participants of this study agreed on the fact that the families and schools had to work together to support education and health. Active consultation and collaboration among families, the community and the school to improve the health of children and adolescents is required. The school and student must participate actively in programmes to improve the health and development of the entire community according to the World Health Organization (WHO, 1998b). This belief is shared by the school principal and he mentioned that, families, schools and students should come together to promote health in schools.

To conclude, it can be seen that the participants of this study are willing to improve the current situation of health promotion in schools. They are not only stating the problems, but also thinking on how to reduce the problems. Their practical and result oriented recommendations go hand in hand with the recommendations of the World health Organization which is one of the leading organizations in health promotion. Protecting and enhancing the physical health of students is mainly taken into account by the participants. However, there is evidence that the participants do not have a comprehensive knowledge about the emotional and social dimensions of health promotion in schools. The emotional and social wellbeing is not considered as a recommendation heading for most of the teachers and the administrators. As a result, this case study finds out that health promotion in schools is mainly seen as a matter of physical health and the school population have to improve its vision including social and emotional

wellbeing to recommend enhancements for a comprehensive health promotion system.

5.2 Conclusions

The recent regulations closed an important gap in Turkish education and health policy by regulating the sales of food at school canteens and by distributing milk at schools. But these implementations are not sufficient for establishing health promoting schools in Turkey. This case study that searched how public urban primary public schools promote health in Turkey reveals important clues about the possible problems and necessities of Turkish public primary schools. There is still a long way to go for the policy makers to establish a comprehensive health promoting system in schools.

First of all, teachers, **parents, health officials and other community services seem not to be engaged** in health promotion, yet. At health promoting schools, health and education officials, teachers and their representative organisations, students, parents, and community leaders are all engaged in efforts to promote health, with families and community groups. Moreover, these schools outreach health promotion for school staff. However, in this case study, it is found to be an apparent interval between the families, the school and health officials.

The school studied **lacks sufficient sanitation and clean water**. There is a severe service and infrastructure problem in cleaning and sanitation. Providing the participants of this study have true information about the conditions of other schools, the cleaning and sanitation problem is likely to be true for a significant proportion of Turkish public primary schools. Furthermore, the children cannot use tap water for drinking. As a result they have to bring their own drinking water from home or buy from the school canteen to drink safe water.

Sustaining students two basic rights, healthy eating and healthy learning, are under the risk of infrastructural problems. The **lack of healthy eating, playing and learning facilities** challenges the school population and is likely to cause physical or emotional health problems at this case school. Moreover, according to the opinions of teachers, the children are **not free from abuse and violence**, unfortunately. Other students, foreigners in the school yard, the teachers and even the families are claimed to give psychological harms to the children. There is little known about the reasons and solutions of this problem by the teachers or the administrators. As a whole it can be said that the students of this school are not living in a healthy environment.

The primary education curriculum implemented at this school is claimed not to provide skills-based health education which is a prerequisite for health promotion. Due to the lack of practise and sufficient active learning activities in the curriculum, the children cannot integrate school in their daily lives. Therefore, children tend to know, but ignore to implement the principles taught at school. But, there is a significant contradiction emerging, here. The teachers participating in this study seem not to have adequate knowledge about the programs of primary education courses like Games and Physical Activity course and Knowledge of Life course that aim to practise and teach healthy living. The curriculum is renewed at the beginning of 2012 but the teachers are not mentioning any positive changes in the curriculum. The Ministry of National Education (2012b) states that games and physical activities are important for students to have the opportunity to improve their physical, social and mental capabilities and promote their health as a result. The new curriculum has intended outcomes which seem appropriate for promoting the health of children, according to the curriculum review of this study. But, the **teachers and the administrators all seem to be unaware of the new curriculum and course programs**. It can be concluded that there is a severe gap between the policy makers and the policy implementers or that the teachers are really uneducated

about the aims, intended outcomes and teaching methods of the courses. The new primary school curriculum was not implemented in this public primary school. The teachers and the administrators were not aware of the latest version of the course programmes. There is another possibility that, the teachers do not have the tools and qualification to understand and implement the new course programs in classrooms. In both cases the result does not change: health promotion in the school is losing blood. It does not matter how a fulfilling curriculum the policy-makers develop, it is crucial for change that how much the policy implementers are aware and engaged in the curriculum.

The teachers declared that **the health services** provided by the state were very rare and not functional. Children should and must get a functional health service in schools and their health as well as their education has to be secured by laws and policies. But, the studied school do not have direct access to health services. The findings of previous literature strengthen the possibility that this can be true for all public primary schools. Services such as screening, diagnosis, monitoring growth and development, vaccination, selected medications and procedures have to be provided at schools. It is obvious that establishment of these services depends on school resources. However, the school does not have resources even to sustain adequate cleaning service. Moreover, the families are often accused of not monitoring and taking care of their children's health problems, timely. Also, the teachers do not feel qualified enough to handle with health problems. In this respect, existence of professional health personnel is essential at primary schools. The school requires a professional health officer to protect, treat and promote health of the children. Moreover, partnerships with local health agencies and direct access to health services from schools are required for health promotion in schools.

Turkey is a social state as defined in the constitution and the children have to be seen as the future of this state. But there are prominent **gaps in the current regulations and policies** administered to promote health of children. A

comprehensive policy supported by school administration as well as by teaching practices that help to create a healthy psychosocial environment for students and staff is appropriate for promoting health at schools. Equal treatment for all students, drug and alcohol use, tobacco use, first aid, nutrition, physical exercise and violence are policy areas that should be studied to prevent or reduce physical, social and emotional problems.

A **comprehensive health promotion program is required** in this public primary school to achieve better educational and health outcomes needed for social and economic welfare. In this respect, the programme called “Turkey Healthy Nutrition and Active Life Program” can be seen as an important step for establishing health promotion in schools. However, this program lacks some basic points. First of all, although the programme determines building healthy eating and physical activity behaviours and habits to children as a core target, the strategies and actions related are mainly focused on improving the knowledge and awareness of children, but not on techniques and instructions about how to improve these behaviours. The programme discussed is aiming to prevent obesity; hence the other aspects of health such as, emotional and mental wellbeing are not included within this programme. Emotional, social and mental wellbeing is not subject of any other policy programme, as well. Thus, even if the “Turkey Healthy Nutrition and Active Life Program” is implemented comprehensively and successfully, there will still be a crucial gap in Turkish education system in terms of health promotion.

To sum, although, it will be misleading to generalize this study’s findings for all primary schools in Turkey, the similarities with the previous findings and the socioeconomic background of the school may lead to think that this case is conducted with an average sample of population that resembles the basic features of Turkish education system. None of the results are standing away from the general situation stated in the former studies. This study supports the previous literature that Turkey requires a comprehensive health promotion

program in schools. In Table 5.1, the conclusions gathered through this study are summarized.

When the answers to the research questions of this study are reviewed, it can be concluded that teachers are aware of their significance and perceive themselves as role model in health promotion. But, there are several barriers in front of them that prevent promoting health in school. The curriculum, the school facilities and environment, pre-service and in-service trainings, definition of authority, parents, monetary and structural limitations, working conditions and policies are affecting the teachers' willingness and ability to promote health in schools. The administrators and the parent-teacher association are supporting the existence of these barriers. All of the participants agreed that health promotion in schools is a must not only for the child but the community as a whole.

Table 5.1 *Summary of Conclusions*

1	Parents, health officials and other community services seem not to be engaged in health promotion.
2	The school lacks sufficient sanitation and clean water.
3	The lack of healthy eating, playing and learning facilities challenges the school population.
4	The children are claimed not to be free from abuse and violence.
5	The current primary education curriculum executed by teachers was not skills-based.
6	The teachers and the administrators all seem to be unaware of the new curriculum and course programs and regulations related to health promotion.
7	The health services provided by the state are very rare and not functional.
8	There is not a comprehensive health promotion program implemented in the school.

The findings studied in this report should lead new research areas to improve the literature that will show pathways to the social policy makers to develop and implement new projects and programs to promote health. It is concluded by this case study that social policies to establish a comprehensive health promotion system is required in Turkish public primary schools, to enhance the educational attainment and health status of the children and the society as a whole, which will in turn increase the welfare and productivity of the state.

5.3 Implications for Practise

The implications of this case study explained below can yield data for social policy makers to develop new policies and programs to promote health in middle-sized urban public primary schools whose populations are consisted of migrants from rural areas and that are located in neighbourhoods with lower socio-economic status.

It should be taken into account by policy makers that **an investment in education is an investment in health.** The health of children significantly affects their ability to learn. Schools should be healthy organizations in order to become health promoting environments. In sum, the following implications emerged from the current study are stated below for policy makers that consider health promotion in schools:

1. Investment in schooling and establishing health promotion programs in schools.
2. Providing a healthy physical and emotional environment for the children.
3. Improving and expanding educational opportunities for girls.

4. A safe learning environment for students and a safe workplace for staff.

5. Development of skills-based health education system.

6. Direct access to health services.

7. Renewal of infrastructure at schools.

8. Policies, legislation, and guidelines to ensure the identification, allocation, mobilization and coordination of resources.

As globally admitted, education and health are fundamental human rights. All the children, including the ones with impairments, have the right of accessing education in schools that meets the full range of children's learning and developmental needs (UNICEF, 1998). Moreover, they have the right to live, learn and study in healthy environments. The determinants of health, such as creating health gain for individuals, contributing to the reduction of inequalities in health and building human capital are affected from health promotion through investment and action. Thus, based on this study it can be argued that **investment in schooling and establishing health promotion programs in schools** should be seen as essential by policy makers.

Sustaining cleaning services and sufficient sanitation is very important for a healthy school environment. Lack of hygiene is one of the main complaints of the participants of this case study. Also, healthy eating and physical activity facilities are required for health and education. The school could not **provide a healthy physical environment for the children** due to financial problems. The school should be given the budget and staff (cleaning and professional health personnel) to improve the physical conditions of the school.

Due to the fact that it is significant for countries to have mothers who are well educated and healthy, in order to maintain economic and social development, the girls who are future mothers of the society have to catch boys in terms of school enrolment and retention. The girls should get full educational

participation. **Improving and expanding educational opportunities for girls** is thought to be one of the best health and social investments a country can make. The education of girls can break down all the social, cultural and economic barriers.

Safety is an important factor of a learning environment. Thus, every school must **provide a safe learning environment** for students and a safe workplace for staff. The physical and emotional health of children can be threatened by the school environment. Schools should protect children from diseases, discrimination, harassment, abuse, and violence; and reject the use of tobacco, alcohol and illicit drugs. Training programmes can be developed to inform and activate students and schools about the risks. Moreover, the schools should be given sufficient budget for ensuring the safety of the school and its environment.

The school must enable children and adolescents at all levels to learn critical health and life skills. The **health education should be skills-based** and focused. Infectious diseases, nutrition, preventive health care and reproductive health topics should be covered in the curriculum. Life skills educations that can enable children to make healthy choices and adopt healthy behaviour throughout their lives are required. The health education given to children should protect their current and future families and the community they live in.

Schools may act as an entry point for promoting health of children and intervening health. The school studied should have **direct access to health services**. Schools should prevent when possible, treat when effective, and refer when necessary the common health problems of children and staff. The school have to provide nutritious and healthy food that is needed to foster the growth and development of children, to prevent diseases and to reduce hunger. The use of alcohol, tobacco and illicit drugs should be reduced by programmes established by schools. Infectious diseases such as skin and respiratory infections have to be treated properly and timely. Oral, vision and hearing health

problems should be identified by school and these problems have to be treated when possible. Besides these physical precautions, psychological problems have to be recognized and those children may be directed to take appropriate treatment.

The **infrastructure of the school has to be renewed** before implementing health promotion policies. A sports hall without appropriate play ground or rest rooms cannot be utilized effectively. Thus, completing renewal of schools is also another action that has to be taken within this programme. This renewal will apparently require a noteworthy expenditure, which will challenge the government budget. Once, the current monetary source challenges are considered, funding and allocation of extra resources should be planned carefully.

The **binary education** system is found to cause health promotion problems for the school, besides other difficulties. It is implicated that the education system can be revised and all primary schools should give whole-day education. This will not only decrease the hygiene and cleaning problems but also will create time for the students and the teachers to have time for health promotion activities. Dirty classrooms and toilets, limited school time, absence of lunch break and inadequate course hours for promoting health are problems that can be reduced by cancelling binary education in public primary schools.

Policies, legislation, and guidelines can be developed to ensure the identification, allocation, mobilization and coordination of resources at the local, national and international levels to support school health. To achieve this, first of all, decision-makers and the public must understand that schools could provide the most cost-effective means to improve the health of children and thus to advance social and economic development. Health and education ministries should actively collaborate. School health committees and networks may include representatives of government agencies (such as transport, planning, agriculture and physical exercise and sport) and non-governmental organisations

who can contribute expertise and resources necessary to improve comprehensive school health programmes. Policies, legislation, and guidelines have to identify, train and develop qualified staff at the national and local levels. The frames of responsibility and accountability may be drawn clearly for comprehensive school health programmes.

The teachers and other school staff must be supported properly to enable them promote health. The teachers, school staff and school administrators should be given the resources that will train them about the health and educational needs of children. University education of teachers has to be regulated to include health promotion in their curricula, so that the teachers can be prepared for health education and promotion before they start working. Besides **pre-service trainings, in-service trainings** have to be developed by education and health authorities and non-governmental organizations that will help to improve the health of children and their families. Moreover, there may be facilities and opportunities for teacher, school staff and school administrators to improve their own health. Also, **economic and working conditions of the teachers** have to be improved to engage them in health promotion.

Families, community members, health service agencies and other institutions have an important role to play in improving the health of young people. At the same time, the school can play an important role in improving the health of the community as a whole. The community and schools have to work together to support education and health by advocacy and support for the development of the school as a healthy organisation. Active consultation and collaboration among families, the community and the school to improve the health of children and adolescents is required. The school and students can participate actively in programmes to improve the health and development of the entire community.

The **programs in the school should well-designed, monitored and evaluated** to ensure their successful implementation and outcomes. The

programmes have to be able to develop and adopt affordable and appropriate data collection methods to determine children's health education and living condition according to their sex and age group. The health promotion programmes should emphasize the previous researches about the knowledge and skills of local educators, students, families and community members. New methods have to be developed for rapid analysis and utilization of data at local level.

Health promotion in schools does not have a meaningful implication without **improving the health of the community** as a whole. Thus, attention should be paid to community health concerns and participating in community health projects.

Local communities and schools have to be supported internationally to enhance their ability of health promotion. **A global school health initiative** could be developed by organizations like WHO, UNESCO, UNICEF, UNFPA, the World Bank, the World Food Programme, Education International, the International Union for Health Promotion and Education and others (WHO, 1998b). Their support should include coordinating among international organisations and Member States to share efforts, reduce fragmentation and duplication of effort, and establish a broad vision of comprehensive and integrated school health programmes.

As the last word, it is important to consider what the teachers can do for promoting health in classrooms. Maslow states that self-actualized people are mentally and socially very likely to be physically healthy, able and willing to learn (Maslow, 1943). Likewise, the purpose of learning is to bring about self-actualization, and thus the teachers should include this process as a goal of education system. There are actions that the teachers can take in order to ensure self-actualization of children. First of all, it is crucial to **understand that each student brings his/her own unique background** to the classroom. A student's readiness to learn is not solely dependent upon existing knowledge and skills.

We must develop a relationship with the student in order to determine their current readiness level. Once determined, we must develop a strategy to address current needs as well as the needs in the next level. In many instances this may involve additional community and governmental resources, especially at the lower levels. Afterwards the teachers have to **create a safe classroom environment.** They should develop rules and procedures which provide a structured environment rich in routine and shared expectations. They must use positive reinforcement instead of negative reinforcement to correct student behaviours. The teachers can develop practises to take time out to let each student know how well they are doing. The key must be to focus on the students' positive attributes and aid the student in developing an increased level of self-esteem. Lastly, the teachers should let **students know that teachers care about them.** The teachers should take the time out to explain issues and concerns with them. When feasible, providing student participation in the class decision making process is a good practise for sustaining self-actualization.

5.4 Implications for Further Research

This study found out that teachers who are the main change agents in health promotion are neither properly trained nor engaged in health promotion due to several external and internal factors. The teachers participating in this study are experienced classroom teachers, but they did not get enough pre-service or in-service trainings to adapt the significance and tools of health promotion. A further study should be employed to reveal the factors that prevent teachers from promoting health in Turkish urban public primary schools. Moreover, the less experienced teachers have to be studied to develop a claim that will cover teachers from all levels of experience.

The facilities and environment of the school is not sufficient for implementing a health promotion program. The reasons and solution offers to

enhance the situation of public primary schools can be another research area for experts who are interested in health promotion and education. Besides the physical conditions, the impacts of school staff (teachers, administrators and others) and the approaches of families are also important for constructing a healthy school climate. Thus, the barriers and facilitators that affect health promotion and education in schools have to be studied in a qualitative study to gather generalizable findings that can have an influence on policy makers.

There are recent regulations like “Turkey Healthy Nutrition and Active Life Program” that can improve the health promotion system in Turkey. But, still the recognition of the program is limited and the school is unaware of its duties and responsibilities to achieve the targets stated by health and education policy makers and authorities. The aim and targets of the program could not be transferred by the program developers to the schools which are crucial action areas of this program. The program was announced in 2010, the strategic plan was also published in the same year, but neither the school administration nor the teachers knew anything about the presence of this program. The reasons behind this unsuccessful program implementation or the delay of school based applications of this program can be investigated so that, there can happen quick policy actions to promote health in schools. The reasons may produce the solutions within themselves to handle the bottlenecks of the program which is aiming to reduce obesity and encourage healthy living in Turkey.

Another, further research should be done to understand the parameters behind the irrelevance of families to the education and health of their children. All counterparts, including teachers, administrators and even parent from the school-parent board mentioned their complaint about ignorant families. Families are important rings of the education chain, thus knowing the problems behind their irrelevance can contribute to design policies to motivate and train them to take active part in their children’s health and education.

The curriculum of basic education should be analysed comprehensively to reveal the barriers it sets in front of skill development for health promotion. The burden and distribution of subjects should be reviewed, because teachers have agreed that the curriculum is loaded too much to spare time for extra efforts to execute more active learning applications, including activities for health promotion to build health skills. Also, the procedures and regulations limiting the teachers and administrations to take initiatives have to be examined to picture the current system of education in Turkey.

In a social policy context, this study examined how Turkish urban public primary schools promote health with a case study. To sum, this study is revealing the truth for a small portion of Turkish educational system. However, this study aimed to fire a flame for further comprehensive social policy research studies, that are sponsored and conducted by the government, academicians or global organizations, hence here there is more than enough finding that Turkey need a national health promotion program in schools both for educational and wellbeing concerns of the society , as a constitutionally named “social state”.

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APPENDICES

Appendix A: Teacher Interview Form

ÖĞRETMEN GÖRÜŞME FORMU

Tüm dünyada okullarda sağlık eğitimi ve sağlığın teşviki konuları önem kazanmaktadır. Bu görüşme formu Türkiye'de ilkokullarda verilen sağlık eğitimi ve sağlığın teşviki ile ilgili uygulamaları araştırmak için düzenlenmiştir. Bu kapsamda okulunuzda bir durum incelemesi yapılması öngörülmektedir.

Söz konusu araştırma Orta Doğu Teknik Üniversitesi'nde yapılan bir Yüksek Lisans Tezinde kullanılacaktır. Araştırmacı bu çalışmayı gerçekleştirmek için ODTÜ Etik Kurulu ve Milli Eğitim Bakanlığı'ndan gerekli izinleri almıştır.

Bir öğretmen olarak sizin tarafsız ve aydınlatıcı görüşleriniz bu çalışmanın gerçekleştirilebilmesi için çok önemlidir.

Bu çalışma kapsamında araştırmaya konu olan okulun ve görüşleri alınan kişilerin isimleri tamamen gizli tutulacaktır.

Bu görüşmenin sadece araştırmacıda bulunması koşuluyla kayıt altına alınmasına izin veriyor musunuz?

A. Önbilgiler

Kişisel Bilgiler

1. Hangi üniversite ve bölümden mezunsunuz?
2. Öğretmenlik mesleğindeki deneyim süreniz ne kadardır?
3. Ne kadar zamandır bu okulda görev yapıyorsunuz?

Öğrenci ve ailelerin sosyo-ekonomik durumları ile ilgili bilgiler

1. Çalışmanın amacına ulaşması için okulunuza devam eden öğrenci ve veli profili ile ilgili bilgi toplamam gerekiyor. Genel olarak öğrencilerinizin ve velilerinin sosyo-ekonomik durumlarını anlatır mısınız? (gelir düzeyi, eğitim durumu, mesleki dağılım, cinsiyet, aile yapısı, kültürel etkinlik, eğitime katılım, sosyal hayat)

B. Öğretmenlerin sağlık eğitimi ve sağlığın teşvik edilmesi ile ilgili görüşleri, bilgileri ve icraatları.

1. Son dönemde medyada, sağlık eğitimi özelikle de sağlıklı beslenme ile ilgili vurgunun arttığını görmekteyiz. Bu konuda Milli Eğitim ve Sağlık Bakanlıkları'nın yeni genelgeleri var. Okullarda bu konuda düzenlemeler yapılması öngörülüyor. Sizce, okullarda sağlık eğitiminin verilmesi ve sağlığın teşviki neden önemlidir? (Beslenme, Fiziksel gelişim/Spor, Kişisel gelişim, Mental/Ruhsal, Hijyen)

2. Sağlık eğitimi ve sağlığın teşvik edilmesinde öğretmenlerin rolü nelerdir? Öğretmenler neler yapabilirler? (Beslenme, Fiziksel gelişim/Spor, Kişisel gelişim, Mental/Ruhsal, Hijyen)

3. Öğrencilere sağlık eğitimi vermek için haftada ne kadar zaman ayırıyorsunuz? Bu zamanı nasıl değerlendiriyorsunuz? Hangi konularda eğitim veriyorsunuz? Verdiğiniz eğitiminde neyi amaçlıyorsunuz? (bilgilendirme, davranış kazandırma vs.) Hangi yöntemleri kullanarak bu eğitimi gerçekleştiriyorsunuz?

4. Sağlık eğitimin öğrenciler tarafından benimsendiğini nasıl gözlemliyorsunuz? Verdiğiniz eğitimin öğrencilere ve ailelerine ne gibi katkıları oldu?

5. Öğrencilerinizin sağlık durumlarını gözlemlemek için neler yapıyorsunuz? Bu konuda velilere nasıl bilgi verdiğinizi anlatır mısınız? Ne sıklıkla ve hangi konularda (fiziksel sağlık, hijyen, ruhsal sağlık, beslenme) bilgilendirme yapıyorsunuz?

6. Sağlıklı beslenme, fiziksel sağlık, hijyen, spor ve sağlık bilinci ile ilgili olarak öğrencilere örnek olmak üzere geliştirdiğiniz davranışlar ve alışkanlıklar nelerdir?

7. Bir öğretmen olarak öğrencilere sağlık eğitimi vermek ve onları sağlıklı bireyler olmaya yöneltmek için kendinizi ne seviyede donanımlı hissediyorsunuz? Neden? Donanımınızı artırmak için nelere ihtiyaç duyuyor ve neler yapıyorsunuz?

8. Bugüne kadar üniversite eğitiminiz ve sonrasında okullarda sağlık eğitimi ve sağlığın teşvik edilmesine yönelik ne gibi eğitimler aldınız (sağlıklı yaşam, beslenme, spor, ruhsal sağlık, hijyen, ilk yardım, cinsel sağlık vb.)? Eğitim kapsamında neler öğrendiniz? Bu eğitim programlarına sizce neler eklenmeli? Şu an ki, sağlık eğitimi ve teşviki ile ilgili donanım ve motivasyonunuzda bu eğitimlerin nasıl bir etkisi oldu?

9. Bir öğretmen olarak sağlık eğitimi ve sağlığın teşvik edilmesi ile ilgili konularda yer almanın sizin için önemi nedir? Neden? Nasıl yer alıyorsunuz? Bugüne kadar ne gibi sorumluluklar üstlendiniz? Geleceğe dair bu konudaki planlarınız nelerdir?

10. Okullarda sağlığın teşvik edilmesi ve sağlık eğitimi verilmesi için okulların ve öğretmenlerin önündeki engeller nelerdir? Bu engelleri aşmak için neler

yapılmalıdır, sizin bireysel ve kurumsal olarak yaptığınız şeyler nelerdir? Bu engeller ne gibi sonuçlar doğurmaktadır?

C. Okul çevresi, okul yönetimi ve okul-aile birliği ile ilgili görüşler

1. Sizce, okul içinde ve çevresinde sağlıklı bir ortam oluşturmanın şartları nelerdir? Öğretmenler bu konuda neler yapabilir (sınıf içinde, okul içinde, okul çevresinde) (Fiziksel şartlar, güvenlik, maddi manevi kaynakların kullanımı vb.)

2. Bir öğretmen olarak sizce, okulunuzun içi ve çevresi ne derecede sağlıklı (fiziksel sağlık, beslenme ve ruhsal sağlık açısından)? Okulunuzdaki eksiklikler nelerdir? Okulunuzdaki iyi uygulamalar nelerdir?

3. Diğer okullarla karşılaştırdığınızda sizin okulunuzda farklılık yaratan uygulamalar nelerdir?

4. Kantin, tuvalet, yemekhane, spor alanı, okul bahçesi gibi alanlarda sağlığın teşviki ile ilgili son zamanlarda ne gibi değişikliklere gidildi, anlatır mısınız?

5.Sizce, sağlık eğitimi ve sağlığın teşviki için okul yönetimine düşen görevler nelerdir?

6. Sizce, sağlık eğitimi ve sağlığın teşviki için okul-aile birliğine ve ailelere düşen görevler nelerdir?

D. Öğretmenlerin müfredat, uygulamalar ve politikalarla ilgili görüşleri

1. Şu an ki müfredat kapsamında, sağlıkla ilgili hangi konularda öğrencilere eğitim verilmesi gerekiyor? (Beslenme, fiziksel sağlık, ruhsal sağlık, zararlı

madde kullanımı, sağlığın korunması ve hijyen kuralları, yaralanmalardan korunma vb.) Bu eğitimlerin süresi ve seviyesi ne kadardır? Bu eğitim kapsamında hedeflenen çıktılar nelerdir?

2. Müfredatta şu an yeterli/eksik olduğunu düşündüğünüz noktalar nelerdir? Sizce, öğrencilerin ve ailelerinin bütünsel bir sağlık bilinci kazanmaları için müfredat programında ne gibi iyileştirmeler/ değişiklikler yapılmalı?

3. Son zamanlarda medyada Milli Eğitim Bakanlığı'nın sağlıklı beslenme ile ilgili uygulamaları sıkça yer alıyor. Öğrencileriniz ve aileleri bu konuyu nasıl değerlendiriyorlar? Öğrencileriniz ve aileleri üzerinde bu yayınların ne gibi etkileri oldu? Bu uygulamaları okulunuzda hayata geçirmek için neler yapıldı?

4. Sağlıklı bir ortam yaratmak ve kapsamlı bir sağlık eğitimi vermek ve sağlığı teşvik etmek için öğretmenler neler yapmalıdır? Yaşadığınız deneyimleri göz önüne alarak anlatınız.

5. Son olarak, okullarda sağlık eğitiminin ve sağlık teşvikinin geleceği ile ilgili düşünceleriniz nelerdir?

6. Eklemek istedikleriniz varsa, lütfen paylaşınız.

Bu çalışmaya katıldığınız için teşekkürler.

(English Translation)
TEACHER INTERVIEW FORM

Health education and health promotion issues in schools are gaining importance all over the world. This interview form is designed to investigate health education and health promotion practises in primary schools in Turkey. In this context, a case study is envisaged for your school.

The research will be used for a graduate thesis in Middle East Technical University. The researcher has taken the necessary permissions from Middle East Technical University Ethics Committee and the Ministry of Education.

As teacher your objective and informative feedback is very important to this study.

In this study, the name of the school and the name of the participants and will be kept **completely confidential**.

Do you allow the researcher to record this interview, provided that it will be kept only for the researcher?

A. Preliminary Information

Personal Information

1. Which university and department have you been graduated from?
2. How long have you been working as a teacher?
3. How long have you been working as a teacher at this school?

Information on the socio-economic status of students and families

1. In order to achieve the objective of this study, gathering information about the profile of your students and their parents is needed. Could you give information

about the socio-economic status of your students and their parents, in general? (Income level, educational level, occupational distribution, gender, family structure, cultural events, educational attainment, social life)

B. Teachers' opinions, information and practises on health education and health promotion

1. Recently we see increased emphasis on the media about health promotion and healthy eating. In this regard, the Ministry of Education and the Ministry of Health have new circulars. It is foreseen to make new arrangements in schools. In your opinion, why is it important to promote health and provide health education in schools? (Nutrition, Physical Development/ Sports, Personal Development, Mental/Psychological, Hygiene, Academic Achievement)

2. What is the role of teachers in promoting health? What can they do to promote health? (Nutrition, Physical Development/ Sports, Personal Development, Mental/Psychological, Hygiene, School Environment)

3. How much time do you spend per week for students to provide health education? How do you make use of this time? Which subjects do you teach? What is your aim with the education you provide (Information, building behaviour etc.)? Which methods do you use while performing this training?

4. How do you observe that health education has been adopted by the students? What was the contribution of this education to the students and their families?

5. What do you do to observe the health status of students? Could you tell how do you inform their parents? How often and in which issues (physical health, hygiene, mental health, nutrition) do you inform the parents?

6. What behaviours and habits have you developed to be a role model for your students about healthy nutrition, physical health, hygiene, sports and health awareness?

7. In what level do you feel yourself qualified, as a teacher, to give health education to students and raise them to become healthy individuals? Why? What do you need and what do you do to increase your qualification?

8. Up to date, which traininigs have you attended in the university and afterwards about health education and health promotion in schools (healthy living, nutrition, fitness, mental health, hygiene, first aid, sexual health, etc.)? What have you learned within the scope of these trainings? In your opinion, which topics should be added to these training programs? How did these trainings affect your current qualification and motivation about health education and promotion?

9. What is the significance of taking part on issues related to health education and health promotion for you, as a teacher? Why? How do you take part? What kind of responsibilities did you take so far? Do you have plans for the future?

10. What are the barriers in front of schools and teachers for health promotion and health education in schools? What are the results of these barriers? What should be done to overcome these obstacles? What are the things you do to overcome these obstacles, individually and institutionally?

C. Opinions about school environment, school management and Parent-Teacher Association

1. In your opinion, what are the conditions for creating a healthy environment in and around the school? What can teachers do about it (in the classroom, in the school, in the school environment)? (Physical conditions, safety, the use of material and moral resources etc.)

2. As a teacher, in your opinion, how healthy is the school and its environment (in terms of physical health, nutrition, and mental health)? What are the short comings of your school? What are the best practises in your school?

3. What are the practises of your school that make a difference in your school?

4. Could you tell what changes were made recently in your school about health promotion in areas such as canteen, toilets, cafeteria, sports field, and playground?

5. In your opinion, what are the duties of teachers for health education and health promotion?

6. In your opinion, what are the duties of school management and parent-teacher association about health education and health promotion?

D. Views of teachers on curriculum, applications and policies

1. In the current scope of the curriculum, which issues in health education have to be taught to students (Nutrition, physical health, mental health, use of hazardous substances, protection of health and hygiene, injury prevention, etc.)?

What is the duration and level of these trainings? What are the intended outcomes of these trainings?

2. In your opinion, what are the adequate/ inadequate points of the current curriculum? What improvements / changes should be done in the curriculum so that students and their families gain holistic health awareness?

3. Recently on the media, regulations of the Ministry of Education about healthy nutrition are often taking place. How do your students and their families assess this issue? What was the impact of these regulations on the students and their families? What has been done to implement these regulations in your school?

4. In your opinion, what should teachers do in order to create a healthy environment, to give a comprehensive health education and to promote health? Please, describe taking into consideration your experience.

5. Finally, what are your opinions about the future of health education and health promotion in schools?

6. Could you please share if you want to add points?

Thank you for participating in this study.

Appendix B: School Administration Interview Form

OKUL YÖNETİMİ GÖRÜŞME FORMU

Tüm dünyada okullarda sağlık eğitimi ve sağlığın teşviki konuları önem kazanmaktadır. Bu görüşme formu Türkiye'de ilkokullarda verilen sağlık eğitimi ve sağlığın teşviki ile ilgili uygulamaları araştırmak için düzenlenmiştir. Bu kapsamda okulunuzda bir durum incelemesi yapılması öngörülmektedir.

Söz konusu araştırma Orta Doğu Teknik Üniversitesi'nde yapılan bir Yüksek Lisans Tezinde kullanılacaktır. Araştırmacı bu çalışmayı gerçekleştirmek için ODTÜ Etik Kurulu ve Milli Eğitim Bakanlığı'ndan gerekli izinleri almıştır.

Bir okul yöneticisi olarak sizin tarafsız ve aydınlatıcı görüşleriniz bu çalışmanın gerçekleştirilebilmesi için çok önemlidir.

Bu çalışma kapsamında araştırmaya konu olan okulun ve görüşleri alınan kişilerin isimleri tamamen gizli tutulacaktır.

Bu görüşmenin sadece araştırmacıda bulunması koşuluyla kayıt altına alınmasına izin veriyor musunuz?

A. Önbilgiler

Kişisel Bilgiler

1. Hangi üniversite ve bölümden mezunsunuz?.
2. Öğretmenlik mesleğindeki deneyim süreniz ne kadardır?
3. Okul yöneticiliğinde deneyim süreniz ne kadardır?
4. Ne kadar zamandır bu okulda görev yapıyorsunuz?

Öğrenci ve ailelerin sosyo-ekonomik durumları ile ilgili bilgiler

1. Çalışmamın amacına ulaşması için okulunuza devam eden öğrenci ve veli profili ile ilgili bilgi toplamam gerekiyor. Genel olarak öğrencilerinizin ve velilerinin sosyo-ekonomik durumlarını anlatır mısınız? (gelir düzeyi, eğitim durumu, mesleki dağılım, cinsiyet, aile yapısı, kültürel etkinlik, eğitime katılım, sosyal hayat)

2. Okulunuzun imkanlarını ve velilerin bu duruma katkısını değerlendirir misiniz?

B. Okul yöneticilerinin sağlık eğitimi ve sağlığın teşvik edilmesi ile ilgili görüşleri, bilgileri ve icraatları.

1. Son dönemde medyada, okullarda sağlığın teşviki özellikle de sağlıklı beslenme ile ilgili vurgunun arttığını görmekteyiz. Bu konuda Milli Eğitim ve Sağlık Bakanlıkları'nın yeni genelgeleri var. Okullarda bu konuda düzenlemeler yapılması öngürülüyor. Sizce, okullarda sağlık eğitiminin verilmesi ve sağlığın teşviki neden önemlidir? (Beslenme, Fiziksel gelişim/Spor, Kişisel gelişim, Mental/Ruhsal, Hijyen, Akademik başarı)

2. Sağlık eğitimi ve sağlığın teşvik edilmesinde okul yönetiminin rolü nelerdir? Okul yönetimi bu konularda neler yapabilir? (Beslenme, Fiziksel gelişim/Spor, Kişisel gelişim, Mental/Ruhsal, Hijyen, Okul çevresi)

3. Okulunuzda, sınıf içinde ve dışında sağlık eğitimine ve sağlığın teşvikine yönelik olarak gerçekleştirilen etkinlikler var mı? Bu etkinliklerde sizin rolünüz nedir (düzenleme, kaynak bulma, katılım, hedefler)?

4. Okul dışından gelen farklı gruplar (sivil toplum kuruluşları, özel şirketler, bakanlık, veli toplulukları) okulunuzda sağlıkla ilgili ne gibi faaliyetler düzenliyorlar?

5. Öğrencilerinizin sağlık durumlarını hangi yöntemlerle gözlemliyorsunuz (sağlık taraması, kişisel gözlem, rehberlik hizmetleri, sağlık personeli)?Okul yönetimi olarak öğrencilerinizin sağlık durumları ile ilgili bilgiyi velilere nasıl aktarıyorsunuz? Ne sıklıkla ve hangi konularda bilgilendirme yapıyorsunuz?

6. Bunca görev ve sorumluluk arasında, okullarda sağlığı teşvik etmek ve sağlık eğitimine yer vermek için ne derecede motive/ isteklisiniz, anlatır mısınız?

7. Bir okul yöneticisi olarak öğrencilere sağlık eğitimi vermek ve onları sağlıklı bireyler olmaya yöneltmek için kendinizi ne seviyede donanımlı hissediyorsunuz? Neden?Donanımınızı artırmak için nelere ihtiyaç duyuyor ve neler yapıyorsunuz?

8. Bir okul yöneticisi olarak sağlık eğitimi ve sağlığın teşvik edilmesi ile ilgili konularda yer almanın sizin için önemi nedir? Neden? Nasıl yer alıyorsunuz? Bugüne kadar ne gibi sorumluluklar üstlendiniz? Geleceğe dair planlarınız var mı?

9. Okullarda sağlığın teşvik edilmesi ve sağlık eğitimi verilmesi için okulların ve okul yönetiminin önündeki engeller nelerdir? Bu engelleri aşmak için neler yapılmalıdır? Sizin bireysel ve kurumsal olarak yaptığınız şeyler nelerdir? Bu engeller ne gibi sonuçlar doğurmaktadır?

C. Okul çevresi, okul yönetimi ve okul-aile birliği ile ilgili görüşler

1. Sizce, okul içinde ve çevresinde sağlıklı bir ortam oluşturmanın şartları nelerdir? Okul yönetimi bu konuda neler yapabilir (sınıf içinde, okul içinde, okul çevresinde)? (Fiziksel şartlar, güvenlik, maddi manevi kaynakların kullanımı vb.)

2. Bir yönetici olarak, sizce, okulunuzun içi ve çevresi ne derecede sağlıklı (fiziksel sağlık, beslenme ve ruhsal sağlık açısından)? Okulunuzdaki eksiklikler nelerdir? Okulunuzdaki iyi uygulamalar nelerdir?

3. Diğer okullarla karşılaştırdığınızda sizin okulunuzda farklılık yaratan uygulamalar nelerdir?

4. Kantin, tuvalet, yemekhane, spor alanı, okul bahçesi gibi alanlarda sağlığın teşviki ile ilgili son zamanlarda ne gibi değişikliklere gidildi, anlatır mısınız?

5. Sizce, sağlık eğitimi ve sağlığın teşviki için öğretmenlere düşen görevler nelerdir?

6. Sizce, sağlık eğitimi ve sağlığın teşviki için okul-aile birliğine ve ailelere düşen görevler nelerdir?

D. Okul yönetiminin müfredat, uygulamalar ve politikalarla ilgili görüşleri

1. Şu an ki müfredat kapsamında, sağlıkla ilgili hangi konularda öğrencilere eğitim verilmesi gerekiyor? (Beslenme, fiziksel sağlık, ruhsal sağlık, zararlı madde kullanımı, sağlığın korunması ve hijyen kuralları, yaralanmalardan korunma vb.)Bu eğitimlerin süresi ve seviyesi ne kadardır?Bu eğitim kapsamında hedeflenen çıktılar nelerdir?

2. Müfredatta şu an yeterli/eksik olduğunu düşündüğünüz noktalar nelerdir? Sizce, öğrencilerin ve ailelerinin bütünsel bir sağlık bilinci kazanmaları için müfredat programında ne gibi iyileştirmeler/ değişiklikler yapılmalı?

3. Sizce, sağlıklı bir ortam yaratmak ve kapsamlı bir sağlık eğitimi vermek ve sağlığı teşvik etmek için okul yönetimi neler yapmalıdır? Yaşadığınız deneyimleri göz önüne alarak anlatınız.

4. Son zamanlarda medyada Milli Eğitim Bakanlığı'nın sağlıklı beslenme ile ilgili uygulamaları sıkça yer alıyor. Bu uygulamaları okulunuzda hayata geçirmek için neler yapıldı?

5. Sağlık eğitimi ve sağlığın teşviki ile ilgili son dönemde çıkan genelge ve politikaların olumlu yönleri ve yetersiz tarafları nelerdir? Bu genelgeler okulda ve sınıflarda ne derecede uygulanabiliyor? Okul yönetimi olarak bu genelgeleri uygulamaya koymak için ne gibi önlemler aldınız? Bu uygulamalar için okulunuza gönderilen kaynaklar nelerdir (maddi ve hizmet alanında)?

6. Okullarda sağlıklı bir ortam yaratmak, kapsamlı bir sağlık eğitimi vermek ve sağlığı teşvik etmek için politika yapıcılar neler yapabilirler? Yaşadığınız deneyimleri göz önüne alarak anlatınız.

7. Son olarak, okullarda sağlık eğitiminin ve sağlık teşvikinin geleceği ile ilgili düşünceleriniz nelerdir?

8. Eklemek istedikleriniz varsa lütfen paylaşınız.

Bu çalışmaya katıldığınız için teşekkürler.

(English Translation)

SCHOOL MANAGEMENT INTERVIEW FORM

Health education and health promotion issues in schools are gaining importance all over the world. This interview form is designed to investigate health education and health promotion practises in primary schools in Turkey. In this context, a case study is envisaged for your school.

The research will be used for a graduate thesis in Middle East Technical University. The researcher has taken the necessary permissions from Middle East Technical University Ethics Committee and the Ministry of Education.

As teacher your objective and informative feedback is very important to this study.

In this study, the name of the school and the name of the participants and will be kept **completely confidential**.

Do you allow the researcher to record this interview, provided that it will be kept only for the researcher?

A. Preliminary Information

Personal Information

1. Which university and department have you graduated from?
2. What is your term of experience in the teaching profession?
3. What is your term of experience in the administration of school?
4. How long have you been working as an administrator at this school?

Information on the socio-economic status of students and families

1. In order to achieve the objective of this study, gathering information on the profile of students and parents is needed. Could you tell socio-economic status of students and their parents, in general (income level, educational level, occupational distribution, gender, family structure, cultural events, educational attainment, social life)?

B. School administrators' views on health education and health promotion, information, and actions.

1. Recently we see increased emphasis on the media about health promotion and healthy eating. In this regard, the Ministry of Education and the Ministry of Health have new circulars. It is foreseen to make new arrangements in schools. In your opinion, why is it important to promote health and provide health education in schools? (Nutrition, Physical Development/ Sports, Personal Development, Mental/Psychological, Hygiene, Academic Achievement)

2. What is the role of school adnimistration in promoting health? What can administrators do to promote health? (Nutrition, Physical Development/ Sports, Personal Development, Mental/Psychological, Hygiene, School Environment)

3. What kind of activities are performed in your school for health promotion and health education? What is your role in these activities (regulation, funding, participation, objectives)?

4. What kind of health-related activities are organized by different groups coming from outside (non-governmental organizations, private companies, ministries, parents' communities)?

5. How do you observe the health status of your students (health screening, personal observation, guidance services, health personnel)? As the school administration, how do you transfer the information to the parents about the health status of their children? How often, and about which issues do you inform?

6. Besides all your duties and responsibilities, could you tell, to what extent, are you motivated/ eager to promote health and health education in schools?

7. In what level do you feel yourself qualified, as an administrator, to give health education to students and raise them to become healthy individuals? Why? What do you need and what do you do to increase your qualification?

8. What is the significance of taking part on issues related to health education and health promotion for you, as an administrator? Why? How do you take part? What kind of responsibilities did you take, so far? Do you have plans for the future?

9. What are the barriers in front of schools and school administrators for health promotion and health education in schools? What are the results of these barriers? What should be done to overcome these obstacles? What are the things you do to overcome these obstacles, individually and institutionally?

C. Opinions about school environment, school management and Parent-Teacher Association

1. In your opinion, what are the conditions for creating a healthy environment in and around the school? What can school administration do about it (in the

classroom, in the school, in the school environment)? (Physical conditions, safety, the use of material and moral resources etc.)

2. As an administator, in your opinion, how healthy is the school and its environment (in terms of physical health, nutrition, and mental health)? What are the short comings of your school? What are the best practises in your school?

3. What are the practises of your school that make a difference in your school?

4. Could you tell what changes were made recently about health promotion in some areas such as canteen, toilets, cafeteria, sports field and playground?

5. In your opinion, what are the duties of teachers for health education and health promotion?

6. In your opinion, what are the duties of parent-teacher association and families about health education and health promotion?

D. Views of school administration on curriculum, applications and policies

1. In the current scope of the curriculum, which issues in health education have to be taught to students (Nutrition, physical health, mental health, use of hazardous substances, protection of health and hygiene, injury prevention, etc.)? What is the duration and level of these trainings? What are the intended outcomes of these trainings?

2. In your opinion, what are the adequate/ inadequate points of the current curriculum? What improvements / changes should be done in the curriculum so that students and their families gain holistic health awareness?

3. In your opinion, what school management should do in order to create a healthy environment, give a comprehensive health education and promote healthy life? Describe your experience taking into consideration.

4. Recently on the media, regulations of the Ministry of Education about healthy nutrition are often taking place. What has been done to implement these regulations in your school?

5. What are the positive and inadequate aspects of the recent circulars and policies about health education and health promotion? In what extent, can these circulars be applied in your school and classes? What kind of measures have school administration taken to implement these circulars? What resources are sent to your school for these implementations (in terms of financial and service)?

6. What can policy-makers do in order to create a healthy environment in schools, to give a comprehensive health education and to promote health? Describe, taking into consideration your experience.

7. Finally, what are your thoughts about the future of health education and health promotion in schools?

8. Could you please share if you want to add points?

Thank you for participating in this study.

Appendix C: Parent-Teacher Association Interview Form

OKUL- AİLE BİRLİĞİ GÖRÜŞME FORMU

Tüm dünyada okullarda sağlık eğitimi ve sağlığın teşviki konuları önem kazanmaktadır. Bu görüşme formu Türkiye'de ilkokullarda verilen sağlık eğitimi ve sağlığın teşviki ile ilgili uygulamaları araştırmak için düzenlenmiştir. Bu kapsamda okulunuzda bir durum incelemesi yapılması öngörülmektedir.

Söz konusu araştırma Orta Doğu Teknik Üniversitesi'nde yapılan bir Yüksek Lisans Tezinde kullanılacaktır. Araştırmacı bu çalışmayı gerçekleştirmek için ODTÜ Etik Kurulu ve Milli Eğitim Bakanlığı'ndan gerekli izinleri almıştır.

Bir okul aile birliği üyesi ve veli olarak sizin tarafsız ve aydınlatıcı görüşleriniz bu çalışmanın gerçekleştirilebilmesi için çok önemlidir.

Bu çalışma kapsamında araştırmaya konu olan okulun ve görüşleri alınan kişilerin isimleri tamamen gizli tutulacaktır.

Bu görüşmenin sadece araştırmacıda bulunması koşuluyla kayıt altına alınmasına izin veriyor musunuz?

A. Önbilgiler

Kişisel Bilgiler

1. Mesleğiniz ve eğitim durumunuzla ilgili bilgi verebilir misiniz?
2. Ne kadar zamandır okul aile birliğinde görev alıyorsunuz?

Öğrenci ve ailelerin sosyo-ekonomik durumları ile ilgili bilgiler

1. Okulunuzun imkanlarını ve velilerin katkısını değerlendirir misiniz?

B. Okul aile birliğinin sağlık eğitimi ve sağlığın teşvik edilmesi ile ilgili görüşleri, bilgileri ve icraatları.

1. Son dönemde medyada, okullarda sağlığın teşviki, özellikle de sağlıklı beslenme ile ilgili vurgunun arttığını görmekteyiz. Bu konuda Milli Eğitim ve Sağlık Bakanlığı'nın yeni genelgeleri var. Okullarda bu konuda düzenlemeler yapılması öngürülüyor. Sizce, okullarda sağlık eğitiminin verilmesi ve sağlığın teşviki neden önemlidir? (Beslenme, Fiziksel gelişim/Spor, Kişisel gelişim, Mental/Ruhsal, Hijyen, Akademik başarı)

2. Sağlık eğitimi ve sağlığın okullarda teşvik edilmesi için okul-aile birliği neler yapabilir? (Beslenme, Fiziksel gelişim/Spor, Kişisel gelişim, Mental/Ruhsal, Hijyen, Okul çevresi)

3. Çocuklarınızın sağlık durumlarını hangi yöntemlerle gözlemliyorsunuz (Sağlık taraması, kişisel gözlem, rehberlik hizmetleri, sağlık personeli)?

4. Bir veli olarak öğrencilere sağlık eğitimi vermek ve onları sağlıklı bireyler olmaya yöneltmek için kendinizi ne seviyede donanımlı hissediyorsunuz? Neden? Donanımınızı artırmak için nelere ihtiyaç duyuyor ve neler yapıyorsunuz?

5. Sağlıklı beslenme, fiziksel sağlık, hijyen, spor ve sağlık bilinci ile ilgili olarak çocuğunuza örnek olmak üzere geliştirdiğiniz davranışlar ve alışkanlıklar nelerdir?

6. Bir okul-aile birliği üyesi ve veli olarak sağlık eğitimi ve sağlığın teşvik edilmesi ile ilgili konularda yer almanın sizin için önemi nedir? Neden? Nasıl

yer alıyorsunuz? Bugüne kadar ne gibi sorumluluklar üstlendiniz? Geleceğe dair planlarınız var mı?

7. Okulunuzda, sağlık eğitimine ve sağlığın teşvikine yönelik olarak ne gibi etkinlikler gerçekleştiriyorsunuz? Bu etkinliklerde sizin rolünüz nedir (Düzenleme, kaynak bulma, katılım, hedefler)?

8. Okullarda sağlığın teşvik edilmesi ve sağlık eğitimi verilmesi için okulların ve okul yönetiminin, öğretmenlerin önündeki engeller sizce nelerdir? Bu engeller ne gibi sonuçlar doğurmaktadır? Bu engelleri aşmak için neler yapılmalıdır? Sizin bireysel ve okul-aile birliği olarak sizin yaptığınız şeyler nelerdir?

C. Okul çevresi, okul yönetimi ve öğretmenler ile ilgili görüşler

1. Sizce, okul içinde ve çevresinde sağlıklı bir ortam oluşturmanın şartları nelerdir? Okul-aile birliği ve veliler bu konuda neler yapabilir (sınıf içinde, okul içinde, okul çevresinde)? (Fiziksel şartlar, güvenlik, maddi manevi kaynakların kullanımı vb.)

2. Bir veli olarak, sizce, okulunuzun içi ve çevresi ne derecede sağlıklı (fiziksel sağlık, beslenme ve ruhsal sağlık açısından)? Okulunuzdaki eksiklikler nelerdir? Okulunuzdaki iyi uygulamalar nelerdir?

3. Diğer okullarla karşılaştırdığınızda sizin okulunuzda farklılık yaratan uygulamalar nelerdir?

4. Kantin, tuvalet, yemekhane, spor alanı, okul bahçesi gibi alanlarda sağlığın teşviki ile ilgili son zamanlarda ne gibi değişikliklere gidildi, anlatır mısınız?

5. Sizce, sağlık eğitimi ve sağlığın teşviki için öğretmenlere düşen görevler nelerdir?

6. Sizce, sağlık eğitimi ve sağlığın teşviki için okul yönetimine düşen görevler nelerdir?

D. Okul aile birliğinin müfredat, uygulamalar ve politikalarla ilgili görüşleri

1. Son zamanlarda medyada, Milli Eğitim Bakanlığı'nın sağlıklı beslenme ile ilgili uygulamaları sıkça yer alıyor. Bu uygulamaları evinizde ve okulunuzda hayata geçirmek için neler yapıldı?

2. Sağlık eğitimi ve sağlığın teşviki ile ilgili son dönemde çıkan basında da sıkça bahsi geçen yeni uygulamaların olumlu yönleri ve yetersiz tarafları nelerdir? Bakanlığın kantin ve beslenmeye yönelik bu uygulamaları okulda ve sınıflarda ne derecede uygulanabiliyor?

3. Okulda sağlıklı bir ortam yaratmak, kapsamlı bir sağlık eğitimi vermek ve sağlığı teşvik etmek için politika yapıcılar neler yapabilirler? Yaşadığınız deneyimleri göz önüne alarak anlatınız.

4. Son olarak, Türkiye'deki okullarda sağlık eğitiminin ve sağlık teşvikinin geleceği ile ilgili düşünceleriniz nelerdir?

5. Eklemek istedikleriniz varsa lütfen paylaşınız.

Bu çalışmaya katıldığınız için teşekkürler.

(English Translation)

PARENT- TEACHER ASSOCIATION INTERVIEW FORM

Health education and health promotion issues in schools are gaining importance all over the world. This interview form is designed to investigate health education and health promotion application in schools in Turkey. In this context, a case study is envisaged for your school.

The research in question will be used in Middle East Technical University in a graduate thesis. Researcher has taken the necessary permissions from Middle East Technical University Ethics Committee and the Ministry of Education.

As a member of a parent-teacher association your objective and informative feedback are very important to this study.

In this study, the research and opinions, which are subject to the names of the school will be kept **completely confidential**.

Do you allow recording of this interview provided for only the investigator?

A. Preliminary Information

Personal Information

1. Which university and department have you graduated from?
2. Could you tell us about your job?
3. How long have you served for parent-teacher association?

Information on the socio-economic status of students and families

1. Could you assess the opportunities of school and contribution of parents? (Donation, Voluntary activities, working with non-governmental organizations)

B. Views on health education and health promotion, information, and actions.

1. Recently we see increased emphasis on the media about health promotion and healthy eating. In this regard, the Ministry of Education and the Ministry of Health have new circulars. It is foreseen to make new arrangements in schools. In your opinion, why is it important to promote health and provide health education in schools? (Nutrition, Physical Development/ Sports, Personal Development, Mental/Psychological, Hygiene, Academic Achievement)

2. What can parent- teacher association do for the health education and health promotion in schools? (Nutrition, Physical Development/ Sports, Personal Development, Mental/Psychological, Hygiene, School Environment)

3. How do you observe the health status of your children (Health screening, personal observation, guidance services, health personnel)?

4. In what level do you feel yourself qualified, as a parent, to give health education to your children and raise them to become healthy individuals? Why? What do you need and what do you do to increase your qualification?

5. What behaviours and habits have you developed to be a role model for your children about healthy nutrition, physical health, hygiene, sports and health awareness?

6. What is the significance of taking part on issues related to health education and health promotion for you, as a parent? Why? How do you take part? What kind of responsibilities did you take so far? Do you have plans for the future?

7. What kind of activities do you perform for health promotion and health education in your school? What is your role in these activities (regulation, funding, participation, objectives)?

8. What are the barriers in front of schools, school administrations and teachers for health promotion and health education in schools? What are the results of these barriers? What should be done to overcome these obstacles? What are the things you do to overcome these obstacles, individually and institutionally?

C. Opinions about school environment, school management and teachers

1. In your opinion, what are the conditions for creating a healthy environment in and around the school? What can teachers do about it (in the classroom, in the school, in the school environment)? (Physical conditions, safety, the use of material and moral resources etc.)

2. As a parent, in your opinion, how healthy is the school and its environment (in terms of physical health, nutrition, and mental health)? What are the short comings of your school? What are the best practises in your school?

3. What are the practises of your school that make a difference in your school?

4. Could you tell what changes were made recently in your school about health promotion in areas such as canteen, toilets, cafeteria, sports field, and playground?

5. In your opinion, what are the duties of teachers for health education and health promotion?

6. In your opinion, what are the duties of school administration about health education and health promotion?

D. Views of school administration about on curriculum, applications and policies

1. Recently on the media, regulations of the Ministry of Education about healthy nutrition are often taking place. What has been done in your home and school to implement these regulations in your school?

2. In your opinion, what are the positive and inadequate aspects of the recent circulars and policies about health education and health promotion? In what extent, can these circulars be applied in your school and classes?

3. What can policy-makers do in order to create a healthy environment in schools, to give a comprehensive health education and to promote health? Describe, taking into consideration your experience.

4. Finally, what are your thoughts about the future of health education and health promotion in schools?

5. Could you please share if you want to add points?

Thank you for participating in this study.

Appendix D: Canteen Staff Interview Form

KANTİN ÇALIŞANI / İŞLETMECİSİ GÖRÜŞME FORMU

Tüm dünyada okullarda sağlık eğitimi ve sağlığın teşviki konuları önem kazanmaktadır. Bu görüşme formu Türkiye'de ilkokullarda verilen sağlık eğitimi ve sağlığın teşviki ile ilgili uygulamaları araştırmak için düzenlenmiştir. Bu kapsamda okulunuzda bir durum incelemesi yapılması öngörülmektedir.

Söz konusu araştırma Orta Doğu Teknik Üniversitesi'nde yapılan bir Yüksek Lisans Tezinde kullanılacaktır. Araştırmacı bu çalışmayı gerçekleştirmek için ODTÜ Etik Kurulu ve Milli Eğitim Bakanlığı'ndan gerekli izinleri almıştır.

Bir kantin çalışanı işletmecisi olarak sizin tarafsız ve aydınlatıcı görüşleriniz bu çalışmanın gerçekleştirilebilmesi için çok önemlidir.

Bu çalışma kapsamında araştırmaya konu olan okulun ve görüşleri alınan kişilerin isimleri tamamen gizli tutulacaktır.

Bu görüşmenin sadece araştırmacıda bulunması koşuluyla kayıt altına alınmasına izin veriyor musunuz?

A. Önbilgiler

Kişisel Bilgiler

1. Mesleğiniz ve eğitim durumunuzla ilgili bilgi verebilir misiniz?
2. Ne kadar zamandır okul kantinlerinde görev alıyorsunuz?

B. Kantin çalışanı/ işletmecisinin sağlık eğitimi ve sağlığın teşvik edilmesi ile ilgili görüşleri, bilgileri ve icraatları.

1. Son dönemde medyada, okullarda sağlığın teşviki, özellikle de sağlıklı beslenme ile ilgili vurgunun arttığını görmekteyiz. Bu konuda Milli Eğitim ve Sağlık Bakanlıkları'nın yeni genelgeleri var. Okullarda bu konuda düzenlemeler yapılması öngürülüyor. Sizce, okullarda sağlıklı beslenme ile uygulamalara gidilmesi neden önemlidir? (Beslenme, Fiziksel gelişim/Spor, Kişisel gelişim, Mental/Ruhsal, Hijyen)

2. Sağlık eğitimi ve sağlığın teşvik edilmesinde kantinlerin rolü nedir? Bu konuya nasıl katkıda bulunabilirsiniz? (Beslenme, Fiziksel gelişim/Spor, Kişisel gelişim, Mental/Ruhsal, Hijyen, Okul çevresi)

3. Sağlıklı beslenme sizce neden önemlidir? Sağlıksız beslenmenin çocuklar üzerinde ne gibi sonuçları olabilir?

4. Kantinlerden beslenme ihtiyacını karşılayan çocukların genel tercihleri ile ilgili bilgi verir misiniz? En çok tüketilen kalemler nelerdir (süt, meyve, meyve suyu, bisküvi, kraker, tost sandviç çesitleri, şekerlemeler vb.)

5. Kantinlerdeki son düzenlemeler tüketim davranışlarını etkiledi mi? Daha önce neler tüketiliyordu?

6. Bir kantin çalışanı/ işletmecisi olarak sağlık ve hijyen konularında herhangi bir eğitim aldınız mı?

C. Okul ve çevresi ile ilgili görüşler

1. Bir çalışanı olarak, sizce, okulunuzun içi ve çevresi ne derecede sağlıklı (fiziksel sağlık, beslenme ve ruhsal sağlık açısından)? Okulunuzdaki eksiklikler nelerdir? Okulunuzdaki iyi uygulamalar nelerdir?

2. Diğer okullarla karşılaştırdığınızda sizin okulunuzda farklılık yaratan uygulamalar nelerdir?

D. Müfredat, uygulamalar ve politikalarla ilgili görüşleri

1. Son zamanlarda medyada, Milli Eğitim Bakanlığı'nın sağlıklı beslenme ile ilgili düzenlemeleri sıkça yer alıyor. Kantininizde, sağlıklı beslenme ve sağlığın teşvikine yönelik olarak bu düzenlemelere ne derecede geçebildiniz? Şu an kantininizde ne gibi uygulamalar yapıyorsunuz?

2. Sağlık eğitimi ve sağlığın teşviki ile ilgili son dönemde çıkan yeni uygulamaların olumlu yönleri, uygulanabilirliği ve yetersiz tarafları nelerdir?

3. Bir okul çalışanı olarak, sizce, okulda sağlıklı bir ortam yaratmak, kapsamlı bir sağlık eğitimi vermek ve sağlığı teşvik etmek için neler yapılabilir? Yaşadığınız deneyimleri göz önüne alarak anlatınız.

4. Son olarak, okullarda sağlık eğitiminin ve sağlık teşvikinin geleceği ile ilgili düşünceleriniz nelerdir?

5. Eklemek istedikleriniz varsa lütfen paylaşınız.

Bu çalışmaya katıldığınız için teşekkürler.

(English Translation)
CANTEEN EMPLOYEE / EMPLOYER INTERVIEW FORM

Health education and health promotion issues in schools are gaining importance all over the world. This interview form is designed to investigate health education and health promotion application in schools in Turkey. In this context, a case study is envisaged for your school.

The research in question will be used in Middle East Technical University in a graduate thesis. Researcher has taken the necessary permissions from Middle East Technical University Ethics Committee and the Ministry of Education.

As a member of a parent-teacher association your objective and informative feedback are very important to this study.

In this study, the research and opinions, which are subject to the names of the school will be kept **completely confidential**.

Do you allow recording of this interview provided for only the investigator?

A. Preliminary Information

Personal Information

Could you give information about your profession and your education?
For how long have you been working in the school canteen?

B. The opinions, information and activities of the canteen employee/employer about the health education and the encouragement of health

1. Recently we see increased emphasis on the media about health promotion and healthy eating. In this regard, the Ministry of Education and the Ministry of Health have new circulars. It is foreseen to make new arrangements in schools. In your opinion, why is it important to promote health and provide health education in schools? (Nutrition, Physical Development/ Sports, Personal Development, Mental/Psychological, Hygiene, Academic Achievement)

2. What is the role of school canteen in promoting health? What can canteen operators do to promote health? (Nutrition, Physical Development/ Sports, Personal Development, Mental/Psychological, Hygiene, School Environment)

3. In your opinion, why is healthy nutrition important? What can be the results of the unhealthy nutrition over the children?

4. Could you give information about the preferences of students shopping from school canteens to meet their nutritional needs? What are the most consumed items? (Milk, fruit, fruit juice, biscuits, cracker, toast, sandwiches, candies etc…)

5. Did the last regulations on school canteens affect the consumption behaviours? Before the recent regulations, what was consumed by students?

6. Have you ever got education about health and hygiene as a canteen employee/employer?

C. Opinions about the school and its environment

1. As a canteen operator, in your opinion, how healthy is the school and its environment (in terms of physical health, nutrition, and mental health)? What are the short comings of your school? What are the best practises in your school?

2. What are the practises of your school that make a difference in your school?

D. Opinions about the curriculum, politics and applications

1. Recently in the media, the regulations of The Ministry of Education's about healthy nutrition take place frequently. How much transition have you done according to these regulations? Currently which regulations are conducted in your canteen?

2. What are the positive effects, practicability and missing features of these recent regulations about health promotion and education?

3. As a canteen operator, in your opinion, what can be done to create a healthy atmosphere in the school, to give a comprehensive health education and to promote health? Please tell according to your experiences.

5. Finally, what are your opinions about the future of health education and health promotion in schools?

6. Could you please share if you want to add points?

Thank you for participating in this study.

Appendix E: Classroom Activity Form

SINIF İÇİ ETKİNLİK FORMU

<u>Okula Gelmeden Önce Yaptıklarım</u>

Sınıfı: **Tarih:**

Öğretmeni:

Sabahçı/ öğlenci:

Sabahları okula gelmeden önce yaptıklarımızı paylaşalım.

Bugün sabah kalktıktan sonra, okula gelmeden önce yaptıklarını yazar mısın?

Bugün okula gelmeden:

-________________________________

-________________________________

Kahvaltını evde mi, okulda mı yaptın? ___________

Evde kahvaltı yapmadıysan kahvaltını nereden aldın? _____________

Kahvaltıda ne yedin/içtin?

Reçel __	Domates/salatalık/biber __	Süt __
Ekmek __	Yağ __	Meyve suyu __
Peynir __	Zeytin __	Çay __
Bal __	Yumurta __	Bisküvi __
Meyve __	Hamur işi __	Kızartma __
Kola __	Sosis/salam/sucuk __	Tost __

Diğer...
....

(English Translation)

CLASSROOM ACTIVITY

<u>Things I did before School</u>

Classroom: **Date:**

Teacher:

Morning/Midnoon:

Name-Surname:

Let's write what you did in the morning before coming school.

Today after you woke up, could you write what did you do before coming school?

Today, before I came to school :

-________________________________

-________________________________

-________________________________

-________________________________

Do you do your breakfast : O at home O at school O didn't do

If you did your breakfast, could you sign what did you eat and drink?

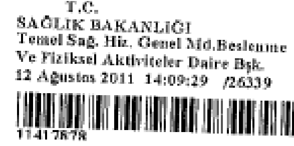
Reçel	__	Tomato/Cucumber/Pepper	__	Milk	__
Bread	__	Butter	__	Fruit Juice	__
Cheese	__	Olive	__	Tea	__
Honey	__	Egg	__	Biscuit	__
Fruit	__	Cake	__	Fries	__
Coke	__	Sosis/salam/sucuk	__	Toast	__

Other...
....

Appendix F: Policy Documents

T.C.
SAĞLIK BAKANLIĞI
Temel Sağlık Hizmetleri Genel Müdürlüğü

Sayı :B.10.0.TSH-0.12.06 /090.05
Konu: Okul Sağlığı


T.C.
SAĞLIK BAKANLIĞI
Temel Sağ. Hiz. Genel Md.Beslenme
Ve Fiziksel Aktiviteler Daire Bşk.
12 Ağustos 2011 14:09:29 /26339
1141 7878

.....................VALİLİĞİNE
(İl Sağlık Müdürlüğü)

İlgi: a) 05.03.2010 tarihli ve B.10.0.TSH-0.12.06 /090.05/9997 sayılı yazımız.
b) Milli Eğitim Bakanlığının 21.07.2011 tarihli ve 2011/41 sayılı genelgesi.

Bakanlığımızla işbirliği halinde hazırlanan ve Milli Eğitim Bakanlığı tarafından yayımlanan 17 Nisan 2007 tarihli ve 2007/33 sayılı "Okul Kantinlerinin Denetimi ve Uyulacak Hijyen Kuralları Genelgesi"nin A- Genel Kurallar Bölümünün 16. maddesi, Milli Eğitim Bakanlığının 21.07.2011 tarihli ve 2011/41 sayılı ekte gönderilen ilgi (b) Genelgesi ile **"Eğitim kurumlarımızın, yatılı veya pansiyonlu yemekhaneleri dâhil olmak üzere kantinleri, çay ocakları, büfeleri, v.b. yerlerde, çocukların dengesiz beslenmesine şişmanlığa (obezite) sebep olabileceğinden, doğal maden suları hariç, enerji yoğunluğu yüksek, besin değeri düşük olan (enerji içecekleri, gazlı içecekler, aromalı içecekler ve kolalı içecekler) ile kızartma ve cipslerin satışları yapılmayacak, otomatik satış yapan makinelerde bulundurulmayacaktır. Bunların yerine Tarım ve Köyişleri Bakanlığı'ndan üretim veya ithalat izni bulunan süt, ayran, yoğurt, meyve suyu, taze sıkılmış meyve suyu ve tane ile satış yapılabilen meyve bulundurulacaktır."** şeklinde değiştirilmiştir.

İlgi (a) yazımızda Okul Sağlığı ile ilgili yapılması gerekenler belirtilmişti. Milli Eğitim Bakanlığının ilgi genelgeleri kapsamında okul sağlığı hizmetleri konusunun İl Hıfzıssıhha Kurulu'nda yeniden gündeme getirilerek ilgili kurum ve kuruluşlarla işbirliği içinde;

- Kantinlerin, Milli Eğitim Bakanlığının ilgili genelgeleri doğrultusunda faaliyetlerini sürdürmelerinin sağlanması ve rutin aralıklarla denetlenmesinin sağlanması,
- Öğrencilerin teneffüs ve öğle aralarında, kantinlerde satışı yasak olan gıda maddelerine okul çevresindeki satış noktalarından ulaşmalarının engellenmesi,
- Okul çevresinde açıkta gıda satışının önlenmesi,
- Kantin ve yemekhaneler ile okul çevresinde gıda satışı yapan işyerlerinin gerekli teknik ve hijyenik şartlara uygun faaliyet göstermesinin sağlanması,

konularında gerekli hassasiyetin gösterilmesi hususlarında bilgilerini ve gereğini rica ederim.

Prof. Dr. Nihat TOSUN
Bakan a.

T.C.
MİLLİ EĞİTİM BAKANLIĞI
Sağlık İşleri Dairesi Başkanlığı

Sayı : B.08.0.SDB.0.11.00.00.313.01.03/ 1782 21/07/2011
Konu : Okul Kantinlerindeki Gıda Satışı

GENELGE
2011/ 41

İlgi: a) 29.09.2010 tarihli ve **2010/22** sayılı Başbakanlık Genelgesi,
b) 17.04.2007 tarih ve B.08.0.SDB.0.31.06.01/1008-**2007/33** sayılı Genelge,
c) Sağlık Bakanlığı'nın 05.01.2011 tarih ve B.10.0.TSH.0.12.06/090-05/436 sayılı yazısı,
d) 26.05.2010 tarihli "Okul Sağlığı ve Beslenmesi Danışma Kurulu Toplantısı Karar Tutanağı",
e) 28.06.2011 tarih ve B.10.0.TSH.0.12.06/090-05/ 21268 sayılı yazı.

Bakanlığımıza bağlı örgün ve yaygın eğitim kurumlarında öğrenim gören öğrenci, kursiyer ve çalışanların güvenli ve sağlıklı beslenme bilinci kazanmalarına katkı sağlamak, olabilecek gıda zehirlenmeleri, bulaşıcı hastalıklar, yetersiz ve dengesiz beslenmeye bağlı hastalıklar ile şişmanlığı önlemek amacıyla ilgi (b) genelgemiz valiliklere gönderilmiştir. Ayrıca konuyla ilgili olarak, Başbakanlığın ilgi (a) Genelgesi ile **"Türkiye Sağlıklı Beslenme ve Hareketli Hayat Programı"** yürürlüğe konulmuştur.

Başbakanlığın ilgi (a) Genelgesi ile Sağlık Bakanlığının ilgi (c) yazısı gereği, İlgi(b) Genelgemizin:

A- Genel Kurallar Bölümünün **16. Maddesi,** "Eğitim kurumlarımızın, yatılı veya pansiyonlu yemekhaneleri dâhil olmak üzere kantinleri, çay ocakları, büfeleri, v.b. yerlerde, çocukların dengesiz beslenmesine şişmanlığa (Obezite) sebep olabileceğinden, doğal maden suları hariç, enerji yoğunluğu yüksek, besin değeri düşük olan (enerji içecekleri, gazlı içecekler, aromalı içecekler ve kolalı içecekler) ile kızartma ve cipslerin satışları **yapılmayacak,** otomatik satış yapan makinelerde **bulundurulmayacaktır.** Bunların yerine Tarım ve Köy İşleri Bakanlığı'ndan üretim veya ithalat izni bulunan süt, ayran, yoğurt, meyve suyu, taze sıkılmış meyve suyu ve tane ile satışı yapılabilen meyve **bulundurulacaktır."** şeklinde değiştirilmiştir.

Ayrıca ilgi (b) Genelgemiz ekinin, "Okul Kantini Denetim Formu"nun B-Gıda Hijyeni Bölümünün **26. Maddesi** "Doğal maden suları hariç, enerji yoğunluğu yüksek, besin değeri düşük olan (enerji içecekleri, gazlı içecekler, aromalı içecekler ve kolalı içecekler) ile kızartma ve cipslerin satışlarının **yapılmaması,** otomatik satış yapan makinelerde **bulundurulmaması"** Bunların yerine Tarım ve Köy İşleri Bakanlığı'ndan üretim veya ithalat izni bulunan süt, ayran, yoğurt, meyve suyu, taze sıkılmış meyve suyu ve tane ile satışı yapılabilen meyve **bulundurulması"** şeklinde, değiştirilmiştir.

Bilgi ve gereğini rica ederim.

GENELGE

Başbakanlıktan:

Konu : Türkiye Sağlıklı Beslenme
ve Hareketli Hayat Programı

GENELGE
2010/22

Ulusal sağlık politikalarının ana hedefi sağlıklı bireylerden oluşan sağlıklı bir topluma ulaşmaktır. Sağlıklı topluma ulaşmak için de, sağlık alanında sektörler arası işbirliğini güçlendiren politikaların geliştirilmesine ihtiyaç duyulmaktadır.

Günümüzde bilim ve teknolojinin hızla gelişmesiyle ortaya çıkan yeniliklerin insanlığın hizmetine sunulması ile insanların yaşam tarzları gün geçtikçe değişmektedir. Bu değişim, insanların daha az hareket etmelerine neden olmakla birlikte beslenme alışkanlıklarını da olumsuz yönde etkilemektedir. Beslenme tarzındaki değişiklikler, fiziksel hareket azlığı, sigara ve alkol tüketimi gibi bir takım olumsuz şartlar bir araya geldiğinde obezite (şişmanlık) riski artmaktadır. Yapılan araştırmalar dünyada olduğu gibi ülkemizde de fazla kilolu olma ve obezite sıklığının giderek arttığını ve obezitenin özellikle çocuklarımızı ve gençlerimizi etkisi altına almaya başladığını göstermektedir. Dünya Sağlık Örgütü verilerine göre önlenebilir bir hastalık olarak kabul edilen fazla kiloluluk ve obezite, her yıl bir milyondan fazla ölüme neden olmaktadır.

Obezite ile mücadele, gerçekte pek çok hastalıkla mücadele anlamına gelmektedir. Obezite; kalp-damar hastalıkları, yüksek tansiyon, şeker hastalığı, bazı kanser türleri, solunum sistemi hastalıkları, kas-iskelet sistemi hastalıkları gibi pek çok sağlık probleminin oluşmasına zemin hazırlamakta, hayat kalitesi ve süresini olumsuz yönde etkilemektedir. Bu sebeple obezite ile mücadele ülkemizin geleceği için büyük önem taşımaktadır.

Obezite ile mücadelede esas unsur vatandaşlarımızın bu konuda göstereceği bireysel gayret olmakla birlikte tüm kurum ve kuruluşların vatandaşlarımızın bu gayretine destek vermeleri önem arz etmektedir. Koruyucu sağlık hizmetleri kapsamında, sağlık otoriteleri ve bu otoriteler ile işbirliği yapacak ilgili tüm kuruluşlar tarafından, toplumun her kesimine ulaşılması, örgün ve yaygın eğitim çalışmalarının hızla yaşama geçirilmesi; birey, aile ve toplumun yeterli ve dengeli beslenme, fiziksel aktivite konularında bilgilendirilmesi gerekmektedir.

Yaşam kalitesini düşüren ve tüm dünyada hızla artan hastalıklardan bir tanesi olan obezitenin önlenmesine yönelik bilimsel ve politik kararlılığın oluşturulması ve sektörler arası işbirliği ve eşgüdümün güçlendirilmesi amacıyla ilgili tüm kuruluşların katılımıyla "Türkiye Sağlıklı Beslenme ve Hareketli Hayat Programı" hazırlanmıştır. Sağlık Bakanlığının http://www.beslenme.saglik.gov.tr/ adresinden ulaşılabilecek olan söz konusu programda, çeşitli kurum ve kuruluşların konuya ilişkin görev ve sorumlulukları belirlenmiştir. Yerine getirilmesi gereken görevler ve eylem planının uygulanması sürecinde ihtiyaç duyulacak her türlü bilgi Sağlık Bakanlığınca sağlanacak; bilgilendirme, işbirliği ve koordinasyon toplantıları düzenlenecek ve uygulamalar yakından takip edilecektir.

Söz konusu programın etkin bir şekilde uygulanması ve eylem planında yer alan görevlerin yerine getirilmesi konusunda tüm kamu kurum ve kuruluşları, üniversiteler, özel sektör ve sivil toplum kuruluşlarınca gereken destek ve yardımın sağlanması hususunda bilgilerini ve gereğini rica ederim.

Recep Tayyip ERDOĞAN
Başbakan

T.C.
SAĞLIK BAKANLIĞI
Temel Sağlık Hizmetleri Genel Müdürlüğü

Sayı : B.10.0.TSH.0.12.06 / 090-05
Konu: Okul Kantinlerindeki Gıda Satışı

T.C.
SAĞLIK BAKANLIĞI
Temel Sağ. Hiz. Genel Md.Beslenme
Ve Fiziksel Aktiviteler Daire Bşk.
05 Ocak 2011 09:58:21

MİLLİ EĞİTİM BAKANLIĞINA

İlgi: a) 17.04.2007 tarihli ve B.08.0.SDB.0.31.06.01/1008 - 2007/33 sayılı genelgeniz.
b) 29.09.2010 tarihli ve 2010/22 sayılı Başbakanlık Genelgesi.

Okul çağı, çocukların fiziksel, bilişsel ve sosyal yönden büyüme ve gelişimlerinin hızlandığı, beslenme alışkanlıklarının geliştiği ve sağlıklı yaşamın temellerinin atıldığı bir dönemdir. Özellikle bu dönemde kazanılan sağlıklı beslenme alışkanlıkları, ilerleyen yaşlarda ortaya çıkabilecek beslenme ile ilişkili hastalıkların (kalp-damar hastalıkları, diyabet, obezite vb.) önlenmesinde temel çözüm yolunu oluşturmaktadır.

Gelişmiş ülkelerin birçoğunda okullarda yeterli ve dengeli beslenmenin teşvik edilmesi ve doğru beslenme alışkanlıklarının kazandırılması amacıyla çeşitli programlar ve kampanyalar yürütülmektedir. Kahvaltı/yemek programları, beslenme dostu okullar ve sağlıklı kantinler kampanyası bunlardan bir kaçıdır. Ayrıca, Avrupa Birliğine bağlı birçok ülkede okul kantinlerinde satışa sunulan gıda maddeleri ile ilgili bazı kısıtlamalar ve yasaklamalar getirilmiştir (Ek:1).

Ülkemizde tam gün hizmet veren ve yemek hizmeti sunan okul sayısının yetersiz oluşu ve öğrencilerin bu hizmetlerden yararlanmaları konusunda bir yaptırım bulunmayışı nedeniyle çocukların birçoğu kantin hizmetlerinden yararlanma yoluna gitmektedir. Neredeyse pek çok okulda beslenme amacıyla tek seçeneğin okul kantini olduğu düşünüldüğünde, kantinlerde satışa sunulan gıdaların niteliğinin çocukların sağlıklı beslenmelerinde ne kadar büyük rol oynadığı anlaşılacaktır.

Yapılan araştırmalar, okul kantinlerinde sıklıkla satılan gazlı içecekler, cips, patates kızartması, şekerlemeler gibi besinlerin tüketiminin artmasının, diyetin kalitesini düşürdüğünü ve çocukların enerji alımlarının %20-42'sinin bu tür besinlerden geldiğini ortaya koymaktadır. Atıştırmalık veya ayaküstü yenebilen bu tür besinler genelde enerji, doymuş yağ asitleri ve tuz içeriği yönünden zengin; posa içeriği, kalsiyum, A ve C vitaminleri yönünden yetersiz olup, yetersiz ve dengesiz beslenmeye neden olmakta, obezite, kalp-damar hastalıkları, diyabet gibi kronik hastalıklara zemin hazırlamaktadır.

Konu ile ilgili olarak 26.05.2010 tarihinde ilgili kurum temsilcileri, akademisyenler ve sivil toplum örgütü temsilcilerinin katılımı ile gerçekleştirilen toplantıda "Okullarda çocukların dengesiz beslenmesine ve şişmanlığa sebep olabileceği için enerji yoğunluğu yüksek içecekler (enerji içecekleri, gazlı içecekler, aromalı içecekler ve kolalı içecekler) ile kızartma ve cipslerin satışı yapılmamalıdır" şeklinde tavsiye kararı alınmıştır (Ek 2).

İlgi (b) "Türkiye Sağlıklı Beslenme ve Hareketli Hayat Programı" ile ilgili 2010/22 sayılı Başbakanlık Genelgesi (Ek:3) 29.09.2010 tarihli ve 27714 sayılı Resmi Gazetede yayımlanmış, bu çerçevede obezite ile mücadele amacıyla "Türkiye Obezite (Şişmanlık) ile Mücadele ve Kontrol Programı" hazırlanmıştır. Mezkûr Genelge ile programın etkin bir şekilde uygulanması ve eylem planında yer alan görevlerin yerine getirilmesi konusunda tüm kamu kurum ve kuruluşlarına üzerine düşen yükümlülükleri yerine getirmeleri talimatı verilmiştir.

Mithatpaşa Cad. No: 3 B Blok 6.kat Sıhhiye 06434 ANKARA
Telefon: (0.312) 435 70 94/1359 Faks: (0.312) 435 00 87
e-posta: beslenme@saglik.gov.tr Elektronik Ağ: www.beslenme.saglik.gov.tr

T.C.
SAĞLIK BAKANLIĞI
Temel Sağlık Hizmetleri Genel Müdürlüğü

Sayı :B.10.0.TSH-0.12.06 /090.05 /9994 05.03.2010
Konu: Okul Sağlığı

....................VALİLİĞİNE
(İl Sağlık Müdürlüğü)

Okul sağlığı hizmetleri; öğrencilerin sağlığını değerlendirmek, korumak ve geliştirmek için yapılan çalışmaların tümüdür. Okul sağlığı hizmetleri kapsamında sağlığın korunmasına yönelik çalışmalar arasında beslenme, spor etkinlikleri, sağlık eğitimi, çevre sağlığı hizmetleri vb. yer almaktadır.

1593 sayılı Umumi Hıfzıssıhha Kanununun 3 üncü maddesinde, okul sağlığının korunması Bakanlığımızın bütçeleriyle belirli sınırlar içinde doğrudan ifa edeceği görevler arasında sayılmış, 163 üncü maddesinde ise, bütün okulların bina ve sağlık şartları, bulaşıcı ve salgın hastalıklardan korunmaları açısından Bakanlığımızın denetimi altında olduğu belirtilmiştir. Ayrıca, 5179 sayılı "Gıdaların Üretimi, Tüketimi ve Denetlenmesine Dair Kanun Hükmünde Kararnamenin Değiştirilerek Kabulü Hakkında Kanun"un 31 inci maddesinde Sağlık Bakanlığının, genel sağlığın korunması ve hijyen ile ilgili olarak diğer mevzuattan kaynaklanan görev ve yetkilerinin saklı olduğu belirtilmiştir.

Bu kapsamda Müdürlüğünüzce, okul sağlığı hizmetleri konusunun İl Hıfzıssıhha Kurulu'nun gündemine getirilerek ilgili kurum ve kuruluşlarla işbirliği içinde;

- Kantinlerin, Milli Eğitim Bakanlığının işbirliği ile hazırlanan ve Milli Eğitim Bakanlığı tarafından yayımlanan 17 Nisan 2007 tarihli ve 2007/33 sayılı "Okul Kantinlerinin Denetimi ve Uyulacak Hijyen Kuralları Genelgesi"nde belirtilen hususlar doğrultusunda rutin aralıklarla denetlenmesinin sağlanması,
- Okul çevresinde açıkta gıda satışının önlenmesi,
- Kantin ve yemekhaneler ile okul çevresinde gıda satışı yapan işyerlerinin gerekli teknik ve hijyenik şartlara uygun faaliyet göstermesinin sağlanması,
- Kantin ve yemekhanelerde sağlığa uygun, çocuk ve gençlerin yeterli ve dengeli beslenmelerinin sağlanmasına yönelik besinlerin satışının yapılmasının özendirilmesi,

konularında gerekli hassasiyetin gösterilmesi ve sonucundan Bakanlığımıza bilgi verilmesi hususunda bilgilerinizi ve gereğini rica ederim.

Prof. Dr. Nihat TOSUN
Bakan a.
Müsteşar

DAĞITIM:
Gereği:
81 İl Valiliğine

Bilgi:
Tarım ve Köyişleri Bakanlığına (Koruma ve Kontrol Gen. Müd.)
Milli Eğitim Bakanlığına (Sağlık İşleri Dai. Bşk.)

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Appendix G: Canteen Audit From

KANTİN DENETİM FORMU
(Millî Eğitim Bakanlığı Sağlık İşleri Dairesi Başkanlığı'nın 22/03/2006 tarih ve 2006/25 sayılı Genelge'si doğrultusunda düzenlenmiştir.)

Kantinin Bulunduğu Kurum	:	…………………………………..........……… ……………………………………………………. ..…
İşletmecinin Adı – Soyadı / Unvanı	:	…………………………………..........……… ……………………………………………………. ..…
Sözleşme Başlangıç – Bitiş Tarihleri	:	…………………………………..........……… ……………………………………………………. ..…

Denetim Tarihi – Saati	:	……………………………………………….... …
Rapor Sayısı	:	…………………………………..........……… …..

Kantin denetimleri haftada en az bir kez kurum yöneticilerince yapılmalı ve sonuçlar 'KANTİN DENETİM DEFTERİ' ne yazılmalıdır.
Kantin özel kişilerce işletiliyorsa, sözleşmeye bu denetimlerdeki eksikliklerin giderilmediği takdirde sözleşmenin feshedileceği maddesi konulmalıdır.

I – Genel Bilgi Durumu

01. Kantini kimin,ne biçimde çalıştırdığı; ......
02. Kirânın zamanında ödenip ödenmediği; ......
03. Kantin işletmecisinin işbaşında olup olmadığı; .....
04. Satışa sunulan ürünlerin fiyat listelerinin kurum yönetimince onaylı olup olmadığı; ...
05. Bu fiyat listesinin alıcılar tarafından görülebilecek yerde asılı olup olmadığı; .....
06. Çalışanların sigortalılık işlemleri,çalışma izin belgeleri, vb; ....

II – Genel Kurallar

A) Sağlık Ve Temizlik Durumu

01. Fizikî koşullarının (havalandırma, aydınlatma, hizmet alanının vb.) durumu;
( ) Yeterli ( ) Yeterli Değil

02. Tezgâhın üzeri mermer, fayans, paslanmaz çelik veya benzeri malzeme ile kaplı olması;
( ) Kaplı ( ) Kaplı Değil

03. Sürekli olarak sağlıklı ve temiz su bulunması; bulaşık yıkama lavabosunun olması;
( ) Var ( ) Yok

04. Bulaşık yıkama için evye ve lavabonun olması; ( ) Var ( ) Yok
05. Tezgâh, evye ve lavabonun bulunduğu duvarın uygun yüksekliğine kadar fayans, mermer veya benzeri malzeme ile kaplı olması; ( ) Kaplı ( ) Kaplı Değil
06. Zeminin mermer, seramik, karo vb. su geçirmez malzeme ile kaplı olması; ( ) Var ( ) Yok
07. Zeminin kanalizasyona bağlı, ızgaralı ve sifonlu yer süzgecinin bulunması; ( ) Var ( ) Yok
08. Çöp ve atıkların konulacağı yeterli sayıda, büyüklükte ağzı kapalı yıkanabilir çöp kutularının bulundurulması ve çöp kutusuna çöp torbası geçirilmesi; ( ) Var ( ) Yok
09. Kantinde sinek ve böcek gibi haşerelere karşı önlem alınma durumu; ( ) Yeterli ( ) Yeterli Değil
10. Kullanılan ve satışa sunulan gıda maddelerinin ilgili mevzuat uyarınca Tarım ve Köy İşleri Bakanlı-ğından izinli / ruhsatlı olması; ( ) Ruhsatlı ( ) Ruhsatlı Değil
11. Temizlik amacıyla kullanılan ve satışa sunulan deterjan ve dezenfektan gibi maddelerin ilgili mevzuat uyarınca Sağlık Bakanlığından izinli/ruhsatlı olması; ( ) Ruhsatlı ( ) Ruhsatlı Değil
12. Kirlenmiş, kokuşmuş, nitelikleri ve görünümü bozulmuş, şişkinleşmiş, kurtlu ve küflü gıda maddelerinin tüketime sunulup/sunulmadığı; ( ) Sunulmuyor ( ) Sunuluyor
13. Ambalajsız satışa sunulan gıda maddelerinin açıkta satışının yapılmaması; ambalajlı gıda maddesinin ambalajının yırtılmış, kırılmış, paslanmış olmaması durumu;( ) Sunulmuyor ( ) Sunuluyor
14. Tavuk, et, döner gibi işleme tabi tutulan ürünlerin satılma durumu; ( ) Satılmıyor ( ) Satılıyor
15. El ile temas etme zorunluluğu olan gıda maddelerinin satış ve servisinin uygun malzeme ve alet / donanım ile yapılması; ( ) Yapılıyor ( ) Yapılmıyor
16. Gıda maddeleri ile toksin madde ve temizlik malzemelerinin aynı yerde bulundurulmaması; ( ) Bulunduruluyor ( ) Bulundurulmuyor
17. Kırtasiye malzemeleri ile gıda maddeleri satışlarının ayrı bölümlerde yapılması; ( ) Yapılıyor ( ) Yapılmıyor
18. Tost makinesi, bıçak, alet ve donanım gibi malzemelerin gıda maddesi ile korozyona uğrayan materyallerden yapılmış olmaması, sağlam ve sıhhi (hijyenik) olması; ( ) Uygun ( ) Uygun Değil
19. Soğuk ortamda bekletilmesi gereken gıda maddelerinin uygun koşullarda saklanıp satılması; ( ) Uygun ( ) Uygun Değil
20. Gıda maddesinin etiketi üzerinde belirtilen son kullanma tarihinin geçmiş olmaması; ( ) Geçmiş ( ) Geçmemiş
21. Kantinlerde yapıştırıcı, oyuncak, ilâç gibi ürünlerin satılmaması; ( ) Satılmıyor ( ) Satılıyor
22. İlk yardım malzemelerinin bulundurulup / bulundurulmama durumu; ( ) Var ( ) Yok
23. Kantinin her gün muntazam olarak genel temizliği yapılmalı, genel temizlik durumu;

( ) Temiz ( ) Temiz Değil

24. Tezgâhların temizliğinde kullanılan toz bezleri temiz olmalı, durumu;
( ) Temiz ( ) Temiz Değil

25. Kantinde ambalajsız yiyecek varsa, saklanma durumu;
( ) Kapalı Olarak Saklanıyor ( ) Kapalı Olarak Saklanmıyor

26. Kantinde tost,sandviç ve simit gibi ambalajsız yiyeceklerin satışa sunulma durumu;
( ) Paketlenip Satılıyor ( ) Açıkta Satılıyor

27. Ambalajsız yiyeceklerin satışında özel ambalaj kâğıtları dışında gelişigüzel, gazete ve uygun olmayan kâğıtların kullanılma durumu;
( ) Uygun ( ) Uygun Değil

28. Yiyecek kesiminde kullanılan bıçak ve kesici aletler kapalı bir kapta tutulmalı; temiz, bakımlı olmalı;
( ) Temiz-Bakımlı ( ) Temiz-Bakımsız

29. Ambalajlı satılan yiyeceklerde fiyat etiketi;
( ) Var ( ) Yok

30. Etiketlerindeki son kullanma tarihlerini aşan yiyecekler;
( ) Yok ( ) Var

31. Yiyecekler ve diğer satılan malzemeler yerden yüksek raflarda ve cinslerine göre birbirlerine zarar vermeyecek şekilde sınıflanmış mı?
( ) Evet ( ) Hayır

32. Lavabo ve evyede kullanılan temizlik malzemesi, sıvı sabun tercih edilmelidir;
( ) Var ( ) Yok

33. Lavabo ve evyede kullanılan kâğıt havlu, durumu;
( ) Var ( ) Yok

34. Kantinin personeli için ayrılan tuvalette tuvalet kâğıdı ve sıvı sabun, durumu;
( ) Var ( ) Yok

35. Kantinde bozulabilen yiyecekler satılıyorsa buzdolabı-soğutucu, durumu;
( ) Var ( ) Yok

B) Çalışanların Sağlık Ve Temizlik Durumları

Çalışanlar sağlık mevzuatı yönünden yılda en az bir defa genel muayene olmalı; esnaf sağlık karnesi tutulmalı; tüberküloz taraması ve portör tahlili yapılmalı; üç ayda bir dışkı kültürleri alınmalı; sonuçlar sağlık karnesine işlenmeli; personel hastalandığında herhangi bir bulaşıcı hastalık ihtimaline karşılık hemen muayeneye gönderilmelidir. İlgili mevzuat hükümleri çerçevesinde aksatılmadan yürütülmeli.

01. Kantinde çalışan personelin sağlık karneleri;
( ) Var ( ) Yok

02. Çalışanların sağlık mevzuatı yönünden yılda en az bir defa genel muayene olup / olmadığı;
( ) Muayene Olmuş ( ) Muayene Olmamış

03. Çalışanların gerekli tahlilleri yaptırıp / yaptırmadığı;
( ) Yapılmış ( ) Yapılmamış

04. Çalışanların gerekli periyodik portör ve dışkı kültürleri muayeneleri zamanında yapılıyor mu?
( ) Yapılmış ( ) Yapılmamış

05. Personelin kantinde çalışmayı engelleyecek hastalığının olup / olmadığı;
( ) Hastalık Yok ( ) Hastalık Var

06. Çalışanların, kişisel sağlığa uygunluk (hijyen) kurallarına uymasının sağlanması;
( ) Uyuluyor ( ) Uyulmuyor

07. Personelin tırnakları kısa kesilmeli; eller temiz tutulmalı. İltihaplı yara olmamalı. Kesiklere yara bandı yapıştırılmalı; el ve tırnaklarının durumu;
( ) Temiz ( ) Temiz Değil

08. Çalışan personelin temiz iş kıyafeti giymesi;
( ) Var ( ) Yok

09. Çalışanların yaka kartı taşıması, eldiven, bone ve maske kullanması;
( ) Var ( ) Yok

10. Çalışanların görev mahallinde sigara içip / içmediği;
( ) Sigara İçilmiyor ( ) Sigara İçiliyor

11. Çalışanların bir eğitim kurumunda çalışabilecek niteliklere sahip olup / olmadığı;
( ) Uygun Nitelikli ( ) Uygun Değil

C) Güvenlik Durumları

01. Kantinde ocak kullanılıyorsa tüpgaz, tank veya borularının emniyeti sağlanmış mı?;
( ) Sağlanmış ( ) Sağlanmamış

02. Yangın söndürücüleri ve benzeri önlemler alınmış mı?
( ) Var-Alınmış ( ) Yok-Alınmamış

03. Yangın söndürücülerinin son kullanma tarihleri;
( ) Geçmemiş ( ) Geçmiş

04. Kantinde kullanılan elektrik tesisatının yıllık kontrolü;
( ) Yapılmış ( ) Yapılmamış

Ç) Görülen Diğer Eksiklikler Ve Düşünceler

…………………………………………………………………………………...………

	Denetim Komisyonu		Denetlenen
	Denetleyen	Denetleyen	
Denetim Tarihi	. . / . . /	. . / . . /	. . / . . / . . . .
İmzası			
Adı Soyadı			
Unvanı			

Okul ve kurum yöneticilerimiz; okul ve kurumlarının bünyesinde faaliyet gösteren kantin, açık alan, kafeterya, büfe, çay ocağı vb. yerlerde yukarıda belirlenen asgari şartlarla ilgili eksiklikler var ise, en kısa sürede giderilmesini sağlayacak ve sürekli takibini yapacaklardır.

. . / . . / . . . .

.... ……………. Müdürü

Appendix H: Voluntary Participation Information Form

GÖNÜLLÜ KATILIM BİLGİ FORMU

Araştırmacı: ARZU ÇETİNTÜRK
E-posta: sahinarzus@yahoo.com
Tel: 0505 248 23 78
Kurumu ve Görevi: ORTA DOĞU TEKNİK ÜNİVERSİTESİ/ SOSYAL POLİTİKA BÖLÜMÜ YÜKSEK LİSANS ÖĞRENCİSİ
Araştırmanın Adı: İlkokulların sağlığı nasıl teşvik ettiği ve geiştirdiği konulu bir vaka çalışması
Araştırmanın amacı: Tüm dünyada, okullarda sağlık eğitimi ve sağlığın teşviki konuları önem kazanmaktadır. Bu çalışma, Türkiye'de ilköğretim okullarında verilen sağlık eğitimi ve sağlığın teşviki ile ilgili uygulamaları araştırmak için düzenlenmiştir.Bu kapsamda okulunuzda bir durum incelemesi yapılması öngörülmektedir.Söz konusu araştırma Orta Doğu Teknik Üniversitesi'nde yapılan bir Yüksek Lisans Tezinde kullanılacaktır.Araştırmacı, bu çalışmanın yürütülebilmesi için gerekli izinleri Orta Doğu Teknik Üniversitesi Etik Kurulu'ndan ve Milli Eğitim Bakanlığı'ndan almıştır.

Bir katılımcı olarak sizin tarafsız ve aydınlatıcı görüşleriniz bu çalışmanın gerçekleştirilebilmesi için çok önemlidir. Çünkü bu çalışmanın sonuçları tamamen sizin görüşleriniz ve yönlendirmelerinizle şekillenecektir.

Bu çalışmada, katılımcılarla yarı yapılandırılmış bir mülakat yapılacaktır.Her bir mülakatın yaklaşık olarak 30 dakikalık bir sürede tamamlanması ve araştırmacı tarafından mülakatın kayıt edilmesi öngörülmektedir.Mülakat sonucunda elde edilen bilgiler sadece bu araştırma kapsamında kullanılacak olup, okul ismi ve katılımcı ismi gizli tutulacaktır.Mülakat kayıtları ve raporlamaları yalnızca araştırmacının ulaşabileceği şekilde depolanacaktır.

Bu araştırmaya katılım gönüllülük esasına dayanmakta olup, katılmamaktan ötürü ya da katılımdan vazgeçme neticesinde olumsuz hiçbir sonuç ile karşılaşılması söz konusu değildir.

Çalışmanın amacı konusunda bilgilendirildiğimi ve yukarıda yer verilen hususlar kapsamında bu araştırmaya gönüllü olarak katılmayı kabul ettiğimi beyan ederim.

İSİM: TARİH:

İMZA

Appendix I: Etik Kurul İzin Formu

UYGULAMALI ETİK ARAŞTIRMA MERKEZİ
APPLIED ETHICS RESEARCH CENTER

ORTA DOĞU TEKNİK ÜNİVERSİTESİ
MIDDLE EAST TECHNICAL UNIVERSITY

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Sayı: 28620816/ 176 - 388

14 Mayıs 2013

Gönderilen: Doç.Dr. Hanife Akar
Sosyal Politika

Gönderen : Prof. Dr. Canan Özgen
IAK Başkanı

İlgi : Etik Onayı

Danışmanlığını yapmış olduğunuz Sosyal Politika Bölümü Yüksek Lisans öğrencisi Arzu Çetintürk'ün "How do Primary Schools Promote Health: A Case Study" isimli araştırması "İnsan Araştırmaları Komitesi" tarafından uygun görülerek gerekli onay verilmiştir.

Bilgilerinize saygılarımla sunarım.

Etik Komite Onayı

Uygundur

14/05/2013

Prof.Dr. Canan ÖZGEN
Uygulamalı Etik Araştırma Merkezi
(UEAM) Başkanı
ODTÜ 06531 ANKARA

Appendix J: Tez Fotokopisi İzin Formu

TEZ FOTOKOPİSİ İZİN FORMU

ENSTİTÜ

Fen Bilimleri Enstitüsü ☐

Sosyal Bilimler Enstitüsü ■

Uygulamalı Matematik Enstitüsü ☐

Enformatik Enstitüsü ☐

Deniz Bilimleri Enstitüsü ☐

YAZARIN

Soyadı : Çetintürk
Adı : Arzu
Bölümü : Sosyal Politika

TEZİN ADI (İngilizce) : A CASE STUDY ON HOW PUBLIC PRIMARY SCHOOLS PROMOTE HEALTH

TEZİN TÜRÜ : Yüksek Lisans ■ Doktora ☐

1. Tezimin tamamından kaynak gösterilmek şartıyla fotokopi alınabilir. ☐

2. Tezimin içindekiler sayfası, özet, indeks sayfalarından ve/veya bir bölümünden kaynak gösterilmek şartıyla fotokopi alınabilir. ■

3. Tezimden bir bir (1) yıl süreyle fotokopi alınamaz. ☐

TEZİN KÜTÜPHANEYE TESLİM TARİHİ: