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Caring principal leadership for the support of teachers leading committees for promotion of healthy school environments

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Abstract

Caring lies at the heart of effective enhancement of healthy school environments and good school leadership. This is evidenced by health policies wherein principals are indirectly obliged to act ethically and morally. By doing so, they assume their caring role that will enable the development of human capital. This study was conducted in schools in two provinces in South Africa with principals, school management team members and leaders of health committees as participants. This is a qualitative research study which included two rural and two township schools. As this was an exploratory, phenomenological study, data were collected using multiple data collection tools: narratives, interviews and shadowing. The findings of this research indicate signs of caring leadership in the actions and interactions of the principals and teachers; principals and community members; and principals and other external stakeholders. More caring leadership was, however, experienced for the programmes than for the leaders of committees *per se*.

Keywords: Health promotion, caring for, caring about, communal orientation, school leadership.

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1. Introduction

School leadership is an important precursor for school level's adoption and implementation of school health promotion strategies. School health promotion is an internationally recognised approach that connects health promotion and education in a planned, integrated and holistic way. South Africa adopted the health promoting school concept in 1994 in an attempt to address historical imbalances in both educational and health services (World Health Organization, 2013). The policy and school health promotion programme was thus progressively institutionalised and integrated between 1994 and 2000. The four distinct but interrelated pillars of school health promotion in South Africa are: healthy school policies, supportive learning environments, strong community links, personal skills development and the provision of appropriate education support services (Johnson & Lazarus, 2003; UWC, 2006). School health committee leaders who are teachers themselves are at the forefront in ensuring that learners in their schools benefit from the nation-wide initiative. A continuous search for factors that can contribute to the competence of teacher leaders of school health promotion needs to be embarked on. For instance, the results of a recent study by Brunette (2017) suggest that personal health beliefs may only be a small factor in the construction of health promoting roles. Such roles may have less to do with inherent feelings about health and more to do with the structural factors that define and support them. Teachers are fundamental to the success of developing a health-promoting school. The pivotal role of teachers in shaping and improving the health-promoting school concept in their school communities is one of the drivers for health-promoting schools in many countries (St Leger, 2000). Leithwood and Jantzi (1999) argue that the principal is likely to have an impact on a health promotion programme if the teachers that he/she actively supports, especially by the development of capacity and commitment among teacher leaders. Moreover, the caring school leader has an obligation to provide everyone within the school a caring and safe working environment. This compulsion is derived from the South African Constitution (South Africa, 1996), which states that each person has the right to work in an environment that is not hazardous to his/her health and well-being. However, achieving and sustaining school-wide implementation continues to pose a challenge to the advancement of school health promotion and research shows that principals do not play a caring leader role. Caring leadership provides a favourable contextual school atmosphere for the promotion of healthy environments. The principal can, by signalling support for teachers leading health committees and revealing caring leadership, influence the programme implementation in a positive way.

A research conducted by McIsaac, Storey, Veugelers and Kirk (2015) found that schools that were stimulated by jurisdictional vision and provided with relevant Health Promoting School (HPS) support exhibited enhanced HPS functioning through the implementation components. Rowling and Samdal (2011) have suggested that attention is required to the 'functioning' of components (how they are implemented) and postulate that an emphasis on function could bring about a new focus to strengthen the scientific basis for HPS. A study conducted by Johnson and Lazarus (2003) on building health promoting and inclusive schools in South Africa found that good leadership and management are important for successful school-based interventions. They further postulate that the school staff requires guidance and assistance with new interventions. However, studies that focus on caring leadership, especially with regards to health promotion in schools are sparse. For instance, the research conducted by Louis, Murphy and Smylie (2016) which intended to propose a conceptual framework for caring in schools and caring school leadership focussed on caring principal leadership to school-level supports for student academic learning. The research concerning provision of care by school leaders towards teachers is limited. There is vast body of literature on caring about and caring for learners (Ellerbrock & Kiefer, 2010; Louis et al., 2016). It is for such reasons that this research focusses on the 'functioning' within schools to contribute and advance the current understanding of how coordinators and teachers leading health promotion committees can be supported in order for them to be effective in their actions. In this research, I argue that teachers as leaders of health promotion committees are care givers they need to be cared for. This research intended to investigate provision of caring principal leadership for support of teachers leading committees for health

promotion. The objectives were to determine the nature of caring leadership enacted and the essence of experiences of being provided with the caring leadership. Although much research pertaining to the ethics of care in education focusses on teachers and learners, the researcher believes that it can be extended and enacted in school health promotion. If schools are to have caring teachers who lead health/wellness programmes, we cannot assume that they understand care; and if they are not cared for themselves, they might be overwhelmed with the realities of caring for learners and caring about the programmes they are responsible for. The basic assumption of Nodding's (1994) ethics of care is the reciprocal relationship between the one caring and the one cared for, where the former feels obligated and responsible to empower the latter (Owens & Ennis, 2005).

2. Problem statement

The health-promoting schools framework comprises programmes that are to be implemented by each school that has obtained a health promotion status. The difficulty is in encouraging staff members to lead health promotion programmes, staff acceptance of a programme according to Guggl-berger (2011) and Ingemarson, Rubenson, Bodin and Guldbrandsson (2014) is crucial to its integration into the everyday core business of a school, which in turn makes positive health-related change more likely. Programme implementation according to Clarke, O'Sulivan and Berry (2010), De Meij, van der Wal, van Machelen and Chinapaw (2012) represents a complex interaction between the characteristics of the innovation (school health promotion), the providers (teachers leading health and wellness committees) and various aspects of the organisation and functioning. Teachers as the essential supporters of school health promotion are often concerned with seeking practical solutions and gaining new knowledge that meets their situational needs, organisational circumstance and stage of growth (Boot, van Assema, Hesdahl & de Vries, 2010).

Macnab, Gagnon and Steward (2014, p. 174) emphasise the importance of leadership in programme implementation which can help to embed the program in the structure and life of the school. Teachers that are leading committees need all the assistance they can get from their managers, colleagues, learners, parents and community members. These teachers are regarded as among the most influential organisational factors facilitating implementation of health programmes in schools (Fullan, 2001). If the negative impact of the implementation becomes too challenging, it may hinder programme development and decrease leaders of health committee's motivation. The leaders of school health committees are effectively 'the drivers for change' or urgents of change, such an understanding is central to the health promoting school model. Moreover, schools have education and not health as their mission, therefore, these teachers may experience a conflict of goals (Viig & Wold, 2005).

The findings of a study conducted by Jourdani, Stirling, Mcnamara and Pommier (2011) indicated that the majority of the participants interviewed mentioned that the programme implementation created tension among staff. These tensions were linked to the fact that the school health programme approach is not shared by the whole staff. The tensions may lead to withdrawal of staff members from the programme, thereby reducing the support for the programme implementation and leaving the leader on her/his own without any kind of assistance. This situation could generate potential failure in the implementation in other contexts (Merini, Victor & Jourdan, 2009). Such forces from within the school and among the teaching staff also mitigate attention for caring.

The involvement and provision of leadership by teachers in health promotion has always been classroom based. The multi-pronged approach (policy development, community engagement, programme development, health and social welfare sector collaboration, a focus on enhancement of healthy physical and social school environments) to health promotion in schools by the World Health Organizations suggests that teachers will become more proactive outside the classroom in working with other key stakeholders in the school communities (St Leger, 2000). Day (2000) advocates for teachers to be assisted in sustaining their enthusiasm for and commitment to their work in school health promotion, and one of the ways for supporting teachers could be provision of a caring

leadership. The principal as the most potent person in position can shape the organisational conditions necessary for success and can be pivotal in enforcing implementation more than just a teacher.

3. Conceptual and theoretical framework

In promoting healthy school environments, the World Health Organization suggests a model that advocates the whole-school approach (Nutbeam, 2000). This approach includes a top-down process, especially in the development of health promotion policies employed principally to address significant health issues identified by national or local agencies; health promotion programmes that are developed from policies; involvement of staff members and learners in the implementation of programmes; and community engagement by means of collaborations and partnerships. A bottom-up approach has also been used in many instances to introduce the concept of HPS using a single health issue of local relevance (Macnab & Kasangaki, 2012). Such an approach in South African schools has allowed for the implementation of adopt a learner, gardening projects and others. Macnab and Kasangaki (2012) also maintain that with successful implementation of a program to address an identified issue, schools are intended to take ownership of their program, identify additional health topics of relevance to them and expand their HPS activities.

Teachers leading health programmes have to first form a committee that is going to be responsible for implementing the health policy the committee is responsible for. The policies can be nationally developed or school based. The leader has to convene meetings with the committee members and make sure that every member understands what the role of the committee is and what processes are to be followed when implementing the policy. The programme that the committee is responsible for is usually linked to the policy. The leader together with committee members determine the target group, usually learners who are targeted by the policy or nut support, follow-up visits, motivation and effective communication from those initiating the HPS program is a given requirement.

Caring according to Weissbound and Jones (2014) refer to a concern for and acting on behalf of others and to kindness, fairness and the pursuit of a common good. Caring as postulated by Noddings (2005) is not only what one does but also how and why one does it. Van Direndonck and Patterson (2015) contend that caring involves observation and assessment of identification with, and response to situations, needs interests, joys and concerns of others. Caring is grounded in motivation towards the betterment of others (Lawrence & Maitlis, 2012). In order for caring to be effective and benefit teachers burdened with the responsibility of school health programme implementation, it has to go beyond feelings of concern and sentiment to actions to achieve particular aims on behalf of others as indicated by Aarjoon (2000). Caring is particularly important in school health promotion as teachers' experiences of being cared for can help them learn to be caring as Luthans and Yussef (2007) postulate: caring begets caring. McKamey (2011) argues that the two most important concepts of caring are: caring for and caring about. Caring for on one hand involves the day-to-day interpersonal interactions that attend to a person's needs at a specific time. Caring for in this research would encompass teacher programme leaders caring for learners that are the beneficiaries of the interventions they are implementing. The interactions in caring for are private and attend to specific individual situations of learners. Caring about on the other hand denotes an action or interaction that attends to a more general principle, concept or policy. In other words, the act of caring about has implications that are greater than any one interpersonal relationship. *Caring about* is sometimes associated with social or hierarchical positions of power, and in other instances it can be associated with communities of practice. The processes of caring about are often attributed to people in positions of power in schools, hence this research focusses on caring principal leadership. In school health promotion, the processes of caring for and caring about cannot be separated although they are distinct concepts, as school managers because of their position in the hierarchy are expected to care for the leaders of health and wellness programmes and about health promotion. Paying more attention to one of the concepts and processes at the expense of the other would be detrimental to

the school as health promoting. Leaders of health/wellness programmes in schools deserve to be cared for and the caring about their wellbeing is a prerequisite as they are responsible for leading a team of people to drive a school health programme forward. Thus, failure in engaging in both caring for and caring about can lead to the collapse of health promotion. Providing care to teachers who are caregivers of vulnerable learners would intend to address their particular needs in order to promote their functioning, success and their general wellbeing.

Caring leadership requires particular competencies of which according to Louis et al. (2016) are: knowledge which is the authentic understanding of others and their needs; understanding the relative efficacy of approaches and strategies that address the needs and concerns of others; knowledge of self and the ability to develop the capacity for caring; and knowledge and skills for developing caring among others and creating contexts even beyond the school that are conducive to developing and expressing caring (Lawrence & Maitlis, 2012). In his theoretical study, Van der Vyfer (2011) discussed the three main determinants of principals' care: psychological, organisational/workplace and management. The emotional intelligence as a psychological determinant is linked to the notion that an emotionally intelligent school leader has the ability to show empathy, be optimistic, build morale and motivate (Harms & Crede, 2010), these abilities are directly associated with care. The school leaders' duty, therefore, is to ensure that a conducive environment in which the wellness/health leader operates is also provided. Teacher leaders of school health programmes teach first and foremost, they have the same teaching load as all the staff members in a school in South Africa, leading a health programme is added on top of what they are responsible for. Providing necessary resources and capacity building can contribute to a commitment of leaders of the programmes to their work. Darling-Hammond (2003) argues that despite being recognised as agents of change in schools teachers are not experts in health promotion, therefore they need all the assistance they can get to be effective in leading health programmes. The management determinants in this situation would pertain to such issues as empowerment, providing leadership and support and the caring leader should be an understanding listener (Kroth & Keeler, 2009).

This research intended to explore by means of empirical research how school leaders provided caring leadership to teachers that were heading health and wellness committees in public schools in South Africa. The objectives were to determine the nature of caring leadership enacted and the essence of experiences of being provided with caring leadership. The focus on the nature of caring is based on the implicit assumption in the educational literature that caring is primarily dyadic (on a small group). The belief is that school leaders must be able to master caring for those closer to them first in order for them to extend their acts of kindness beyond the school environment.

4. Empirical research

This study made use of a qualitative approach which enables researchers to empathise with participants and discover how they see the reality of a particular situation (Kreuger, 2009). Phenomenological design was preferred as the aim was to describe as accurately as possible the phenomenon of a caring leader from the perspective of the participants, refraining from any pre-given framework, but remaining true to the facts. I made use of both the existential and transcendental phenomenologist, both can be applied in search of foundational structures of experience, thought and reality (Edie, 1964). In using exstentialism, I wanted to focus on the nature of caring leadership that was provided to the teachers by the principals and with transcendental phenomelology I was going to be able get data on the essence of the lived experiences of the participants (teachers) with regards to the caring leadership provided.

4.1.1. Participant selection

Prior to the start of a four-year project on: Organisational Development and Change Management and Promotion of Healthy Physical School Environments that involves researchers and student in three provinces in South Africa, a pilot study was conducted in two of these provinces. Regarding the

selection of schools for the project, the criterion was based on schools with more than 1,500 learners. The assumption was that in such schools it would be more challenging to promote healthy physical school environments. This preliminary study was conducted in schools that were not selected for the project in both provinces. However, both schools in the Free State (FS) were part of another research project. Working with the same group of teachers' overtime gave me an opportunity to build a relationship and understand the context of the schools better. I was able to observe patterns of events that occurred and reoccurred over time because of the "hanging out" as suggested by Luttrell (2010). The selection of participants was guided by the objective to understand the perceptions of the participants with regards to how school leaders provided caring leadership to teachers that were heading health programmes. To better understand the elements that make up action and interaction caring for and about teachers leading committees for the PHSE, I purposefully selected principals, teachers and coordinators of health committees in the FS and Limpopo (LS) provinces of South Africa. As suggested by Kruger (1988), I looked for participants who had experience relating to the PHSE.

Two schools in the FS and two in LS participated in the research. I had a mixture of township (in a peri-urban area of the FS) and rural schools (LS) in the sample. All the schools are non-fee paying and rely on the subsidy from the Department of Education. These schools had enrolment from 890 to 2,000 learners from disadvantaged communities. This places a huge burden on the school in terms of care and support. I had a sample of four principals, eight coordinators of health committees and four school management team members [deputies and Heads of Departments (HODs)] (n = 16). In the FS as in Gauteng, two teacher leaders of health committees from each school participated. Most of the leaders were females (n = 6), while principals were mainly males (n = 3). To elicit teachers' perception of enactment of caring leadership by principals to facilitate or deter their leadership of health committees, I listened to their own descriptions of the development and implementation of the programmes as discussed below.

4.1.2. Data collection strategies and processes

Three methods of data collection were employed: narratives, individual interviews and observations. First, each teacher leader had to provide a narration about caring leadership or lack thereof during the development and implementation of a health programme he/she was leading. The narrations of school principals, deputies and HODs were based on their provision of caring leadership to teacher leaders during implementation of the programmes. The prompts for both groups included: development/implementation of programme and enactment of care, enabling and restraining factors to provision of caring leadership, care needs during development/implementation of programme, impact of provision or lack on individual leadership.

Individual face-to-face interviews were conducted after data were collected by means of narratives. As the semi-structured interviews followed a conversational format (Patton, 2002), an interview guide was developed for teacher leaders and for school managers from the gaps identified from the narratives. Interviews with principals only focussed on how they provided caring leadership for teachers who were leading health committees, what factors enabled the provision of caring leadership and which did not. The individual interviews with teacher leaders were based on their experiences of being cared for, the nature of caring leadership provided and how the latter influenced their own leadership of health committees. Participants were interviewed in their classrooms and offices where they were most comfortable. The interviews at schools were conducted after the teaching time when learners had already left. I had one interview of an hour and a half with each participant.

One day was dedicated to each participant for focussed shadowing of each individual teacher leader of health committee. Shadowing was done as a means of observation. Shadowing according to McDonald (2005) is a research technique which involves a researcher closely following a member of an organisation over an extended period of time. As both the school managers and teacher leaders were shadowed, I had to spend 4 days in each school for this. Shadowing helped in revealing what the participant does, but also how the participant interacted with other people (teacher leader *vs.* principal and vice versa). I chose to shadow on days when the teacher leaders were involved in

programme implementation or development but the observation was also focussed on other duties of the teacher leader. The shadowing was done after the data were gathered using two data collection tools. The reason for this was the acknowledgement that my presence as a shadower might change the behaviour of the participant being shadowed and set a stage for what she/he wants me to see. I had a fairly good understanding of what the situation was with relation to the provision or lack of caring leadership in the participating schools based on the data I had collected.

After each phase, I transcribed the data and at the end I had three sets. Then, I started with the initial analysis which included familiarising myself with the data by reading the transcripts several times to acquire general feeling for the experience.

4.1.3. Data analysis

Content analysis was conducted to analyse the textual data gathered by means of narratives, interviews and shadowing. Following steps in analysing phenomenological data, I extracted the significant statements pertaining to the phenomenon in each set of data. Then I formulated meanings of the segments of statements I had extracted. I grouped these segments under different categories. The themes were formed from the clustered categories and were validated with the original text to identify experiences common to all participants. Contradictory themes were also considered for their relevance. The section on results below presents a description of the experiences of the participants, developed through empirically derived themes.

4.1.4. Trustworthiness

Data were gathered from multiple sources of data, integrating multiple methods which also pertain to complementarity and documentation of different perspectives on the phenomenon of provision caring leadership to teacher leaders of health committees reduced researcher biases. Trustworthiness is enhanced when two or more methods of data collection that have offsetting biases are used to assess a given phenomenon, and the results converge or corroborate (Scandura & Williams, 2000).

4.1.5. Ethical considerations

After ethics approval of the project by the university, I applied for permission to conduct research in schools from the Department of Basic Education, of which it was granted. Ethics applications in each of the provinces had to be sought for the schools to participate. Participants signed informed consent forms for participating in the research and other consent forms for being shadowed. The meetings about the project processes and procedures provided an opportunity for relationship building before the preliminary study commenced, enabling data collection and the understanding of the school context.

5. Results

The results of the data gathered by means of narratives, interviews and shadowing are presented. Teachers in LS will be indicated with LT, principals with LP and other school managers with LM. Participants in FS will be identified as FT, FP and FM. The excerpts from the notes taken during shadowing will be indicated as LS and FS.

5.1. Leadership in health promotion programmes

Leadership and management of the committees who are responsible for the implementation of health programmes are held together by the teachers. Teachers in a school democratically select a leader of a health committee in a meeting. This person is responsible for keeping the committee focussed on their role by having meetings with them about what has to be done and how it should be done. Other programmes that the teachers were leading were linked to other government departments of which teachers had to liaise and collaborate with. The administration of the school health programme is the sole responsibility of the committee concerned.

Planning is done by the committee; the itinerary is then submitted to the school management for approval and for their own planning in terms of time and resources (FT4); I work with the trainers (other teachers) to organise activities within and outside the school (*LT2*); *I am responsible for a programme that supports vulnerable learners. I have to liaise with other government departments to garner support for the programme especially the department of health and social development (LT3).*

Participants stressed the importance of a having committees for the programmes and electing the right people to lead them. As this role included operating health promotion programmes, management tasks (planning, organising, monitoring and evaluation) were important to embark on. Leadership and management at this level differ from that of school managers as it only focusses on one programme. Participants also mentioned the importance of having a committee leader who loves leading the programme.

Leading the programme must not be regarded as a burden otherwise there will not be progress. The person leading the programme must love it and also working with committee members (F3); at our school the leader is allowed to choose committee members after all it her or him who is going to work with them (L4); committees are important in making sure that plans are implemented and the school benefits from the programme (F1); without a leader there is no committee and the programme will fall flat (FM3); a leader has to be visionary, a person who puts health promotion on the agenda always (L1).

The school managers consisting of the Principal. Deputy and HOD provide resources for the school-based programmes while others are funded at national or provincial level. The provision of resources at school level by the principal included allocating funds for attendance of workshops organised by the district, buying equipment for learner activities, supporting planned activities by actually being involved and or motivating learners, teachers and parents to participate. These funds come from the money allocated by the ministry of education to each public school. Schools in poor communities that are classified as Quintiles 1 or 2 (based on the socioeconomic environments in which the schools reside) get more funding as learners in these school do not pay school fees. Communication with external agencies is done by the principal on behalf of the teacher responsible for the programme and communication with external bodies is done with or through the principal. Responsibilities of principals and other school managers included management and providing leadership to all health committees within the school, they played a role of overseeing programmes.

The principal is responsible for the implementation of policies including those that deal with learner wellness. He sets up the committees and make sure that each of the committees is led by people that are committed and capable. In our school our policy indicates that a committee has to be in place for three years then new elections are done (SM3).

All participants indicated that the health programmes would not be sustainable without the support of the principals. They emphasised the importance of a positive attitude towards the programme by the principal and the impact that might have on keeping the programme going.

The principal is the engine of the programme, without her support everything collapses (LT3); it makes a difference when the principal provides motivation, to me as a leader and others to participate (F2); …that authority is needed to push things a bit (LM1); the principal cannot watch the implementation of a health programme form a distance, he must be able to see for himself or her

5.2. Restraining factors that were indicative of teachers' care needs

There were challenges that were related to resources that were indicated as beyond the authority and power of the principal to deal with which had a negative impact on how the committees functioned. These pertained to the lack of time for the programme and its implementation and finding assistants for teachers who lead programmes during the time when they have to be fully involved in the health programme.

We are not afforded time to focus on the programme, we do it when we have time, this becomes a problem (F3); the only time when one can focus on the programme is after teaching time in the afternoon, although we are tired by then we force ourselves to work on the programme (F1); the school cannot afford to hire an assistant teacher, this has to be the school governing body post, it happens in schools that are not in poor communities where learners pay fees (TM3); we have shortage of water and this becomes a serious concern regarding the feeding scheme, drinking and washing of hands.

Most challenges that were highlighted by participants encompassed lack of resources. The support needs were revolving around these issues. This challenge was supported by both school managers and leaders of committees in both provinces. All participating schools were in poor areas where community members were struggling themselves. The priority for health programmes in such areas is to deal with social issues first and foremost, and then the little resources that are left can be used for health programmes. Even the challenge of shortage of material resources seems to be out of control of the schools. The interventions are top in the list of the health committees and participants indicated that there is no progress that can be made with regards to the programmes unless the basic needs are met, then, the maintenance, the beautification of the school and the focus on the physical environment and others. The situation was even worse in schools in the rural area where there was no running water.

There is shortage of equipment, there are not enough dustbins that makes it easy for learners to litter (LT2); the drummers' uniform and equipment is expensive (LT4); we do not have a sick bay, learners have to be taken to the local clinic by teachers who have to abandon their classes to attend to a sick learner. This is the situation with all schools in rural areas (SM2);

There was an indication of unequal treatment of committees, especially with regards to the allocation of finances. The school managers indicated the importance of prioritising when allocating resources. There seemed to be a lack of understanding between managers and the teachers with regards to which committee gets more money and why. The criteria are not communicated to teachers leading committees. This situation leads to uncertainty and lack of satisfaction with the procedure.

Finances are not equally distributed among the committees, you can see that they are not treated equally, more support is given to others (F3); the reasons that are given are that the favoured committees have more learners and learners need them more than the others, my opinion is that learners need a healthy environment as much as they need feeding scheme, to me the two are equally important (FT4);

Rapid changes in education in South Africa have led to new challenges for teachers. The new curriculum and its demands, the behavioural problems of leaners and teachers, the rising number of learners in need of educational support who demand for a degree of adjusted teaching and more individualised teaching make it difficult for teachers to focus on health programmes. More attention is given to classroom activities and least time is afforded for health promotion. Teachers in both provinces indicated that the contact time with learners in primary schools is 5 and 6 hours in high schools but teachers have to be at school for 7 hours. The extra 2 hours in primary schools and an hour each day in high schools is for development and planning. The work related to health promotion is supposed to be budgeted for in the extra time but some participants indicated otherwise.

We have no time for to focus on the health programmes, I love being involved, and contribute to the health of learners but there is no time (LT3); it is a struggle to do justice to the health programme, but we try, there is no time (LT1); there is time in the afternoon after teaching time, the 2 hours that is allocated for development, I have to choose between giving my struggling learners an extra class, sit with a learner who seems to be encountering problems to provide counselling or focus on a health programme. One is faced with such tasks daily (FT4); if you love something you sacrifice for it, I make time in the afternoon after class and in some weekends (FT2).

Being cared for was non-existent in both provinces, perhaps it was because of the forces exerted by the socioeconomic conditions of the communities the schools were in. All resources had to be pulled to meet the most basic needs of the learners, living no room for showing concern for the leaders of committees.

When we report to the principal pertaining to the problems we encounter as a committee he tries his level best to attend to them, but he is more concerned about the outcomes of the programme than us (TLE); he helps the committee by making follow ups with the departments of health and social development when we are not getting response from them. He also recently visited the local clinic to request them to give learners priority when they visit the clinic especially if they are with teachers and in school uniform (TLE); we talk to him about our problems and he helps where he can, but I think it is about the programme not us (TLC).

5.3. Factors that enabled caring leadership

Assistance by school managers included collaborations and individual endeavours to make things work by providing the necessary resources that enable effective implementation of programmes.

When learners are punished for late coming they clean the surroundings supervised by the Heads of Department (TLD) I take it upon myself to involve the community to supply water to school, I also involve public works to assist in cleaning the school (SM3). Learners come with water from home so that they can wash hands, drink and wash utensils after their meals (TLE); he hires the services of local people with light delivery vans to supple the school with water and hire people who clinic the toilets (TLE); the principal usually ask for donations of flowers to plant in the school (TLC); the principal requested parents to assist us with the tree felling and chopping of wood but the problem of wood being stolen could still not be solved (SM1); the principal organises prisoners to clean the surroundings and take care of the garden (TLC)

The two schools in LS have no running water as they are situated in rural communities. Support from the school principal becomes an essential in such circumstances. While sharing some characteristics with schools in the township, these schools had strengths. Teachers leading committees mentioned a close working relationship between them and the principal and between the school and the community. This was so because of the daily struggles that they were faced with, of which they realised that sharing the burden works better than working individually.

Parents are willing to assist with whatever they can, even if they do not have much in terms of resources, they offer their services (LT3); the principal is very close to the parents, they support the school because of this good relationship, he tries to support us in every way he can (LT4); we are a team, there is no way that you can make a difference in these schools on your own, we are compelled to work together (LT1); it is difficult to see if they are coping if you are not involved (FP3).

Principals in the rural schools of LS, despite being in deep disadvantaged communities exhibited signs of caring for the programmes and providing caring leadership, knowing that it would be impossible for teachers leading committees to do it on their own. This situation was similar to that of the township schools in the FS. Principals of the two schools in the latter province knew everything about the programmes, what the challenges were and what they needed to do to improve the situation. They emphasised the importance of having the programmes and their benefits to the whole school community. They would also motivate

The principal ask about the progress, you could see that he is concerned, he wants to assist (FT4); I do not hide the problems I encounter with the programme, she knows about them and she is always willing assist (LT3); the principal organise the resources even before the start of the school year for the following year, he thinks ahead (FT1); I work closely with committee leaders, they are responsible for the programme but I am the accounting officer, if things do not go well I am the one to account (FP1);

It is my responsibility to assist with the project, I make time to get the resources they need, besides teaching and leading a programme is real hard work in our communities (LP3).

6. Discussion

The findings of this research indicate signs of caring leadership in the actions and interactions of the principals and teachers; principals and community members; and principals and other external stakeholders. The caring leadership was however, more caring for the programmes than about the leaders of committees *per se* was observed.

Caring leadership in its nature occurs through actions and interactions where tasks and activities can be filtered through a lens of caring leadership. Several building blocks of caring leadership are indicated in the literature. Those that were found in this study included organisation of material and human resources, trustworthiness, accountability in matters of programme development and implementation, support and cooperative work. These resources were allocated specifically for the support of the programmes, teachers might benefit indirectly as their stress is reduced by being supported. The provision of human resources by mobilisation of community members, other teachers within schools and other external bodies to support the programmes was an indication of caring for the programme. Whether this was done because of the feeling of being responsible or accountable, their success was the concern of the principals.

Caring leadership raised cooperative work in LS. In rural areas, community members and teachers who grew up in such communities tend to be communal oriented. Communal orientation is defined by Clark (2011) as general inclination to be sensitive to the problems of others, and to help others primarily in response to their needs and out of concern for their wellbeing. Principals were concerned about the success of the programmes, they were aware of their benefits for learners. They worked together with the teachers in a way that reflects their understanding of the difficulty of the tasks especially under such harsh conditions of lack. It also reflected their eagerness to address the needs and interests of the teachers to the benefit of the learners. They were prepared to do everything in their power to support the programmes. The principals' caring leadership was boosted by their communal orientation. Communal orientation is associated with caring in the literature (Bryan, Hammer & Fisher, 2000). Because of the shared problems, teachers and community members were brought together to work towards meeting the existential needs of the learners and to a lesser extent to programme implementation. The activities of the committees were mainly focussing on interventions rather than the cleanliness of the surroundings, the beautification of the school and the greening of the environment. Thus, promotion of healthy school environments in the actual sense was at the bottom of the list in the participating rural schools. The constraints in the communities where the schools resided provided few opportunities for the schools to move beyond the limits imposed on them by their disadvantaged background in terms of health promotion. As much as rural schools were in deep disadvantage with regards to resources, they were much more able to draw essential support on social and community resources than their township counterparts.

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