The Hong Kong Polytechnic University

School of Nursing

COLLABORATIVE ACTION RESEARCH IN CHILD HEALTH PROMOTION: A SCHOOL NURSING EXPERIENCE

by

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Certificate of Originality

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Abstract

Background and Aim

The agenda for quality health care seems to be a non-ending matter of concern which is commonly shared by the government, healthcare professionals, and public communities. The intent of a healthcare change is to provide affordable, effective, and better healthcare services from the perspectives of all parties concerned. The partnership of school and nursing in contributing to the well-being of children is a well-known strategy to enhance primary health in overseas literature. However, most school health studies were developed by non-nursing researchers, and they focused mainly on the outcome intervention and policy issues. Nurses have played a key role in school health but little data are evaluated from a nursing perspective. Hong Kong's school nursing is at its infancy stage of development. It is lacking in terms of school nursing research data for designing intervention and research. Therefore, this study set out to capture this initiative of development through a nursing research within the context of school health practice. Knowledge and insights from the research findings will be taken for future reference in designing the settings of school nursing service, research, and practice.

Design and Method:

The primary aim of this project is to attain a theoretical understanding of the process of primary school and nursing collaboration in healthcare through real world practice. In consideration of this innovative practice in the natural school setting, a collaborative action research (CAR) design was purposively selected to guide the intervention process and data collection. Theories of holism and hermeneutic interpretation were applied in understanding and relating the meanings of the social data in human context. Public participants who were treated as co-researchers rather than as subjects were engaged in the research dialogue and discussion. The purposive design was adopted to enable a school community to be involved in the planning, implementation, and evaluation of the total school

health intervention process in a participative and non-dominant manner. This research strategy underpins the public and community health nursing principle that every human being should have the opportunity to participate in promoting his/her own health.

Results and Discussion:

The collaborative action research of introducing change of school health practice induces multiple stages of social interactions. The first stage of research work generated a team-building framework of school health participation. The results of the second stage of team implementation constructed a theory of school health practice that promotes the understanding of human dynamics in social health settings. The context of school health embraces 'team relation', 'empathetic dialogue', 'mutual participation', 'peer support', 'parental caring', and 'school health integration'. These concepts are the motivational forces of enhancing school health partnership, resource mobilisation, and school life integration. The realisation of these concepts takes place in not only the physical environment of the school but in communicative, supportive, caring and educational context.

Implication and Conclusion

Dimension of school health collaboration was found to be socially dynamic, interpersonal, and intrapersonal. It required social competence, intervention skill, and practice knowledge. The development of school health environment serves the dual purpose of sustaining school's health as well as to enhance planned change in professional advancement, community partnership and service intervention.

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Chapter One

Introduction

This chapter aims to identify child health concerns, the concept of school health, and its relationships to quality childcare. Child health promotion through school collaboration has been strongly recommended worldwide as one of the effective strategies for optimising community and school health resources to improve the quality of childcare. There are many proposed strategies to sustain quality school health practice, but most of them are based on literature rather than on research findings. Applied research that focuses on using empirical knowledge to develop practical approaches in real settings is lacking. In this chapter, issues on child health, school health visions, and professional practice for supporting quality childcare are discussed. The significance of a school health study in applied research settings is particularly highlighted.

1.1 Health concern of the child population

Toward the goal of Healthy People 2010, both public health and education sectors have recognised the importance of

school health education in preventing health problems in the areas of unintentional injury; violence; suicide; tobacco use and addiction; alcohol and other drug use; unplanned pregnancy, HIV/AIDS, and STD (sexually transmitted disease) infection; unhealthy dietary patterns; inadequate physical activity; and environmental health (US Dept of Health & Human Services 2000). Well-designed and appropriately implemented health education programmes are not categorical such that they deal with a particular disease or disorder only, but they provide general knowledge which is relevant to the health needs and experiences of the youth (Defriese et al. 1990, Pigg 1992). The children are the future pillars of the society. Their needs which are vital for their physical and psychosocial health development are matters of concern. Hence, intervention on health risk behaviour at an early age will be more beneficial. Likewise, the appropriateness of service support and participation in matching school, family, and child health needs are

necessary.

Health surveys help decide the healthcare priorities and needs of the population. In the school years 1995 and 1996, student health service centres detected prominent health problems in primary school children. These were visual acuity (36%), obesity (11.8%), and psychosocial problems such as low self-image, poor relationships with parents, emotional and behavioural problems, and stress related to academic performance (4.9%) (Department of Health 1996). Common child health concerns include physical and psychosocial growth and developmental health issues such as a child's problems on maturity, behaviour, cognitive development, learning difficulties, interpersonal skills, and others. Past and current child health surveys have documented an unchanging trend of childhood problems such as preventable injuries, obesity, vision problems, respiratory disorders, and emotional and behavioural problems (Cheng et al. 1990, Chow, Chan & Chiu 1993, Chan 1995, Tse 1997, Department of Health 1998, Gasco 2004,

Woo 2004). Although no similar survey has been conducted recently, obesity is still one of the most common child health problems amongst the 5-14 age group attending Student Health Service centres (Department of Health 2001, 2003). In fact, amongst all child health problems, childhood obesity is the most critical health concern, as it may cause other body system malfunctions in future growth and development (Linton & Maebius 2003, Gasco 2004, Woo 2004).

Moran (1999) and the Hong Kong Sports Development Board (2003) highlighted that childhood obesity in relation to inactivity may affect a child's future physical and psychosocial health and hence should not be neglected. Although Fogelholm et al. (1999) advocated that parent-child relationships affect physical activity patterns, modern lifestyles have shifted child living toward a pattern of minimised energy expenditure, increased high-calorie food consumption, lack of physical

activity, and increased static activity. Attention and effort toward minimising this social culture and home living behaviour are thus indicated.

1.2 School function of quality childcare

The complex health and educational needs of today's school children are prompting schools to develop more responsive school health programmes. There can be many possible ways of promoting children's health. In consideration of the facts that children spend most of their lifetime in school and that parents are their closest and most influential family members when it comes to their habitual behaviours, the collaboration of child health professionals with parents and teachers in promoting children's well-being has always been recommended as a preferred practice. This practice can maximise social resources by involving the direct informal caregivers.

The public has equal rights to access health. Providing an accessible primary healthcare service to the public has long been promoted by the World Health Organisation

as a strategy for achieving the mission of global and local health (WHO Report 1991, WHO 1991). School health, a part of the school health system, provides primary healthcare for children and their caregivers (WHO 1995,1997). However, research on its influence is mainly focused on rare and accumulated. Research evidences which may lead to the development of school and nursing collaboration in child and school health practice, as well as a mechanism for promoting the involvement of related parties such as the child, family, and the school should thus be explored. Research results guide school health action for future school health development strategies. This vision may become possible if there are initiatives in exploring the feasibility of this practice.

1.3 Collaborative environment of quality childcare

Schools have been recognised as a wellness and holistic setting for collaborative child health promotion (Lee 2002, Moon 2002, Douglas & Machin 2004). They can be seen

as effective settings to promote the health and well-being of all people in communities associated with school life (Thomas et. al. 1998). This is because an adult and a child's spirit must be well cared for (Grotberg 1995). It is part of an essential component of enhancing long-term mental growth and development. Moreover, being able to make informed choices about behaviour affects an individual's health (McGinnis 1992). Schools serve as accessible and available public settings for delivering health messages to children and their caregivers. Interventions invoking the public to make healthful decisions and fulfil an active role in sharing health responsibilities have always been considered to produce mutual benefits to people and the society at large.

Primary school children are an appropriate age group for acquiring new concepts and attitudes, and adopting healthful living habits from their parents and their teachers who are also potential clients to learn health knowledge through health teaching and practice.

Healthcare professionals could work together with the school to promote student well-being and health. Modern education should help young people to acquire values and accept responsibility for their health and social behaviours (Lee et. al. 2002). Students and teachers with strong minds and health achieve success in education, and school involvement in child health is seen as directly related to school education. Health behaviour is a habit that cannot be imposed. It is gradually formed and integrated in living practice. Primary healthcare emphasises that every individual should have the right to access and participate in basic care to sustain his/her healthy survival. Public participation in social action, practice, and reflection promotes self-understanding and social awareness (Kolb 1984, Bourner & Frost 1996, Mumford 1996, Berg & Sarvimaki 2003). Moreover, an active participation in reinforcing a sharing of health decision making and responsibilities in different levels of health acts at most times is regarded as one of the desirable

approaches in behavioural health promotion.

Family and school environments play key influences on children's health. This is so because individual school and family culture affect children's health and development. The school and family health environments should therefore be considered in forming an integrated concept in promoting long-term child health behaviour. Healthcare practice is culture specific because it involves individual, environmental, and social dimensions of change. From a socio-economic perspective, it seems unrealistic and difficult if only school personnel and individual families take up school health responsibilities. As school health may affect the entire cognitive and social development of a child, individuals, families, and related organisations should also be involved in improving the health behaviours of health risk populations. In pursuit of this goal, support from health professionals, the community, and the society is

necessary in order to enhance their continuous and voluntary participation in promoting and maintaining a healthier community and population.

1.4 School health as a global vision of quality childcare

Health covers not only the concept of the absence of disease but embraces the meanings of physical, mental, and social well-being. Children spend most of their lifetime in school, and their parents are the closest and most influential family members when it comes to their habitual behaviours. From the perspective of community resource support, the school partnership approach in which a school, its professionals, and the children's parents are involved in promoting child health practices is more preferred than one side just taking the lead and sole responsibility. Roles and duties should be shared. There can be many possible ways of supporting and reinforcing healthcare initiatives. The concept of the health-promoting school has resulted in a variety of

health-promoting initiatives in the school, community, and national levels; strategies that can be applied to both pupils and the staff, and the integration of school programmes with community resources are the central themes of integration (Thomas et. al 1998). A committee to initiate action, a plan to guide work, and school support are likely to facilitate organisational health change in schools (Mitchell et. al. 2000).

School-family-community partnership is valued as an effective initiative in moving health participation from the simple classroom setting to the whole school (WHO 1997, Thomas et. al. 1998, Hawkins et. al. 2004, Connecticut State Department of Education 2005). The classroom approach is more individually focused, whilst the partnership approach shifts toward a broader range of whole school settings. At the same time, the collaboration of child health professionals with school partners is mobilising community resources into involving teachers

and parents as child health promotion agents.

1.5 Professional practice for quality childcare

Many developed countries such as Australia, Canada, United Kingdom, the U.S.A, and other Asian regions such as Mainland China and Taiwan have implemented school-based nursing services as one of the strategies in promoting child health in school. School nursing roles, functions, and standards are stated in accordance with the national healthcare policies which guide nursing practice in schools. The Hong Kong model of student health service is community/district based, and prevention and curative orientated. School-based child health services and intervention programmes are provided upon schools' demands and needs. Student health services are operated in multi-disciplinary settings. Medical, nursing, and other specialised healthcare teams offer school children physical and mental health services in centres or specialist clinics (Student Health Service Report 2004).

This district-based government service has the strength of providing free annual primary health screenings and focused interventions for school-age children and the youth on a voluntary basis. Owing to the limited centre environments and service settings, general child health promotion and education issues would involve time constraints in their implementation. On the average, each student client will have no more than 15 minutes per visit. Therefore, many individualised child and family health concerns that require more time for communication and understanding may not be attended to.

Collaboration and community-based research skills are considered essential in generating scientific evidences for the dynamic roles and functions of school health practice. However, there is a lack of school nursing practice research in providing recorded evidences, data, and knowledge to guide theoretical practice and service development (Thomas et. al. 1998, Leger 1999, American Academy of Nurse Practitioner 2002, Anderson 2004).

School health implementation, similar to other healthcare interventions, needs to be observed and documented in terms of its effects and effectiveness through research toward a sound knowledge of practice and development. Health conception is highly influenced by individual life experiences. School health-promoting practice is organisation and culture specific (Thomas, Parson & Stears 1998, Hawkins et. al. 2004). A model that is found successful in one school organisation might not be applicable in another. As each school is unique, no matter which model is considered as the best, there would still be some arguments in deciding which is the best model for the individual school. Other debatable issues also include the relation of a school nursing system to the whole child healthcare system and its becoming a part of the existing healthcare system. The fundamental infrastructure settings of school health function such as the learning environment, staff preparation, and resource support should thus be investigated for school

health practice plan and development.

Current student health services are advocated and decided upon by healthcare professional teams. These services mainly include health risk assessment and intervention. Whilst healthcare professionals are encouraging the public to take a more active role in personal and community care, healthcare researchers could also involve the public in expressing health service needs and other ways of improving personal care. To transform this vision into reality, healthcare professionals should exert efforts in creating opportunities for public health involvement by all means. Majority of the current school-health studies are focused on health curriculum, teacher development, student health intervention outcome, and policy development (Rowling & Ritchie 1996, Leger 1998, Mitchell et. al. 2000, Brindis 2003, Patton et. al 2003, Selekman & Guilday 2003, Lee 2002, 2004). Research of the school health settings in nursing practice is lacking.

The actual benefits of the collaboration of the school and nursing profession in school health context remain unclear.

Health is a fundamental human right as well as a shared responsibility of an adult citizen. Primary healthcare in promoting public health is a common community and population-based practice. Each person is assumed to have equal opportunities of seeking health information so that he/she can make informed life choices. With this belief, primary healthcare, in principle, encompasses the general practice of delivering healthcare and service that are perceived by the public as accessible, affordable, available, and acceptable. From a social justice perspective, people should not be denied of their rights to access health resource owing to age, poverty, disabilities, or the deficit of knowledge and environmental resources. According to the Alma-Ata agreement, individuals, professionals, and global

societies should play an active role and set a realistic agenda for achieving the health of a community toward promoting the health of all (WHO 1991, 1995, 1997). Primary healthcare principles serve as the benchmark of public service, as they become common evaluation indicators for assessing the basic quality of public health services (Barnes et. al 1995, Allensworth et. al 1997, Taylor 2005). Although government documents, such as the recent healthcare reform report, have identified a list of healthcare problems in relation to an ageing population and increasing healthcare expenses, recommendations on policy implementation or service restructuring to increase the efficiency of primary healthcare delivery mode are rarely mentioned (Taylor 2005). With the decrease in healthcare budget and increase in financial resources needed to sustain the quality standard of the community infection control service after the SARS crisis (Hospital Authority 2003), the increase in budget for primary health promotion may even become

more arguable and evidence focused.

More than 15 years ago, the Hong Kong society has already acknowledged the significance of developing community health services to meet increased public health demands (Primary Healthcare report 1990). However, long-term plans for primary healthcare are relatively neglected; a systematic approach of reviewing the effectiveness of healthcare system is needed (Ho 2002, Yip & Hsiao 2004). The major client population of Hong Kong community nursing services is comprised of elders (Community Nursing Service Report 2004). The services are mainly provided by public hospitals that render services and healthcare programmes at the residential and private homes of elders with chronic diseases or illnesses. The ageing population, a global health issue which has a prominent impact on decreasing the economic productivity and increasing the health expenses of a society, has widely been discussed and planned for by inter-disciplinary professions.

Responding health policies and service plans are designed and implemented in future social service settings (Hospital Authority 2003, Community Nursing Service Report 2004, Health Care Reform 2005). Relatively, the services provided by the Department of Health, which offers the major primary health services for children and provides programmes or services to schools, organisations, and specific communities, are inadequately evaluated (Department of Health Report, 2005). Local research data for developing sound models for long-term primary child health practice are insufficient. Healthcare in Hong Kong was criticised because it lacked a coordinated system of financial and policy planning to adapt to and prepare for increasing healthcare demands and expenses (Health & Welfare Bureau 2000, Taylor 2005). The goal of the Hong Kong Hospital Authority, as remarked in a recent healthcare reform of establishing a community and professional collaboration of taking health as a lifelong investment, seems to address part of the uncoordinated

health system and constrained health budget. The effectiveness of community collaboration on public health requires further studies rather than being taken for granted as a rule of human goodness.

1.6 Significance for nursing practice

Nursing people in hospitals as a form of role learning is the mainstream nursing practice. Hospital nursing practice plays a major component of the Hong Kong nursing education curriculum. On the other hand, it seems to contrast with the global trends of expanding and extending primary health services from hospitals to the primary and community care settings. As a matter of fact, many developed countries advocate the significance of establishing a coordinated system of a hospital-community network for quality healthcare provisions (ICN 2006, Academy of Nurse Practitioner 2006). Such strategy puts forward three benefits. First, it helps relieve the burden of heavy clinical workload. Second, it promotes a shared

health responsibility amongst the public. Third, primary and community care practice as compared to a hospital or a rehabilitation institution accommodates more flexibilities, continuities, and cost-effectiveness in the process of healthcare intervention for both healthcare providers and clients (Community nursing service report 2004). A community-based primary health service will need to be expanded in order to provide a more coordinated, less fragmented, better safety health net which can meet the future increase of primary care demands and needs of the society (Hospital Authority Report 2003, Health Care Reform 2005).

Children are considered as one of the more vulnerable groups with less formal networks in voicing personal needs compared with the youth and adults. The school as a community resource for promoting health is at its infancy stage of development in Hong Kong. There exist varieties of caring practice, research opportunities, and

innovations for the child health population.

1.7 Significance of applied school health research

A health-promoting school has been advocated globally as an approach to enhance public health through school-based health promotion (Rogers et. al. 1998). School health promotion, with its goals of providing primary healthcare for school-age children and their informal caregivers, is assumed to be the essential component of the child health system. The effectiveness of a school health-promoting movement depends largely on its ability to integrate forces in ensuring that a variety of health, educational, and social services is made available in non-traditional sites, particularly schools that are able to reach out to children and their families (Brindis 2003). The social implications of school health practice, such as changes in environmental settings, human resource development, culture, roles, values, effects, and others, are hardly accessible and known in local settings without

its research of practice. As a professional, the theory of guiding school-based health practice is hence essential. Health professionals recognise schools as rich settings for promoting health despite their unknown collaborative settings. No research has been found in theorising the patterns and effectiveness of school health collaborative practices in schools. Collaboration is a mutual human interaction other than informed practice. The effectiveness of school health collaboration practice needs to be evident in its social settings other than plain text knowledge. Research findings leading to a theory on school and health sector collaboration in child health, a mechanism for enhancing the involvement of related parties such as the child, parent/guardian, and the school, are thus required if we perceive this as a worthwhile goal to pursue.

Summary

School health is a school-based wellness health-promoting concept that involves more than a scientific paradigm of thinking and interpretation. School health roles, functions, and practice in social environments are diverse in settings; school health's focused intervention on the distinct category of needs is necessary in establishing a quality dynamic social care system of management. The whole can be more than the sum of its parts. The effectiveness of school health is highly dependent on individual school commitment in addition to separate intervention outcomes.

Effective healthcare strategies including an organised and systematic plan of interventions and evaluations toward a continuous monitoring and controlling of quality practice are thus needed. Although the health needs of

children across different schools may be different, literature or research findings could assist in predicting and assuming common school health concerns and needs.

In view of the insufficient data on local school health practices, a school health research in the applied settings is launched to accumulate experiences and gather data in shaping facts, knowledge, and other useful information toward a better system of quality school health practice.

Chapter Two

Literature Review

This chapter aims to discuss and delineate the dimensions of school health practice. Likewise, the effects of the child health system, its implications to innovation of school and nursing sector practice, and relevant research approaches are reviewed. From these, conclusions are drawn to understand the nature of school nursing research and its significance to quality care development and practice.

2.1 Child involvement in school health practice

School health serves a significant function of promoting and protecting the physical and mental health of school members when a school works with students, their families, and their community in a coordinated, planning way (ASHA, 2006). Schools have more influence on the lives of the youth than any other social institution besides the family

(Olson & Mccubbin 1983, Kann et al. 1995). A facilitative school environment sustains an interactive learning atmosphere and provides varieties of educational opportunities for children to participate in at different levels of acting as a follower as well as a leader. Furthermore, it has been said that pupils and students learn positive and negative social skills from their immediate social settings that involve their friends and other peers, learning groups, teachers, and family. Therefore, schools are appropriate educational social settings for children to practice the integral values of being trustworthy, caring, honest, empathetic, responsible, and other social and self-valued attitudes that help promote positive self-concepts.

School health, which promotes treating a child as a client in practice, has the function of developing the self-care capacity of a child as its ultimate goal. A long history of overseas studies has documented the benefits of school

nursing in promoting the health of children and in acting as a primary health provider, focusing on illness and injury prevention such as immunisation, screening, expert referral, keeping school injury and medical records, and monitoring follow-up programmes (Dilworth 1949, Ford & Silver 1967, Slack 1978, Siegel & Krieble 1987, Cohen 1994, Hawkins, Hayes & Corliss 1994, Hootman 1994), where parents and children take recipient roles most of the time. School nursing practice also provides practitioner development opportunities and professional practice enhancement (Walker, Butler & Bender 1990) in which practice experiences can be accumulated and evaluated. The focus and result of practice evaluation are value driven. When measurements are targeted on outcome effectiveness, less attention may fall on the knowledge gained from discourse or reflection on practice experience.

2.2 Family involvement in school health practice

School health practice, which regards the school as the client, offers opportunities of developing the healthcare capacities of school members including parents and communities (Brandis et. al. 2004). Schools and families can influence the lives of the youth more than any other social institution. Child health protection in school is not considered anymore as an individual problem; attention has been drawn to a different level of health awareness across children, parents, and the school.

It has been said that parental inactivity strongly begets a child's inactivity (Fogelholm et al. 1999, Francesca 2002). Parental influences are early determinants of food attitudes and practices in young children (Wood 2000). Based on this observation, a healthcare professional may try to design a reflective sheet on which to write a family's diet pattern in order to provide them with the opportunity to reflect on their personal family diet and

to discuss ways of modification, if necessary. Attitudes are developed through our daily practices that we have never doubted, whether the practices we keep are worthwhile or not. Parents, through actively involved in the health-in-action process, will gradually develop their own models of health for themselves as well as for their whole family. Some active parents may even volunteer and be eager to share and promote their healthy living skills, such as cooking, in school. Hence, healthy families create more healthy beings for the society at large.

2.3 Community involvement in school health practice

Public participation in its own is considered to be one of the most effective strategies for promoting community and personal health (Bournes 2000, Thompson et.al 2002), with people taking more responsibility and accountability for their health (Mitchell et.al. 2000).

Community health participation is an important element in primary healthcare (Wong 1989, Barnes et al. 1995, Kessler & Alverson 2003). The major purpose of community participation is to avoid the professional identification of problems and issues in isolation from the subjects under study (Zimmerman & Rappaport, 1988, Ritchie 1996). The effective outcomes of community participation improve the readiness and willingness of people to take responsibility for their own health using existing community resources (Maglacas 1988, Abatena 1997, Gadin & Hammarstrom 2003). Community partnership is one of the effective healthcare strategies for promoting public health (McMurray 1998, Wong 1998, Ravella 2001, Thompson et.al 2002). Moreover, healthcare consumers consistently say that they want to be listened to and make their own health choices by formulating their plans for changing health patterns in collaboration with health professionals (Bournes 2000). Zakus (1998 p. 481) describes community health participation as a process by

which members of the community are enabled to develop the ability to assume greater responsibility for determining and assessing their own health needs and problems.

Collective decision making is emphasised in resolving community concerns (Hawkins et. al. 2004). By sharing power and considering clients as active participants, health professionals may help them identify their own health problems and address their own healthcare needs. Such an approach may be one of the feasible health strategies in developing a culture of health participation. At certain circumstances, the Hong Kong public seems to be passive in this regard when they perceive that public policies and services should be designed and run by the government. Some people think that their opinions would not be taken into serious consideration by the government even if they were to voice their concerns. Moreover, the public may perceive community participation as an excuse for health

professionals' lack of commitment to deliver health services (Sawyer 1995).

The physical and mental health of children affect student learning. The extent to which educators understand the unique needs of children with chronic conditions may influence their school experience (McCarthy, Williams & Eidahl, 1996, Mojuar 2003). A school that is well informed of any change in a child's health condition may help understand the special learning needs of the child. In relation to this, child injuries or sudden deaths in school whilst attending classes arouse public concern about the special health needs of children in school.

It is not a common practice for health policymakers to actively involve the grassroots or the general public in planning and designing health promotion activities and programmes. In most cases, healthcare planners presume public health demands. Many of them are healthcare

providers or professionals who are considered experts in their respective areas. The public voices of health concern can be heard, but whether they are taken into serious consideration or not is another issue. In addition, it is unrealistic and unnecessary for the government or a citizen to take total health responsibility because the social mission of a healthy city is hardly achievable without the concept of shared health responsibilities. Physical care of the human body is conventionally considered as an expert or privileged knowledge by health professionals (Tovey 2000), so it is time to re-focus our roles from those of direct care providers to other learner-centred pedagogic strategies such as facilitating, supporting, mentoring, and empowering others. Learners may tend to be more willing to accept role changes if they are offered opportunities to act differently and experience the positive effects and gains of such changes.

The collaboration between the school, the family, and the community has been considered as an essential component in developing the standard practice of school health (Kann et. al 1995, Commission on teacher credentialing 2004, Connecticut State Department of Education 2005). Its potential effects on optimising social resources and mobilising public involvement are prominent. Certain support can be shifted toward family and school participation on child health.

Many studies have suggested that contemporary school health programmes should extend from traditional objectives and focus on changes in capacity, social support, and control over decision making and resources on the individual, network, organisation, community, and political levels in order to address health problems (Israel et. al. 1995, Godin 1996); programmes must be tailored locally to meet the cognitive, affective,

experiential, and linguistic capabilities and needs of target learners so as to make these appropriate for learners. It has also been suggested that the organiser must be sensitive to the expectations and needs of the community to make a health programme effective (Cook et. al. 1988, Walker, Butler & Bender 1990, Macaulay et al. 1999). Approaches of implementation affect outcomes. School health intervention could not be taken for granted to be effective without valid supporting data. The preparation of health knowledge, interpersonal skills, and social awareness are crucial factors which affect the roles of school health practitioners. Educators and pubic health officials should work together to enable schools to use community resources in implementing effective health education policies and programmes, and in eliminating barriers that impede school's potentials to improve the health and well-being of children and the youth (Kann et. al. 1995). Public involvement in healthy living, including an application of health knowledge in

modifying lifestyles and decreasing health risk behaviour, should always be reinforced in practice. The primary objective of school health education provided by professionals is to strengthen the education of children and support their families; the collaboration of school personnel, families, and communities will assist students to achieve their highest health and educational potential (Commission on teacher credentialing 2004). Healthcare collaboration espouses the belief that clients should have the right and autonomy in decision making for personal health, and in developing skills and knowledge to optimise the strength of healthcare practice for sustaining physical and mental well-being. Intervention design that aims at inducing a long-term voluntary participation in changing health practice must involve the public in decision making in order to achieve mutually desirable goals.

The school as a part of a community environment is the preferred setting for providing primary healthcare for

children and their informal caregivers such as teachers and parents. Community-based care is a prominent practice of primary healthcare provision (Health & Welfare Bureau 1999, 2000, Tovey 2000, Hospital Authority 2002) in which opportunities for public participation are offered. A shift in healthcare delivery mode from hospital based to a community-based setting is becoming a common concern and interest in promoting cost-effective healthcare.

2.4 Strategy of quality school health practice

The settings of school health practice are diverse. For a school to adopt a theoretically sound model as a long-term practice is more desirable than adopting an ‘outsider’ model which is developed by the school’s outsider as not being the staff of the school. As evident from living, affordability and accessibility are always of health practice concern. People traditionally seem more willing to participate in workplace programmes than in health promotion activities in other places (Ritchie

1996). The workplace offers an attractive setting with social and environmental support, convenience, lower cost, and regular availability (Travers & McDougall 1997). Some time-intensive health services such as health counseling and education are convenient for children and their families if provided in school. As health education involves discussion and sharing of information, developing collaborative strategies, and implementing direct action, children or their related caregivers may be more willing to participate in activities in schools (Connell et al. 1991, Lavin 1993, Ralp et al. 2002, Education & Manpower Bureau 2004). School staff who become interested and active in improving the health of students become powerful role models in school (Education & Manpower 2004). After all, the school is described in most of child health studies as an excellent place for promoting child health. The healthcare impacts might not only be on the children but also on parents and school personnel.

In many ways, schools have become vehicles for addressing larger social issues that involve the health needs of children (Walker, Butler and Bender 1990, Francesca et. al. 2002). School-based healthcare provisions have been demonstrated by many developed countries to deliver a cost-effective school health service with parent, children, and teacher involvement (Igoe & Giordano 1992, Graham et al. 1992, Hawkins, Hayes & Corliss 1994, Clemen-Stone, Eigsti & McGuire 1995, NHS Report 1997, Hong Kong Annual Report 1999, Appleton & Hammond-Rowley 2000, Chudley et al. 2003, Lee et al. 2004). Many school heads likewise agree that school nursing is an essential support service (Bagnall 1994, Cohen 1994, Hootman 1994). A school health coordinator can maintain an ongoing dialogue with members of the public and leaders of the health and education sectors, linking up and utilising resources of the two systems. Nurses are viewed by children as sympathetic, trained professionals whom they find easier to talk to compared with parents and teachers regarding

taboo health issues such as sex (Cohen 1994). In compliance with the mandatory primary education in Hong Kong, schools enrolled probably more than 95% of the entire school-age population (Hong Kong Statistics 1996, 2000, 2004). The school is an accessible and available setting for promoting child health participation as it allows a large number of children to be reached. Each age-specific group of the child population and their parents can be engaged in understanding the unmatched healthcare needs.

Specifically, the existing child health service that is of annual and district basis may be perceived as more remote and less accessible than that which is stationed in schools. Thus, this may hinder the public's involvement in promoting child health. Schools provide environments with which children and parents are familiar. In the healthcare setting, children are allowed to talk freely with the people they know. This allays anxiety and reduces

the unwillingness of children to express needs and concerns. School health activities not only serve the children but also their parents, the school staff, and the community at large (Walker, Butler & Bender 1990, Allensworth et.al. 1997, NHS Trust Report 1997, Lee et.al. 2004). Health activities conducted in school seem to be a cost-effective way of delivering health concepts and promoting community health. Parents' participation in decision making and discussion about the child's healthcare plan are recognised as important aspects to consider (Chan & Twinn 2003). It is also necessary that the focus of discussion would involve the participants in solving individual healthcare problems. Achieving their readiness is an essential process for gaining their long-term participation behaviour. Voluntary lay participation could be maintained and sustained with persistent social support and encouragement from healthcare providers.

Schools can be treated as educational and social settings for pre-adulthood development. School policy and regulations help direct a school to grow and develop in a dynamic social learning setting (Allensworth et. al. 1997). Many Western and Asian countries have shifted the focus of quantitative and logistical concern to improving the quality of education (Dimmock & Walker 1998). Learners can be motivated in self-exploring how knowledge makes the quality difference in human interaction, behaviour, or action, evaluating impacts of getting work done with and without knowledge.

Children are one of the vulnerable health groups in society. Therefore, schools have the primary responsibility of preparing learners to participate and contribute intellectually not only in the future, but for the present and the next stage of role development. With age, children are granted increased decision-making power. Their constructs of beliefs and values can be easily

changed in relation to what they are repeatedly practicing, experiencing, and learning, and these can allow them to make increasingly differentiated judgments about their social world (Yau & Smetana 2003). Social learning and cognitive-behavioural learning strategies assume that people are able to learn from social observation and undergo cognitive change to accommodate social demands. Thus, cooperative or collaborative participation from school personnel and parents is highly necessary in promoting child health. As health affects learning capacity, schools that emphasise the quality of learning and education should likewise perceive the promotion of child health to be as important as developing academic performance.

The involvement of parents and teachers in child healthcare is essential, since they act as direct health advocates and have the most contact with children. Teachers who know the children and their families well can help in child health planning. This interactive

involvement may extend and expand the communication channels among students, parents, and teachers within a school community. The practice of effective community partnership assumes that community members have control and ownership of the problem identification process, and the planning and design of health promotion intervention (Walker-Shaw 1993, Hawe 1994). The World Health Organisation (1995, 1997) has advocated that school partnership programmes could be of great benefit to child health promotion. Participants as members of the programme's design team could initiate a process of taking more active ownership and control of the organisational culture (Cook et. al 1988, Whyte, Greenwood & Lazes 1989, WHO Report 1991, Abatena 1997).

2.5 Resource of the school health system

The Central Health Education Unit, a branch of the Department of Health, is responsible for public health promotion, serving clients of all age ranges (Department

of Health 2003). School health inspectors or nurses from the Department of Health visit schools regularly for school environmental assessment and immunisation. Their main duty is to give advice on environmental hygiene, including proper sanitation systems and practices. The services provided to schools are mainly health education activities, training and community-based health education projects for students and teachers, and the production of health education materials. Public health nurses organise a limited quota of school-based health talks as requested by individual schools. Exhibitions are arranged in accordance with community needs, and are usually held in public plazas. Although the Unit has conducted a community-based student health ambassador training project, only a limited school population could be targeted given the reduction of the healthcare budget.

The provisional Tai Po District Council (Tai Po Survey Report 1998) conducted a survey of parent opinions on

student health services in the Tai Po community. Most parents find health services available and accessible if these can be provided when their children are sick. Most parents perceive health services as curative treatment rather than preventive health measures. This is in coherence with a certain public belief which regards health services as medical treatment rather than health protection. This public perception sounds logical as people are observed to take their health for granted and believe that health can be maintained even without efforts of protecting it. People, in general, prefer an accessible source of medical or healthcare support in terms of cost, time, place and need; these are factors which affect public perception of quality health care(Taylor 2005). The Department of Health in Hong Kong started to invest US$87 million in student health service in replacement of the former School Medical Service since 1995 (Annual Report 1995). The health service adopts a district/community-based approach in providing school

children with free annual health screenings of physical and mental wellness. The major provider sectors of student health services in Hong Kong are the divisions of the Department of Health, the Hospital Authority, the Social Welfare Bureau, non-government organisations, and voluntary agencies. The Education Department shares partial responsibility in financing nurses for mental disability schools, but not for mainstream schools. According to the current annual report of the Department of Health (2003), the major sub-units of the government department that are responsible for primary health services for children and the youth are the School Dental Care Service, the Central Health Education Unit, Family Health Service units, and the Student Health Service. These were formally established for promoting the general health of children. Amongst these services, only the School Dental Care Service is affiliated with a university, whilst other sectors belong to government social services. The university-affiliated dental health service and

training school aims at promoting the oral hygiene of primary school children, and accommodates special dental healthcare referrals from the community. Annual dental check-ups and basic dental care are provided to children at the dental clinics.

Since its inception in 1995, the Student Health Service that provides the major primary healthcare for school-age children and the youth has shifted from a disease-orientated service to a preventive service (Department of Health 1996). Its main objectives have been highlighted as health promotion, disease prevention, and continuous care for the health of school children. The service teams originally planned to conduct school-based health checks, but these were converted to community-based services due to accessibility reasons. Each child who joins the service scheme attends a free annual appointment for health assessment that includes physical examination, health screening, individual

counseling, mass health education, and specialty referrals, as may be necessary. Quality care evaluation was conducted by the service sector and public bodies after the new service implementation. As reported by Tse (1997), the number of students who patronise the service is about 30,000 which is 1/3 of the population of primary and secondary school children. Assuming each enrolled student will be given an annual appointment for a health check which includes physical examination, health screening, individual counseling, and mass health education, on the average, the number of visits would be around 100 per day, as reported by a health nurse. Each family may have at most 15 minutes contact time per visit. With this volume of service, it may be difficult for parents or their children to raise issues or ask for sufficient details about health problems. Consequently, health professionals may be exhausted from attending to clients' needs. In the past, it was widely reported through the local media that existing child health

services fail to deliver services efficiently and equitably (Wong 1996, Moy 1997 Tai Po Survey Report 1998). Although such comments may not be representative of the majority of the client population, the message does reflect the minority of public concern.

Other than non-government agency resources, health-learning resources such as written health information and videos are available from government sectors such as the Central Health Education Unit and Student Health Service Units, or their Web sites. Child health education resources for parents and professionals are systematically available on the global and local Web sites of well-trusted organisations such as the Family Planning Association, World Health Organisation, and other child health and parenting associations. Audio-visual health information resources are now easily accessible on local and global channels for school health practice. A nurse officer of a student health centre said

that teachers, counsellors, and social workers, in general, are expected to be major direct caregivers of children in school. Furthermore, it is also expected that teachers spend time not only in teaching but also in counseling and supporting children with learning difficulties and concerns. Teachers may be able to observe children's health informally during school-breaks, checking on their lunch diets and safety at play; and formally during class learning, taking note of their inattentiveness and absenteeism in class. However, since teachers are taught to be general educators, they might not be adequately prepared for formal health teaching (Leger 1998, Kann et. al. 2001). Could the collaborative work between a school and a community health nurse help to relieve part of the teachers' role of promoting the well-being of the school children?

2.6 Significance of innovative practice and research

Whilst the collaboration of school and nursing sectors

is evaluated as an effective strategy for promoting child health, it is rarely practiced in Hong Kong schools. Traditionally, nursing research methods are shared and borrowed methodologies, but rigorous adherence to borrowed methods is likely to retard the development of nursing because the methods that work for one discipline, culture, or setting may not work for another (Rasmussen 1997). Fagan (1995) pinpointed that school nursing has an enormous potential impact on the positive health of the nation's children if social constraints can be addressed. However, there is little research on the acceptable quality of school nursing to give a clear view of its roles or functions in health promotion (Wainwright et. al. 2000). As such, evidences of effective school nursing practice in health promotion remain unclear. Knowledge of nursing practice in the context of school-family collaboration in wellness health promotion is proven to be lacking. The lack of local school nursing data may be related to the fact that the Hong Kong school

health policy of employing a school nurse is only applied to few disability schools and is not made mandatory in mainstream schools. Healthcare practice is culture specific and is subject to the organisational and social environments. As suggested by Ackerman (1997), school health practice will be empowered through research and consciousness in community care practice. Collaborative health participation in child health promotion can be integrated as a school health development project, taking it as one of the strategies in providing a quality environment for school learning. Child health collaboration in schools may help strengthen and support the initiatives of teachers to implement changes to the school curriculum (Booth & Samdal 1997). Specifically, when the primary education curriculum is so detailed, school personnel may hesitate to commit to the collaboration process. Decisions on how many health promotion activities can be devoted to school education is still uncertain.

Bobo et. al. (2002) strongly recommended that developing a national perspective on school nurse competencies is essential for the development of curriculum design as well as the practice settings. The American Academy of Nurse Practitioners has advocated the need of preparing nurses for community-based primary care services since 2002. The core competencies in specialty areas include adult, family, gerontological, pediatric, and women's health (US Department 2002). Primary health interventions such as health promotion, protection, and education are considered as core competencies for undergraduates as well as post-graduate specialty students (Hong Kong Nursing Council 2005). Health interventions have increasingly been developed to address settings rather than individuals; school-based interventions have lagged in this respect (Patton et. al.(2003), Selekman & Guilday 2003). Currently, the Hong Kong nursing practice is positioned more in the secondary and tertiary care

settings where nurses are posted. Nursing specialist service or nurse-led clinics are concerned to provide rehabilitation care for chronic illnesses such as diabetes and stroke, which is attached to district hospitals and involve community outreach services. Meanwhile, a primary care setting for the nursing practice is lacking. The possibility of mainstream schools to be structured as the primary care setting of nursing practice is worthy to be explored for future professional collaboration, practice, and development.

School health has its dynamic role of sustaining and promoting physical safety and a social health climate for the well-being of a school community. School health practice, placing the care setting in school, facilitates the needs assessment of school personnel, families, and children. Appropriate intervention settings and strategies that match the collaborative nature of caring practice are determined.

Absence of disease does not imply health. Acquiring knowledge of diseases does not mean understanding health. Child health problems involve individual, familial, and social factors that require the collaborative support of healthcare resources. Economic development, technological advancement, and the ageing population are increasing public health demands. Whilst the society is advancing, healthcare issues become more sophisticated as well. Nursing as a healthcare profession has the role of providing individualised primary healthcare for the public. New approaches of primary healthcare and health promotion could be explored with existing resources. Innovative practice could be implemented and evaluated for its effectiveness through research and development.

Health intervention research seldom involves public participants as co-researchers and engages the public in the full swings of the intervention process. Most school

health intervention studies put the emphasis of intervention designs on their structure and outcome to further policy and practice implications; less focus is placed on understanding the process of caring practice such as the collaborative care relationships and interactions occurring within the practice settings. In addition, all human, environmental, and social factors are interrelated with school health outcomes. The researcher's main perspectives of focus will affect the overall research framework and likewise the interpretation of results. The nature of this school health research is therefore shifted toward a process orientation of informing the practice outcome in nature, with the application of a community involvement strategy of engaging the public in working together for a mutually desirable model of school health practice.

2.7 Rationale of using collaborative action research

The essential features of collaboration across nursing settings are characterised by working together with the

key stakeholders in building up human and communities' capacity and potentials of attending to problems and concerns in an optimised manner. Social innovation is participatory and collaborative in nature. Innovation plans and designs need to be adjustable as the process proceeds. The main focus is seeking knowledge for processing practice in nature other than informing practice. Community-based nursing intervention research mostly focuses on the quality of care for people with special health needs such as disabilities, illnesses, diseases, poverty, and other social vulnerabilities. Very few nursing studies focus on the health promotion needs of a school community. School community involvement is recognized as one of the best strategies for child health intervention (Hawkins et. al. 2004). However, there is little empirical evidence which demonstrates its effectiveness on school health (Deschesnes et. al. 2003). Nursing research and the practice of school nursing collaboration is rare. This may become a concern whilst

the claim of health-promoting school is becoming a global strategy for child health intervention. School health requires community effort and practice. With the shortage of valid school health nursing intervention data, strategies on establishing school health partnership remain unclear. Therefore, the development of this nature of study becomes prominent in contribution to this particular practice knowledge.

This research project, which accommodates a collaborative social intervention strategy for promoting school health, does not employ a research design involving a controlled intervention setting. Research approaches and methods are purposely selected to match the collaborative nature of real practice. This also leads to another innovative shift in the professional practice of practitioner-led intervention in school collaboration settings, which places a shared role of public involvement in healthcare practice. The changing phenomena of public health participation and professional practice form the two

major foci of the study. Effectiveness of care is influenced by the appropriate use of knowledge as well as the caring environments. Physical and psychosocial health needs are altered with variations in health states, social roles, and settings. The shift in healthcare setting from hospital to school health environment affects caring relationships and demands. Researching the process of the changing practice in school realities helps generate insights and develop theories on integrating knowledge in practice for child health collaboration in school-based settings.

Health professionals use theories and research to identify and predict healthcare strategies appropriate for the social-cultural environments. Based on documentary and research references (Commission on teacher credentialing 1994, Thomas et.al 1998, Kann 2001, US Department of Health & Human Services 2006), successful school health development is based on the dynamic roles

of healthcare coordinators such as the healthcare manager, educator, researcher, collaborator, client advocate, and other active health-promoting roles. Health-focused intervention is only a part of the multiple components of school health. Most school health research studies have placed more emphasis and value in studying the effectiveness of researcher-led models of health intervention (Cook et. Al 1988, Walker, Buitler & Bender 1990, Israel et al. 1995, Godin 1996, Macaulay et al. 1999). Community based research offers a means to reduce the gap between theory, research and practice that has been problematic in the field (Israel et. al.1998). Propositional knowledge on school health is widespread, but realistic research on its effective outcomes are rare (Israel et. al. 1995, Godin 1996, Tovey 2000). Very few overseas studies and no local data provide research evidences on the impacts of school health-promoting strategies in their application to actual settings. Most of the school health intervention research is based on

the researcher-led framework and is evaluated on pre-conceived settings and outcomes, leading to further implications and recommendations. Researchers have full control of the intervention settings. Moreover, more unknown is the theory of applied practice in realistic uncontrolled settings, such as human resource management, individual value integration, and intrinsic motivation, which can lead to a long-term voluntary social practice and development.

In nursing sciences, the purposes of theory should go beyond description, explanation, and prediction, but for a higher level of theorising and prescribing nursing phenomena, nursing care and actions may change the undesirable situations in systematic stages (Powers & Knapp 1995). Community-based collaborative action research is viewed as having multiple strengths and potential benefits for research practice that offers means of public collaboration, research practice and

praxis, and bridging knowledge gap through integration (Hart & Bond 1999).

Knowledge involving the significant impacts of school health has already been well established by literature; however, its effectiveness is still under-explored. The development of practice theory from real world settings will enable researchers to make enquiries from an observable social setting that is evident to both the researcher and the research participants. If nursing theory has the primary role of guiding practice and leading a quality change in situations, practice theory is then ideal if it can be understood from both real and theoretical dimensions. However, people will feel that the concept is abstract if they have not experienced its application. Similarly, it will be abstract to most nurses if they are not involved in its process of reasoning and development. It may help promote understanding if the theorist will explain the underlying nursing phenomena

that generate the rationale for its significant implications to one's practice, and the reasons for the change of practice. The secondary interpretation of the theories may sometimes lead to a more confused state when the theorist's experience on theory development is excluded. This may further lead to the misinterpretation of its original meaning or making the theory more abstract.

The collaboration of schools and health professionals has been encouraged worldwide in order to bring up healthy children. In contrast, the realistic practice of school-family-community collaboration in teamwork settings is rarely researched on at local and overseas levels. Therefore, research on collaboration in child health promotion is worth conducting in order to explore the possibilities of establishing a long-term primary healthcare partnership for future Hong Kong school communities.

2.8 Action research in real world setting

Both action research and participatory action research can be viewed as real world practice research that enables a semi-structured intervention plan, allowing the action plans to be modified and changed. Recent attempts in viewing development and learning as more than cognitive phenomena, including theories of situated cognition and practice, put action research into a more preferred setting of social research (Sarantakos 2005). Kurt Lewin, a social psychologist, felt that the best way to move people forward is to engage them in their own enquiries into their own lives and consequently change what needs to be changed (McNiff 1988). If research is to produce and generate a theory for understanding, a social action research should aim at producing a social action theory and knowledge which can be testable and are practicable in real world settings for common understanding.

The notion of the real world is ambiguous and riddled with

paradox (Hunter 2000). Action research, in contrast to other nursing intervention research, allows flexibility in changing intervention design and settings to match the real needs in social settings. If the researcher also acts as the evaluator, it will cause role conflict and assumption bias (Bowling 1997). The legitimacy of a participant taking a dual role as a participant and a researcher is not common in mainstream settings of health research. The quantitative research or the pre- and post-research design places less focus on the participation process. Health-related intervention involves social interaction. The interpersonal and social process of intervention is equally important to the effectiveness of health interventions. People tend to believe more in what they see and experience. Even though some of the health promotion models, strategies, or structures have been tested with valid evidences of statistical support, end-users may not perceive it as appropriate or applicable. Different social environments

and cultural practice may lead to certain constraints and limitations of the practice. Action research aims at understanding and enhancing practice through real world settings, and inviting the change to be implemented in a collaborative and cooperative manner.

Action research involves a social science research paradigm in which the participants are co-researchers rather than subjects. Action research is a possible research strategy for implementing planned changes whilst optimising social, public, and professional resources in community care practice (McTaggart 1997, Hart & Bond 1999, CARN 2005). Effective healthcare policies and interventions allow the practice to reduce inequalities in health (Mackenbach 2002). Healthcare policies shall not be taken for granted without monitoring the effects of their implementation. Participatory action research can be a powerful resource of developing worthwhile professional and institutional practice,

taking into account that multiple realities and the interpretation of social truth can be shared and understood through the action research process (Winter 1987, Danley & Ellison 1999). If conventional science wanted to give a group of people the power to determine 'truth' for and on behalf of others, the new science should arise from a world of multiple and competing versions of truth, and reality acts as a way of assisting people both to come to terms with their own reality and to embrace that of others (McTaggart 1997, Carson & Sumara 1997). Surveys or quantitative questionnaires on human health practice are less able to reveal fully the underlying mental contents in relation to a point of view. Researching the dimensions of social and human data from a human science perspective needs to involve the knower's interpretation or the thoughts of the original sender, and not that of the researcher.

Many social scientists argue that randomised controlled trials are inappropriate and unrealistic for evaluating

social interventions; they always involve complex multi-level interventions and unpredictable human factors affecting the stability of research environments (McTaggart 1989, Oakley 1998, Petticrew & Roberts 2006). Social intervention is inappropriate for its application of a focused model of experimentation or evidence-based principles, besides the ground that experimentation is often unethical or impractical in real life (Emmet & MacIntyre 1970, Petticrew & Roberts 2006). Controlled intervention studies can demonstrate unanticipated adverse results; action research has, as its central feature of changing practice, a way of inducing improvements in the practice itself using strategic action to probe for improvement and understanding (Winter 1989, McNiff 1992). Social research has a significant role of generating knowledge or theories that can be logically understood or tested in a social environment for its applicability, feasibility, transferability, and worthiness to a socially valuable meaning (Chambron 1995,

Petticrew & Roberts 2006). This legitimacy leads forward to a more open and free framework of collecting information and ideas from the informants.

2.81 Theory of action research

Winter (1987,1989) conducted a thorough review of the principles and practice of action research in classroom settings. Action research movement is based on the belief that theory has no real value, unless it can be demonstrated to have practical implications. Action research strategy is implemented and applied with pre-existing concepts and monitoring effects, which are reconstructed and expanded from repeated cognitive action practice. Action research is an approach to solve problems that evolve from knowledge application. Its purpose in classroom settings is primarily focused on teacher development, inducing change in the teaching practice, and a research paradigm shift of theory-based science to real world research.

Researchers work with teachers in class to implement new methods of teaching. In this setup, researchers do not act as observers but as collaborators in order to be aware of the gap between attempt and achievement. The teacher is seen as the best judge of the total educational experience. This is an effective method of bridging the gap between the theory and practice of education. Action research should be systematic and not an ad hoc event. It is particularly conducive when it involves a self-reflective spiral of planning, acting, observing, reflecting, and re-planning. Teachers are encouraged to develop their own personal theories of education from their own class practice. This liberates them from their prejudices and allows their intuitive instincts to develop and blossom. Action research is not considered as the best approach in addressing educational issues, but it is a very useful and appropriate strategy for understanding interpersonal issues and other complex

social contexts of education. Action research is political in that its aim is to change, and change is bound to affect people and induce negative feelings and uncooperativeness particularly when it is involuntary. The politics of action research involves the battle of ideas and values which are established from theoretical and propositional knowledge developed with institutionalised, practical knowledge from school and other institutional realities. Its effectiveness depends on the collaborative efforts of the team rather than the researcher. Another limitation and challenge of action research is the absence of an interpretative standard for guiding the action researcher's practice, leading to the uncontrolled intervention design. The philosophy of action research is based on respect for the integrity of individuals, the desire to act as one's true self with own initiatives, and the quality that is often lacking in the conventional theory–based or statistical-based educational research. Thus, the main focus of the research

is vested by the enquiry rather than the methodology. The validity of the data is often challenged, as the interpretation is more personal and interpersonal rather than methodological.

Other studies have highlighted the outcome expectations of enhancing the awareness and active stance of learners toward their own life through active or practical learning (Vygotsky 1978, Van Manen 1990, Salazar 1991, Tinsley 2003), meaningful participation strategies in engaged contexts (Oliver 2004), and realistic evaluation which can produce an enhanced effect on teaching (Pawson & Tilley 1997, Hoffman & Burrello 2004).

Rasmussen (1997) argued that action research is an authentic methodology for nursing theory development, when methodology is simply defined as a way, technique, or process of or for doing something. If nursing is a scientific holistic process directed toward personal and public well-being, authentic methodology means being able

to affirm and advance the scientific, practical, and ethical tenets of nursing. Hard sciences and classic experimental design ignore the major realities of nursing phenomena. The core elements of action research cycles on fact finding, planning, action, and evaluation serve as the basis for structuring objectives and action; research results guide planning and theory development, successfully reinforcing the quality of care practice, and guided continual quality improvement is perceived as responding to the scientific nursing paradigm. Rasmussen described that action research enhanced by this communicative action is a collaboration process. Communicative action is described as a collaborative dynamic process by which participants come to understanding with one another, where actions are orientated to mutual understanding. The validity of action research, similar to nursing, is valid when it derives its legitimacy from those to whom it is applied, that is, the clients. Through this dynamic and

communicative action, the client, the nurse, and the environment come to understand one another. The nature of action research demands a deeper interactive dialogue among participants for an understanding of a further plan, action, or evaluative finding.

According to Rasmussen’s experience, action research could end at understanding the caring relationships as a whole. If this experience is true, it implies that an action research practitioner will ultimately become a holistic or reflective practitioner. A holistic action researcher will tend to seek for wholeness and truth of action. Holistic action research practice may also have a potential effect in developing holistic learning.

Brencick and Webster (2000) theorised that to prevent nurses from losing their identity as persons and from being perceived as skilled technicians, the expected caring must first be pre-understood by the giver, the

receiver, and the observer in order for all three to recognise caring through its concomitants. Nurses, when solely concentrated on the mastery of standard intervention skills, may lose the other side of human natural intelligence, that is, the processing of personal insights both within himself/herself and on the client. The experience of connection with the client is central to human practice and is integrated in a total practice experience (Kikuchi & Simmons 1994). Models of nursing are explicitly and implicitly underwritten with the author's theoretical assumptions of the nature of nursing guiding the practice because practice without theory is like sailing without a map in a ship without a rudder (Thorne & Hayes 1997). The nature of total nursing practice research best accommodates the conscious connections of the healthcare experiences gained at the state of being caregivers, receivers, and observers.

2.82 Philosophy of participatory action research

Discipline in community psychology defines participatory action research (PAR) as one type of action research which consists of the collaborative feature of practice in change where participants are reinforced to make changes based on enlightened self-interest (Chesler 1991). PAR allows flexible input from subjects in the development of the intervention programme (Greenwood et al 1993). People choose to make changes, and the programmes to be implemented should reflect their preferences and address their concerns (Norman & Brandeis 1992, Hart 1996, Nichols 1997, Balcain 1997, Macaulay et al 1999). The sharing of knowledge and a co-learning relationship between researchers and participants exists in PAR (Elden & Levin 1991). However, there is little data on studying the approaches and processes in such mental and intellectual states of change and development in active learning.

McTaggart (1989) criticised conventional social science

for following a linear model in proceeding with hypothesis testing, fieldwork study, data analysis, and recommended conclusion, without placing emphasis on its practicability in social realities. He theorised that action research ought to be participatory and systematic in nature. The cyclic process of data analysis, starting with reflection on field actions and proceeding to new action and further study, was recommended. The development of the new action which differs from the old action is reflected, compared, and studied as a wholly related situation.

McTaggart's theory of participatory action research claimed that when enquirers are aware of the implications of enquiring, they are faced with choices of change. McTaggart claimed that minds and things inevitably change as a result of research - the mere act of asking questions is an intervention in a situation, and giving and hearing answers and making sense of them inevitably bring about changes to those involved. The

moving to new and improved action involves a creative ‘moment’ of transformation. This involves an imaginative leap from a world of ‘as it is’ to a glimpse of a world ‘as it could be’. The process of participatory action research is a genuine open-minded enquiry. According to McTaggart’s experiences, action researchers consciously know that the research process is coming from somewhere and will go somewhere, even though they do not know in advance where precisely it is going to end up or what the new state will look like; participatory action research, unlike conventional science, does not consider this to be an embarrassment. Instead, it sees this situation as a necessary social process of understanding. McTaggart concretely specified three practice principles of participatory action research in contribution to different paradigms of knowledge generation. The first principle tells action researchers to interpret change as a throughout process rather than doing this at the end; the second requires participants to focus and refocus

their understandings on what is really happening and what is really important to them; the third principle states that research participants can learn from their own experiences and make this experience accessible to others.

Participatory action research (PAR) is applied in healthcare research where public participants and practitioners are expected to take an interactive role in the intervention process including evaluations of the standards of practice (Elden & Levin 1991, Whyte 1991, Norman & Brandeis 1992, Greenwood et al. 1993, Hart 1996, Nichols 1997, Balcain 1997, Macaulay et al 1999,).

‘Participatory action research is an innovative way of creating partnerships at the local level to promote health in a process through which all partners learn. PAR is conducted within a nonparametric conceptual framework under the assumption that all phenomena occur in variability rather than in a normal distribution. It is

a form of research in the sense that qualitative and quantitative information is continuously collected, analysed, and acted upon. It differs from traditional research because community members participate and are not simple passive subjects or informants. PAR is a flexible process and implies a willingness to change as new situations and needs arise, and old issues are resolved. Although not all partners may participate in the same way, they all have an equal opportunity of contributing as appropriately as possible. Conflicts and disagreements can arise, and part of the process is to resolve them in a constructive way (WHO Report, 1991 p. 16)'.

PAR emphasises social structures and processes that accommodate new ideas arising unexpectedly during the participation process. Reflection cycles with participants on the structure, process, and outcome of the programme provide a great opportunity for them to be

involved in the health promotion process; the scientific community focuses its attention on the power of social dialogues, interactions, and collaborations in scientific work; interpersonal contacts between investigators are required before teams could successfully construct the first lasers (Walton & Gaffney 1991, Minkler & Wallerstein 2003). It can be through comparative and evaluative enquiry of each other's conversation contents that scientists become aware of each other ideas, thoughts and needs.

Various literatures support PAR methods as one of the appropriate strategies for health promotion research (Greenwood et al 1993, WHO 1995, Ritchie 1996, McTaggart 1997). In such methods, participants are not considered as subjects but as co-researchers, with the chief researcher acting as the team captain. Hence, participants can contribute to the development of the promotion programme. Qualitative and quantitative

information can be continuously collected, analysed, and acted upon. Participants contribute as appropriately as possible, and the factors enhancing and constraining health programme participation are observed, reflected, and analysed. Therefore, PAR is in sharp contrast with the conventional method of pure research in which members of organisations and communities are treated as passive subjects who receive results after the study's completion. Moreover, in conventional research, the researcher is considered to be the expert who has already planned out the actions to be performed to 'produce' the expected outcome. The subjects are not involved in the research design, as the experimental intervention needs to be controlled by the researcher. Meanwhile, PAR implies that people in the organisation under study should participate actively with the professional researcher throughout the research process – from the initial design to the final presentation of the results and discussion of their actions' implications (Whyte 1991, Douglas 1999).

Whyte, Greenwood, and Lazes (1989) highlighted the characteristics of PAR that are considered as appropriate for health promotion research. They pointed out that PAR is an applied research. However, it also 'contrasts with the most common type of applied research in which researchers serve as professional experts, designing the project, gathering the data, interpreting the findings, and recommending action to the client organisation (p. 514)'. PAR leads researchers into 'previously unfamiliar pathways; involvement in the process is likely to stimulate the researcher to think of new ways and generate provocative new ideas (p. 538)'.

2.83 Limitations, threats, opportunities, and challenges

New initiatives create new thinking as well as anxieties and fear. PAR practitioners are mostly concerned with difficult situations of social change, the loss of ways

to meet human needs, and the rise of anxieties and fear as people in a new practice setting become strangers to each other.

This research strategy is worked toward a commitment and long-term goal of working together with community members, in which there is an emphasis of translating principles and knowledge into action strategies for a quality change in the community and of social practice (Israel et. al 1998). However, there are limitations and predictable constraints in terms of time and effort when dealing with the variety of practice settings. The uncontrolled and changeable settings of the intervention process may lead to conflicts in management. Researchers may anticipate the failures and barriers that hinder work progress in reality. Hence, professional work depends upon the willingness to ask questions on one’s own practice, and to explore challenging ideas and practices; even the values that underpin these ideas can be a challenge and opportunity for professional development.

The action of inviting a school as an action research partner is also an innovation. So far, there has been no study conducted in Hong Kong or in other countries with this nature. The process of implementing change in intervention settings can hardly be done without a research study. Promoting health in school involves many uncontrollable human and social factors. Predetermined policy standards, strategies, and work principles should not always be assumed to lead the expected change and effects without a deep enquiry of their underlying mechanisms that work or fail. Building up a new collaborative network can be difficult especially when the two sectors are serving in different professional fields. From the aspect of community and hospital work, people in autonomous fields are barely willing to work together without external forces and reinforcements. Collaborative work itself, successful or not, is worth to be reported and studied if we agree with the general saying that ‘people learn best from their mistakes’. In

this way, the research becomes an authentic setting of life and work.

The theory of nursing practice will be less abstract if it can be evident in applied settings. The researcher's view, which may be shared by other practicing nurses and researchers, is that theory without practical values will most of the time show no value of its existence despite the satisfaction gained by the theory's proponent. Proposition knowledge only informs a vision but not a theory of practice. From a constructivist's perspective, practice knowledge is undeliverable but is learnt by self-construction in practical experience. The professional theory of practice is evolved from multiple social realities and is integrated with expert's knowledge and text knowledge. Therefore, it is a highly sophisticated concept which is integrated with multiple thinking paradigms. The theory of human practice which can be developed from a real world setting will be a better approach for forming a sensible theory for human practice.

A research paradigm that enables a practitioner researcher to apply knowledge in practice, observe, reflect, and refine work with the servicing client is a desirable model of practice for both parties. Based on this dual purpose of changing practice whilst researching the effects, the PAR approach was selected because it represents a more ethical and human approach of public involvement. It represents an equity participation model rather than a researcher-led model. In this action research project, all participants commit themselves toward improving the quality of school health work through systematic enquiry in the group work. It is conducted with a mission of working together and finding research means to make the school healthier.

Policy changes and healthcare reforms have advocated the significance of expanding community-based health services in catering to public health needs. With the increased education and economic development of the society, the demands of primary health services by the

public are also increased. Innovative nursing and evaluation help generate, in advance, knowledge and insights for quality care practice, research testing, and service development. Cumulative school health practice data have potential use in developing and introducing the new roles and functions of school health in meeting increasing healthcare demands.

The foci of nursing research for enhancing professional development as recommended by the International Council of Europe (2006) and the American Academy of Nurse practitioner (2002) include four major aspects, such as (1) nursing care and its evaluation, (2) the use of advanced technology and technical equipment, (3) planning and organisation of healthcare, and (4) the profession itself and its history. Nursing is a scientific practice profession. Therefore, nursing research has a role in making information available for the design of appropriate healthcare strategies and service practice.

Its foundation of knowledge for practice ought to be logical, testable, and empirical.

2.9 Conclusion

The literature findings reflect the significance, direction, and strategies of the appropriate research design for social action sciences. The nature of school and nursing collaborative action is of social action that requires a non-linear research model for its complete discourse.

Health is an individual and social form of wealth. Health promotion and disease prevention are always believed to cost less than medical treatment. To make health services and resources more cost-effective in a mutually beneficial relationship, the public could be encouraged and provided with opportunities to practice health measures together. School health is a public and community health concern. The findings of community-based practice

research would contribute another distinct set of practice data to the quality system of care. Innovative health promotion practice in a school-based setting could involve drastic changes and development. Ethically and effectively, these must be based on sound knowledge and principles. All participants must understand the value and meaning of participating in the change process before they render voluntary involvement.

Nursing research has a significant role of informing theoretical nursing practice that could be seen as appropriate and practicable in real settings. Innovative collaborative practice involves evolving patterns of change. The research philosophy and methodology of this practice-in-action research needs to accommodate this range of interpretation. Fortunately, the philosophic and methodic issues in relation to the science of real-world collaborative practice are manageable in participatory action research settings.

Specifically, participatory action research is derived from the action research paradigm. Both share common and discrete features that could be integrated into a concrete model of collaborative action and research practice setting.

Chapter Three

Research Methodology

The primary aim of this project is to attain a theoretical understanding of the process of primary school and nursing collaboration in healthcare through real world practice. Collaboration is defined as “assertive and cooperative means of conflict resolution that results in a win-win solution; working together to establish a priority common goal (Marquis & Huston 1996 p339).”

3.1 Research Aim:

The research implements and evaluates a theoretical practice strategy of school and nursing participatory action research (SNPAR) in the context of child health promotion. The SNPAR team comprises of the school principal, primary

school teachers, parents, and a community nurse researcher. The collaborative phase components include (1) problem/need identification (2) planning (3) implementation (4) evaluation (5) re-planning.

3.2 Research Objectives:

- To apply the school and nursing participatory action research(SNPAR)strategy in healthcare practice
- To act, observe and reflect on the *planning* process in preparation for the *implementation* of the SNPAR practice
- To act, observe and reflect on the *implementation* process in preparation for the *evaluation* of SNPAR practice
- To act, observe and reflect on the *evaluation* process in preparation for the *refinement* of SNPAR practice

- To act, observe and reflect on the changes of SNPAR practice

The SNPAR team acts, observes and reflects during each of the three stages of planning, implementation and evaluation as outlined below. The framework of the SNPAR process is illustrated in diagram 3.2.

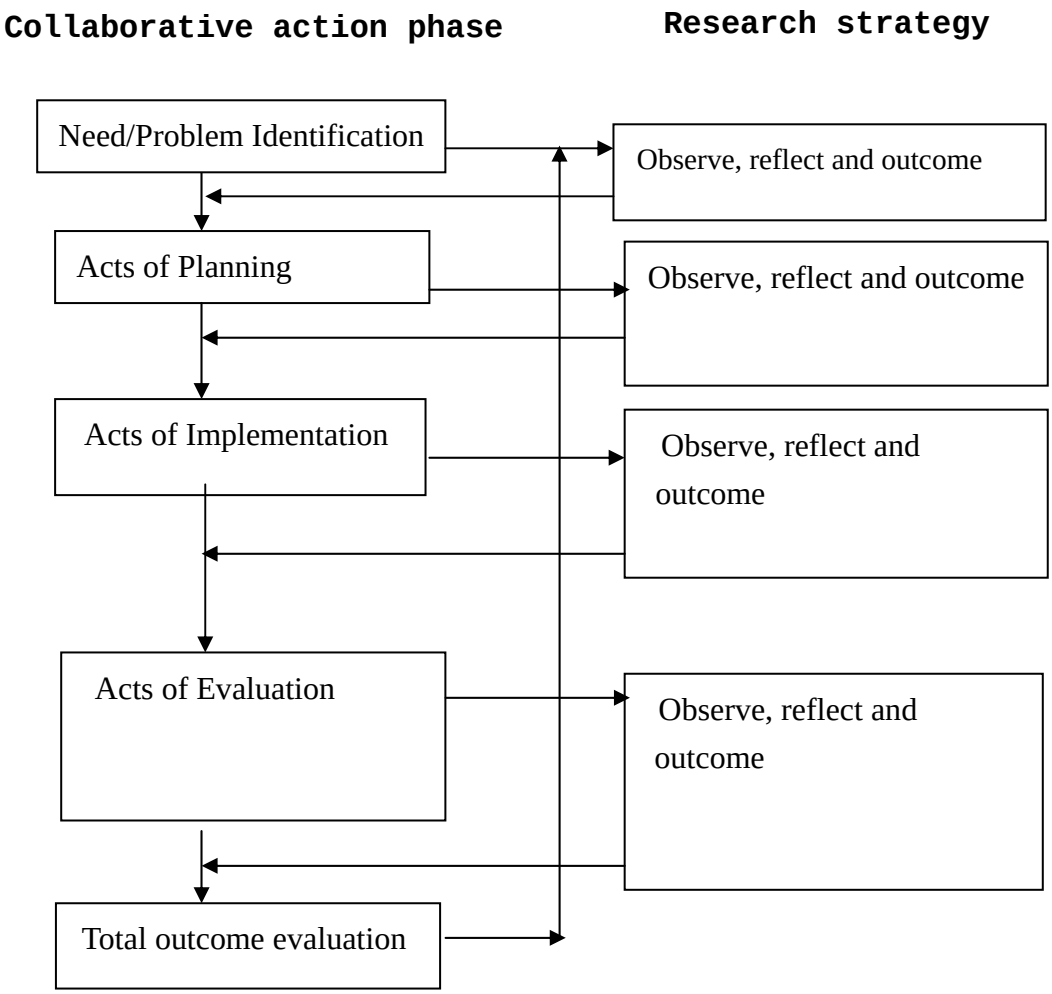


Diagram 3.2: The SNPAR framework

The SNPAR framework follows systematic cycles of identification of problems/needs, activities of planning, implementation, and evaluation. Observation and reflecting on effects as a prelude to further planning and identifying the significant factors leads to the next stage of action of improved practice (Winter 1989, Allison & Rootman 1996, Hart & Bond 1999).

This collaborative action project research ended with the emergence of a theoretical construct of change. The hermeneutic inquiry of lived experiences transcends existential meanings of living phenomena. Under the hermeneutic paradigm, it is in the nature of interpretation that any human being, for instance, a researcher, can be ultimately responsible for the types of interpretations if they were with that

experiences. Human perceptions, thoughts and feelings are inevitably changed by live settings, moments, space and time (Adler 1962, Tappan 1987, Davis et al. 2001 & Toulmin 2002). The truth of the interpretation becomes evident through the consciousness of these genuine effects in the cognitive process of analysis. The state of making sense of data grounded by this rule is becoming a valid source of life data. The discourse of research findings contains the pronouns, ‘I’, ‘we’, ‘they’, ‘me’, ‘she’, ‘he’ and ‘it’. These pronouns, however, do not necessarily indicate that the researcher is subjectively observing; these are genuine words that represent the position at which the researcher stands and observes. Thus, ‘I’ refers to the researcher, ‘we’ indicates what the researcher and co-researchers think and assume to share a point of view. ‘They’ refers to

outsiders or people who are not involved in the project. “He” or “she” does not indicate any gender bias but refers to the ‘real participant’s gender’.

3.3 Collaborative school recruitment

Voluntary participation was a pre-requisite and a high level of commitment to the innovation of planned practice was also very important. Under the strategy of affiliating the neighborhood schools, ten schools geographically located in the same region to the researcher’s academic institution were selected. Letters of research invitation were sent to individual schools, and project meetings were arranged for those schools which expressed interest. Details of the school project commitment and role of the school as a research partner were explained, along with the research proposal, summary information, and

consent forms.

The research school that eventually expressed interest in this three-year project is a public school, thus this is non-fee paying school with a student capacity of 1,120, which in Hong Kong, is considered as high-range student population. The school has one chief and one vice principal, 32 teachers, one school counselor, one curriculum officer, 6 teacher assistants and 13 school personnel assistants. The school has adequate rooms and space for activity implementation and discussion sessions. Computer facilities and audio-visual aids are accessible during and after school hours. The school also showed flexibility and willingness to integrate health activities into classroom teaching or extracurricular activities.

At the end of the project, the participants involved in the total research process included the chief school principal, 15 mothers, 2 fathers, 6 teachers and 1 office assistant. The number of participants who attended talks and activities were estimated as 228. The total school health activities were categorized as:

- Three sessions for project introduction and briefing
- Five project meetings with school personnel and parent-teacher association
- One session of sexual health talk for all primary five and six students and parents

One session of sex-education workshop for teachers

- One session on child obesity awareness for parents
- Three sessions of children discussion and workshop for participant numbers 5 to 16

- Six sessions of parent discussion groups for participant numbers 4 to 12
- Five sessions of individual teacher interviews running from 0.5 hour to 2 hours
- Four sessions of individual parent interviews running from 0.5 hour to 2 hours
- Two sessions of individual family interviews running from 1 to 1.5 hours
- Six sessions of parental counseling running from 1 to 2 hours

3.4 Data collection method

Sources of data include the program photos, discussion tapes, and field notes. Data were sorted according to the categories of planning, implementation and evaluation. Social data was observed and reflected in a range of frames in terms of individual, nursing, and life meanings. Data collection commenced at the beginning of

the first encounter between the researcher and the research subjects. The discussion dialogues were recorded with the consent of participants and the recorded conversations were transformed into transcripts. Other sources of data included photographs and field notes. All data were classified into units of analysis and they were contextually and conceptually categorized. A cognitive process of analysis was conducted, whereby data were compared longitudinally and crosswise for broader and deeper meanings with reference to interpretation rules. A converging construct of patterns and features was gradually developed and applied to explain the evolving process of social change phenomena.

3.4.1 Guided principles of Participatory Action Research (PAR)

The social interaction approach of participatory

action research is guided by McTaggart's conceptual definitions of PAR. It includes

(1) systematic and collaborative process of collecting evidence from group reflection, and planning change

(2) seeing values of planned work in the real world and by people themselves; learning how to improve from the effects of the changes made

(3) not a research done on other people; is research by particular people on their own work, treats people as autonomous, responsible agents of making their own histories and conditions of life

(4) not a method or technique for policy implementation and does not accept truths created outside the community, but may accept propositions from outside as worthy of testing for understanding and developing own understandings of what is happening as a guide

to action

(5) is a non-conventional scientific method as it involves more than one view of scientific interpretations, it is not just about testing hypotheses or using data to achieve conclusions but adopts a view of social science that is changing while interpreting the change, is a living process that changes both the researcher and the situations in which he or she acts; neither the natural sciences nor the historical sciences have this double aim (McTaggart 1997, p40).”

The collection of qualitative data using the PAR process requires rigorous checking of the true meanings of perceptual statements made by those participants with first-hand knowledge from experience, in order to produce accurate and effective reports. Objectivity is maintained through constructive reflexivity (Goodwin &

Goodwin 1984, Chesler 1991). Constructive reflexivity in this research project was applied in a triangulation approach. Participants were involved in verifying, correcting and adding in new viewpoints to make the set of data used as a basis for subsequent theses more complete. Parents, teachers, and children who were participating in different roles and positions were expected to visualize the phenomena from their personal views and perspectives. The triangulation approach of data verification helps to ensure the validity and reliability of the interpretive data.

3.5 Cognitive processes of interpretation

The fields of the cognitive process of observation, reflection and feedback on its action settings are illustrated in diagram 3.5. Participants were engaged in confirming and

clarifying the field observation and findings. The interweaving action and reflection cycles show the way to the critical inquiry process of interpersonal and intrapersonal encounters. Each concept gain should have its roots of learning process which may or may not be retrievable. Each lived experience should have its meanings based at least on its living state. The question that arises is whether the knower is stimulated to its conscious learning-in-living. Collective reflection on participatory events develops themes of critical reflection on the interconnected meanings of the field observations to collective life meanings.

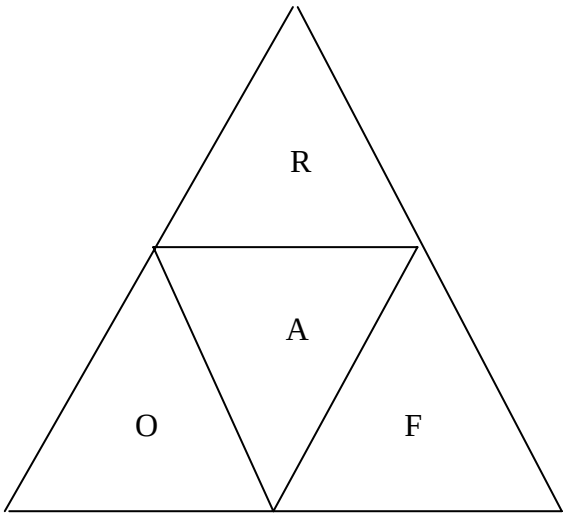


Diagram 3.5: Fields of action and cognition

O-observe, R-Reflect, F-Feedback

A-Act (Act of Planning, Implementation and Evaluation)

Trigger question set for the data collections are shown in Box 1.

Box 1

First action and reflection cycle before the intervention practice

1. Could you describe your experience in promoting the health of children?
2. How would you describe your involvement in this experience?

Second action and reflection cycle during the intervention practice

1. How would you describe your level of involvement in this project experience?
2. Could you describe any experiential difference, if any, in promoting health to other children and to your own child?

Third action and reflection cycle after the intervention practice

1. How would you describe your level of involvement in this project experience?
2. Can you describe any experiential difference, if any, in promoting health for these children?
3. Are you willing to be involved if such opportunities will be offered again? Why?
4. Are there other issues which have not been discussed or asked that should have been discussed/asked?

3.6 Reliability and validity

Triangulation of data involves the use of multiple and varied data collection techniques to obtain and confirm information (Powers & Knapp 1995, Hart & Bond 1999). It implies that

each interpretation should be viewed from at least three social perspectives relating to actions and behaviors (Salazar 1991, Flick 1992, Chambron 1995). Photographs and field observations help to construct a relatively authentic scenario (Gould 2003, Robert 2003, Krajewski 2004, Gutenschwager 2004). The source of data collection thus included the original participants' interview dialogues in tapes, activity nature in photos, discussion contents in tapes, and field observations.

3.6.1 Rationale of data interpretation

In interpreting for the phase of theorizing nursing practice, the research participants were involved in the process of shaping the facts leading to the change in school health practice.

Based on different foci of the research phases, appropriate interpretative approaches at different phases of research were adopted to obtain explanations and elaborations for the observation. Necessary clarifications were directly sought in the research field with the research participants.

The retrospective theoretical analysis of key phenomena and relationships of the participatory process is a critical and invaluable component for the theory synthesis (Whyte 1989, Alison 2000, Allan & Laura 2002). Action research, most of the time, involves the political nature of realities, and is open to different approaches of interpretations according to the context nature (Hart and Bond 1999). Nursing theory is involved in repeatable and shareable universals, especially events that change the lives of

people (Brencick & Webster 2000).

3.6.2 Reflexive objectivity in social context

The data collected in the social phase of the research experience was interpreted in a collective account. It included field notes, interview transcripts, and handbook of the research school. The discourse on the overall observation and interpretation which integrates with researcher’s views was verified by the research participants for its generality and validity. This approach of data interpretation followed the rules of reflexive objectivity which involves three basic steps for interpretations (Winter 1989, p43). These include (1) accounts are collected, such as observation notes, interview transcripts and official documents (2) making the reflexive basis for these data explicit (3) observing the

factuality of the data gathered and questioning any claim to generality (Winter 1989, p 43).

Reflexive objectivity or reflexivity is the social science concept used to explore and deal with the relationship between the researcher and the object of the research, investigating the way in which the theoretical, cultural, and political context of individual and intellectual involvement affects interaction with whatever is being researched, often in subconscious ways (Alvesson and Skoldberg 2000).

“Research is seen not only as a process of creating knowledge, but simultaneously, as the education and development of consciousness, and of mobilization for action” (Gaventa 1988 p. 19). Without the self-conscious sense, every piece of

knowledge appearing in front of us becomes an external fact, which is hard to integrate into internal knowledge. Therefore, the action researcher is conscious of the self being affected by the research process as a participant and being driven towards a logical sense of living, action and reaction (Chen 1993).

3.6.3 Hermeneutic inquiry in life context

The hermeneutic approach of interpretation was applied in the analysis of dialogue contexts and remembrance contents. The informants were engaged in reflecting on the innermost meanings of the dialogues and verifying the accuracy of the transcribed texts. Research participants were involved in comparing their research experience with the past related experience of shaping their innermost feelings, thoughts and

initiatives as regards school health participation.

Hermeneutics is a Greek word meaning a conscious critical and creative thought process of interpreting human feelings and spirits (Ruggiero 2004, Toulmin 2002). Hegel's theory of hermeneutics (translated by Emad & Maly 1988) interprets spirit as the science of the experience of consciousness. Understanding lived experience, according to Van Manen's interpretation (1990), is a human science paradigm for an action sensitive pedagogy. The hermeneutical mode of understanding guides the researcher through a vigorous mental process via a deeper method of reasoning (Toulmin 2002). Hermeneutics is a vigorous mental process of understanding the inner world's meaning to the external social world; total interpretation

cannot be seen as genuine and complete without the understanding of interpersonal changes between the researcher and research participants. Reality is an output of human cognitive process that is subjective, integrated with personal experiences and observation (Johnson and Duberley 2000). Human beings may have an individual interpretative meaning leading to individuals' theories-in-use (Coghlan & Brannick 2005). "Life was squeezed out of human experience when we attempted to make sense of it in a numeric and non-contextual way" (Morse 1997, p89). Moreover, hermeneutic understanding of the whole action experience implies the seeking of the innermost or deepest meanings of human experiences.

3.6.4 Holistic inquiry in caring context

Research participants were engaged in the

discourse on the underlying meanings of collaborative care participation from a total experience rather than fragmented parts. Research participants were expected to revisit the situations, compare with initial perceptions and identify new findings which may be applicable. Themes developed at the end of each action phase were constructed in the essence of whole learning experience. The holistic learning means the transcendental essence of the action learning experiences empirically organized in a systematic and comprehensible manner, and integrated with any of the researcher’s pre-assumptions and conception.

A realistic evaluation of caring experience needs to consider that the process of implementing an intervention is as important as evaluating the outcome of that intervention (Pawson & Tilley

1997). The caring practice of treating a person as a complete, sentient being with thoughts, privacy, and spiritual sense, have brought nursing towards a sensitive, dual mind practice profession, of attending to patients' individual needs as well as adhering to basic organisational demands and expectations (Sellers 1998, Lynn 2000, McLeod & Wright 2001). Rather than separating body and mind, the healthcare profession, nursing in particular, is aware of the need to care for people as complete beings who possess psychological, physical and spiritual health needs.

In an overall strategy of data interpretation, interpretative action research acknowledges that the actor's accounts are as valid as those of the observer, the valid data are those which are directly experienced; the observable and

experienced data are those reflected, recollected and abstracted from its nature of singularity and universality with regard to its making sense of what is going on in real life (McNiff 1992) or meanings-in-context (Morse 1994). Epistemological and empirical notions of description, pattern interpretation and theory expansion construct ontological reality and nature of the world (Mitchell & Cody 1993, Mitchell & Pilkington 1999). The objectivity of the data emerges from the inter-subjective recognition of its meanings in life context (Morse 1994). As such, a collaborative action researcher is acting as an active participant rather than a detached observer to interpret the field observations and findings.

3.7 Ethical Consideration

The research proposal was submitted to the human

subject ethics sub-committee of the University for ethics approval. Research consents were obtained from the participants, following a full explanation of the purpose and objectives of the research. The participants were given a full explanation of the research design and their roles in the research process. The participants were informed of their rights to withdraw from the research process at any time. Research participants were fully informed of the nature and meanings of the study through briefing sessions. PAR represents a social setting for community participants who act as co-investigators or co-researchers rather than subjects. The research setting reflects a collaborative co-worker relationship, as differentiated from interviewee and interviewer perspectives. All potential participants were given a summary research information sheet for

their personal use. The contact person and address of the independent Research Ethics Board were attached to the information sheet so all participants could raise any direct complaints and opinions regarding the research issues through this independent and direct channel.

Confidentiality of participants' identities in the transcripts was guaranteed by the use of anonymous labels. Additional consents were obtained from the participants whose pictures and photos were to be disclosed in the thesis report as event illustrations. The confidentiality of private data was ensured by ensuring that only the investigator would be able to access the research data.

Chapter Four

Results and Discussion

This chapter evaluates and summarises the process of learning at each phase of school health related action in terms of need identification, planning, implementation, and evaluation as shown in the following conceptual framework (Diagram 4.1). The school health collaboration induces multiple stages of social interaction in intervention settings. Public participants who were treated as co-researchers rather than as subjects were engaged in research dialogue and discussion. Their identities were masked through the use of anonymous names. Knowledge gained from each phase of action was brought forward to next step of acting.

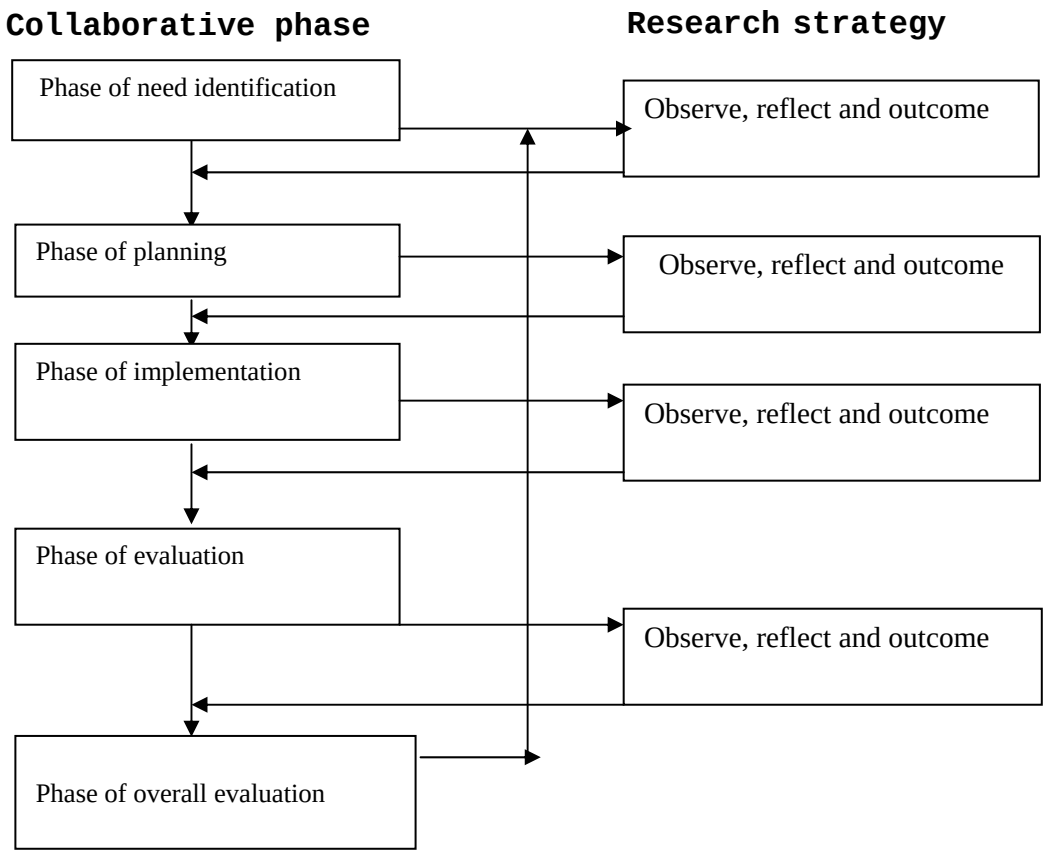


Diagram 4.1 The Framework of School Health Practice

4.1 Process of need identification

The first invited school declined because the school principal thought it was just a school health survey and talk.

The following dialogue between the researcher and Anson, the school principal who was the first to express interest in the research, ended up withdrawing from the research after the project meeting.

Anson*: ……While I am listening to your plan, it seems*

that we need to work together ….

Researcher*: Yes, it is what we call action research ….*

Anson*: …….It will be difficult, as our teachers are very busy and could not do much work for it …..That isn't possible, we rarely give child heathcare promotion our high priority. However, we welcome activities that require less commitment in planning, teaching, or any contact arrangements when arranging school activities, such as health talk, we welcome health talks. Could you just provide us the health talks?*

Researcher*: Health talks will be integrated into this project, can we work out a plan on how a health talk could become part of the element?*

Anson*: As I say, it will be difficult to involve teachers ……*

Researcher*: However, this project will be different. It needs to involve a school community in designing the program and without your commitment to help out in this part, the project won't work ….*

Anson*: Sorry, we can't help; it is not our present goal of school development*

Researcher*: That's fine …..please call me if you have such interest in the future. I will leave my office phone number with you ….*

The first meeting took more time for the introduction of

the nature of the research rather than for future collaborative planning. A Chinese adage says, “You will always be on the winner’s side if you know yourself and the other side well in the battle (知己知彼,百戰百勝)”. The saying provides inspiration to think about in the context of the rejection.

4.2 Outcome of need identification

An unsuccessful experience could generate other ways of action once the experience is carefully evaluated. The school admitted that healthcare was essential for children, but still considered it only as a secondary social responsibility when compared to its primary goal of education. The first contact school regarded the whole school’s participation in health promotion as unattractive. The school preferred the normal practice of directly inviting children or parents for health talks or activities instead of co-organising the function practice. The first conflict arising from the first school meeting stemmed from an inquiry into why such a change was needed. The reinforcement with the underlying philosophies, theories, and values of this nature of project was non-persuasive. The school perceived the project as being too exhaustive and in the end, the response was that the school would think over the research proposal and the researcher would be contacted again if

the school was interested in it.

According to the first research contact experience with the school principal, it was realised that indeed school administrators and health professionals could be working and practising from different disciplines and philosophy. As what has been mentioned in the literature, people and health professionals come from different cultures, and it is natural for them to hold different health beliefs and expectations for health behaviours and practice, which result in conflicting perceptions of what constitutes appropriate health behaviour and health dimensions (Gerrig & Zimbardo 2005).

Viewed from a social function perspective, the standard of a school's performance, in general, was guided by its educational policies as well as its market values. The quality of a school, in general, is measured and shaped by the success of its students' academic performance and talented work rather than the improvement of their health status. An investment in school health in order to influence an individual child's academic performance is an uncertain, long-term effect. This uncertainty would discourage the initiatives and motives of the action.

The first try at finding a research school was

unsuccessful. The lesson learnt from this failed experience was an awareness of the ignorance of not being sensitive to the interests and priorities of the collaborating sector. The focus on healthcare might be the highest priority for nursing, but it may not be the same for the educational sector. Teachers in primary schools do not necessarily share the same vision.

The evaluation of such a failure produces the motivation for improved tactics. To attain a mutual agreement and understanding of the meanings of the collaboration, the initiator could not assume his/her beliefs or assumptions to be the preferred ways of practice; realities should be interchanged with people's own interpretations. Beliefs that could be practiced should be grounded on reality rather than just on theory, and there should be a thread cutting across different settings that will draw people to work together on a common ground. The first thing to do is to seek ways to attain such space.

4.3 Process of school health planning

4.3.1 Setting mutual goal

After the first failed experience, it was learned that values of changing practice needed to be communicated, negotiated, and clarified. By a simple rule, change could be managed in a more successful manner by treating it as an object foreign to an organisation. The object needs to be separated into absorbable parts and managed by functional steps. When the work culture of efficiency and productivity was taken into account, the dialogue with the second school's head Mary covered issues regarding the benefits of the health-promoting efforts and its potential impacts on the staff workforce.

The dialogue as below demonstrated the conversation between Mary and the researcher for attaining a mutual interest of goal setting where willingness was self-induced. The initiatives of the teacher and subsequent parental participation were further explored.

Mary*: Our school has around 1200 students …we have already planned many school activities although it is not of this kind. Anyway, I will be willing to cooperate with you if you are willing to modify your research proposal. ….*

Researcher*: Of course, I am ready to, that's what action research means.*

Mary*: Yes, we may talk further. I also need to talk with the teachers as well, to seek their interest, you know, if they have no interest in it, I also can't help.*

Researcher*: That's reasonable, but in what ways?*

Mary*: You may leave your proposal with me and here is a teacher's name that you may contact. She may be interested in it as she is involved in health education…*

4.3.2 Building helping relation

Around two weeks later, the first meeting with the teacher, Ann, was arranged. It was fruitful as she expressed her willingness to be involved in this project as illustrated by the quotes between the teacher and the researcher.

Ann*: The principal has already briefly informed me about your project, that will be difficult if you would like to integrate into my subject because of the tight teaching curriculum……..*

Researcher*: Yes, I would understand that. We can think of any other ways of cooperation. We may talk about it. I contact you first because the principal recommended you to me …..*

Ann*: If you like to integrate it with the school subjects, I may be the most appropriate person. However, would you like to integrate into extra-curricular activities that may sound more feasible as the schedules are not fixed*

as such …..?

Ann*: It will be difficult for us to teach health, we are not taking any special lessons for it, even for sex education, we only have few hours and not even for health which covers so many areas …. You may contact Sue; she is responsible for the arrangement of extra-curricular activities for the children. …..”*

Researcher*: Yes, that may also be a good idea. We may have a talk together and find some other ways…….*

After two weeks, the researcher met Sue in the teachers’ room.

Sue*: Ann told me about your research interest. At present, it seems that I have already had many activities and outreach programs this year and the upcoming one.. The topic of health though is very important so most of time we invite the Department of Health to deliver a health talk.*

Researcher*: Yes, I understand. It is the norm and that’s why I want to initiate such a school health project so as to increase the participation level among teachers and parents.*

Sue: *Yes, my duty is to attend to the psychological health of the school children. We expect parents to look after their physical health and go with their children for the health check as arranged by the health department*

annually. I think that's the level of our current school involvement.

Researcher*: Then, are there any other ways that you may think of to enhance the parental participation in promoting the health of school children ……*

Sue*: I seldom think of this aspect as it is not my role responsibility ….*

Researcher*: Any active parents that you may think of for my further ideas …….*

Sue: *Yes, you may have the contact of some of our parent volunteers …..*

Researcher*: In what way could I get contact with her?*

Sue*: I can't give their number to you. Perhaps I would ask her for their interests first and call you back ….*

Researcher*: Then, should I also leave my number with you.*

Sue: *Yes, then I can call you later. I think I need to leave you now as I am in a hurry for a second meeting …..*

Researcher*: Thanks a lot!*

A few days later, a school parent called the researcher by phone. She introduced herself as Fanny. The conversation started with her hesitation of offering help towards the possibility of doing. A schedule was arranged for an interview after a week, in the school activity room.

Fanny*: I am not too sure whether I could help. Sue told me that you need someone to help you out in a child health project. Most of time I participate as a volunteer in this school and I think that's why they introduced me to you ……*

Researcher*: Yes, I would need some parents to work with me in this project and your involvement is voluntary and you are also free to opt not to join anytime if you like, there is no obligation ….and hopefully, we expect parents would also learn from participating in this kind of active project …..*

Fanny*: I think I can help a bit if there is flexibility of joining. Can I also ask another parent to join, we used to work together, since she is not working, she may be willing to help….. . and I think that in the future, some more parents would be willing to take part …..many non-working mothers are willing to offer help to other children……We feel if we can help care for other children whose parents are busy at work or not so able to care for their own children, these children who receive our care hopefully might not turn so bad when they grow up….*

Researcher*: I totally agree with you …..hopefully the project can help the children*

Being able to talk with the parents was found useful in understanding their level of willingness and interest in

school health collaboration. Based on the school principal's recommendation, the researcher also made an effort to introduce the project ideas to teachers Ivy and Daisy, the Physical Education and Religious Studies teachers, respectively. Their responses were helpful in offering support for arranging certain after-school activities when needed.

Ivy*: …the school calendar has already been planned, it will be difficult to fit into the schedule; the earliest will be next year…*
Daisy*: It might not be, perhaps it can be integrated with the after-school activities. Some parents might have the interest. We can help distribute the notice in class for children to ask the parents about their interest in joining the programme. I think they may like the idea; we have never arranged such a thing before…..*

It was after the conversation with them that the researcher learned something new; that schools prepared a one-year plan of their school activities and functions before the new term starts in September. The researcher learned about this through the dialogue with the school teachers.

4.3.3 Setting a conducive environment

Setting a conducive work environment, including the staff proved essential. Three months had already passed and the researcher had already talked informally with Mary, the principal, about the meeting with the potential school participants. The meeting was mainly concerned with the layout work-plan of the project activities. Mary and the researcher decided to call a meeting with all the members that had already been met before and with one additional member, the office assistant Dick whom has been recognised to be the person responsible for the room bookings. The agenda of the meeting included the future implementation of the project. Mary, being the school principal, was acting as the chairperson of the first research meeting. She was struggling how the school health activities could be introduced in the school curriculum.

Mary*: I am thinking of whether we could integrate our annual new year school fun fair with this project ….*
Researcher*: It may be a good idea to start with. I probably could support if it works with my work calendar*
Mary*: What further support would you think your project may need?*
Researcher*: Yes, I would need rooms and space for activity implementation and discussion sessions, computer*

facilities, and audio-visual aids

Mary*: I think it should not be a problem, am I right Sue?*

Sue*: Not too sure, but anyway, arrangements can be made if necessary; it should not be a great problem …….*

Mary*: Then, I think you need to arrange at least two briefing sessions, one for the teachers and one for the parents, I would suggest it to be arranged on Saturday for the parents and teachers will be near their lunch break. Dick, would you check about the time when the teachers will be more available and inform Ms Wu.*

Dick*: Yes, I would.*

Dick arranged for the seminar to be around two weeks after the meeting. It was a Saturday afternoon. The one-and-a-half hour seminar was an introductory talk regarding the project. At the same time, questionnaires with reply slips were sent to the participants to inform them of their interest to participate in the project. The parents who were willing to join but unable to attend the seminar were to be interviewed individually for their consent. The seminar started at around 2:30 pm, the time having been set that way so that the working parents could attend after work. As earlier mentioned by Mary, there were 68 parents who attended the talk. She felt satisfied with the attendance rate because based on past observation; parents were not that enthusiastic in

attending non-academic talks. Parents seemed more eager to familiarize themselves with learning skills and other matters that would help promote their children's learning. However, an assumption is child health talks were rarely arranged for parents and therefore they would have felt more interested in them. The talk was conducted smoothly though it was the first time the researcher performed such a talk in a primary school. At the end of the project introduction, the researcher further reinforced parents to join her in the project, which was metaphorically referred to as a newborn baby which could only have been delivered with the help of the parents as assistants to the childbirth.

Researcher*: ……. That's the research aim and purpose of the project. Who can help me out to deliver this baby? …… (waiting for a while of silence)*

Grace*: I am a member of the Parent-Teacher Association, I like your ideas but it seems that there is a high level of commitment.*

Researcher*: Yes, I agree. It is not much the same as with your previous health learning. The project's aim is to provide opportunities for active ways of promoting child health in a program structure. But it is open to change. It is the purpose of today's meeting.*

May*: My child has a problem in her walking posture; could the project help her out?*

Researcher*: Relating to the project themes, there are choices for your school to choose, however, I think we may discuss it further, it should not be a problem.*

Diana*: It will be good if the school can have such project, as it will increase the healthy atmosphere in the school environment. I hope this project can help us to improve the tuck shop; it should be the first priority. At the present moment, children can easily buy unhealthy food from the tuck shop ……*

Researcher*: Thank you all for your interest. I am now distributing a questionnaire with a reply slip for your interests in attending. We would prioritize the topics and select the most interesting topic as the first project theme ……..If you are willing to be volunteer participants, no matter in what nature, please fill in your contact telephone number for arranging a group meeting at the school at a later date.*

Two weeks after the seminar, the schoolteachers helped collect the reply slips, which the parents or children were also able to put into a box which was placed in the teacher room. The researcher met Dick in the office and he was concerned whether all the slips had been collected.

Dick*: Have you received all the reply slips?*

Researcher*: Not too sure, I have just received some from*

the principal, is it all?

Dick*: I have also put a box in the teacher's room for the collection, have you got the slips as well?*

Researcher*: Thanks, I will go and get it.*

Mary, the school principal, was also concerned about the responses elicited by the parents.

Mary*: How is the response so far, are you satisfied?*

Researcher*: Better than my expectations, I received so much in such a short while.*

Mary*: Ha! Our teachers are very efficient in distributing and collecting circulars; we have many circulars and reply slips to distribute and collect, not only yours ….I have also asked the staff to put a box in the teacher room for them to put the slips into after the collection, did it work?*

Researcher*: Yes, that helped a lot! Thanks for the arrangement.*

Mary*: It's my pleasure! I am hoping that more parents will join.*

Researcher*: I am hoping for that as well …..*

Mary*: I am sure more parents will join. Parents in general are keen on taking care of their children's health …..*

Researcher*: …….It reminds me to confirm about the room booking, could I use the school's computer rooms in the future. Am I right that I can use the school's phone near*

the computer room? I plan to run a discussion group for parents and at the same time, their children can play some electronic health games in the room. Is it feasible?

Mary*: That shouldn't be a problem. You may check with our office staff Dick to confirm the booking. We should have enough room for that…*

Researcher: I will contact Dick then…

4.3.4 Essential elements of conducive setting

As revealed in the dialogue, there were elements that were found to be essential in facilitating teamwork and communication. It included:

1. Communication channels available for the school members to make recommendations of their concerns in relation to the practice change
2. A contact system established for the research participants
3. An easily accessible office room with at least the essential needs such as a telephone, a networked computer if possible, and chairs and tables.
4. A multi-function room for holding small group (6-8 participants) discussions with children and parents, and a bigger activity room for running big class (20-30 participants) workshops.

After agreeing upon the preparation of the physical

setting for the school environment, the working group which consists of the school principal, the researcher, a parent, two teachers, and one technical staff started to decide on and subsequently design what health promotion activities should be implemented. A more organised pattern and strategy was adopted in doing so.

4.3.5 Framing strategic work

Strategic work refers to a state of systematic and organised planning of tactics and actions towards a desirable goal. Innovative practice process was monitored and evaluated for the effects of efforts made. A system of outcome knowledge and evaluation needed to be established for improving practice. Furthermore, the introductory talk was useful for clarifying misconceptions and promoting mutual understanding of the values of the nature of collaborative work. One month after the last introductory seminar, a second seminar was held for parents who expressed their interests in joining the project but was unable to attend the last one. After the seminar, some parents stayed behind and sought advice regarding childcare issues. Their concerns were mainly focused on the physical and emotional health of their children. Many of them expressed the difficulties of handling the emotions of the children and the appropriate parenting skills in managing their behavioural health

habits such as diet taking, physical exercises, and choices of health products. Two meetings were held for the teacher and parent members in the consecutive weeks. Opinions and views about health teaching problems and concerns at school were collected. Concerns had been focused on the factor of the time of teaching, the workload in preparing the materials, and the roles in relation to child health. Sue expressed some views in the meeting that may reflect the majority of the teachers' concerns.

Sue*: I do feel that we have the responsibility to teach health. However, as you know, the teaching schedule is so tight. How can we have time to do more? Not including any assessment if needed, I think the current curriculum has already contained the key essential concepts which I think will be enough for primary children….*

We continue our discussion by clarifying the main purpose of the project. The ultimate goal of working out a long-term feasible working relationship with schools in promoting child health is discussed. Classroom health teaching was only one of the dimensions that may be explored.

The teachers whom this researcher met were reluctant to give their commitment to the project. They were willing

to help but expressed concern if they needed to refine their teaching schedules. The suggestion of having some classes be taken as health classes was also found unrealistic owing to the tight curriculum. The teachers were afraid that they would not be able to catch up with the syllabus. Finally, it was recommended that the health activities should be arranged after class as extra-curricular activities. The research school's principal, teachers, and the researcher had gone through a brief talk, exchanging ideas with one another, as well as visions about current child health with its related facts to children's learning performance. The school principal raised specific concerns regarding overweight children and agreed to put forward a theme of healthy eating for the coming school activities. The first research meeting between the school and the researcher framed a possible collaborative strategy for the next stage of work. The idea of strategic framing was meant to narrow the scope of common focus, leading to the future goal and constructing steps that will help the project become more explicit and directive.

After the two research meetings, membership in the research group was expanded. Two more parents were recruited in the team. We now called the research group as a school health team which included the school

principal, Mary; three parents, Fanny, Grace, and Nancy; and teachers Ann and Sue. A feasible implementation schedule was made by this school health team. The original design of the programme implementation plan (table 4.3.5) was modified into separate, but related activities with respect to the context of health interests. The main health learning activities included health talks on diet, vision, sexuality, respiratory health, exercise promotion; and health awareness promotion through individual health consultation, focused parenting group discussion and a school health bazaar programme. Obesity and inadequate exercises were common concerns and were considered to be important child health issues for the schools and families to focus on.

The school health team decided to set every last Friday or Saturday of alternate months as the school health research day. It was perceived as a more manageable and regular work schedule for the school as well as the researcher who was also working as a full-time nursing teacher.

The school health research schedule was confirmed as follows:

Date: Every last Friday or Saturday of alternate months

Time: Between 1100 – 1900

Duration: Three years

Accessible communication channels include:

- Face-to-face consultation by appointment
- Telephone calls (as provided by the school)
- Letter box (placed in the teacher room)
- Reply slips (through the school letter box)

Table 4.3.5 The Collaborative Action Research Plan

(July 2000 – August 2004)

Period / Goal Setting	Activity Plan
July 2000 – December 2000 School culture orientation & team-building	**Target: Parent and teacher** Project introductory talk for teachers and parents Health advisory session for children and parents Meeting with the staff and parents Questionnaire survey of participants' recruitment
January 2000 – June 2001 Promoting health practice behaviour of children and parents	**Target : Child, parent and teacher** Health talks on healthy diet, respiratory health, sexual health, vision health and physical exercise Personal and family health consultation
July 2001– December 2001 Increasing child, teacher, and parent involvement in health practice	**Target: Parent and teacher** Interviews and focused group discussion on child health involvement Child health workshop
January 2001 – June 2002 Increasing child, teacher, and parent involvement in school health implementation	**Target: Whole school involvement** Health Fun Fair Health advisory session Formative evaluation
July 2002 – December 2002 Increasing child, teacher, and parent involvement in school health practice evaluation	**Target: Parent and teacher involvement** Focused group evaluation in school health practice
January 2003 – July 2003 Report writing	**Target: Parent and teacher involvement** Summative evaluation; Data clarification, and interpretation
July 2003 – August 2004	Thesis writing

The school took the responsibility of inviting voluntary members and the researcher conducted the briefing and programme introduction sessions. As suggested by the principal, parents were not asked to actively participate in the question and sharing portions. The parents were more interested in brief health talks that focused more on brief facts regarding health-risk information in relation to well-known diseases such as stroke, cancer, and asthma, as well as advice on how to avoid the risk factors. With this idea in mind, the researcher prepared health talk power-point presentations, translating some of the health science knowledge into Chinese verbal language or into public language.

4.3.6 Building team relation

Group work can develop interpersonal relations and productivity. An interpersonal relationship is characterized by a human's desire to maintain a lasting, positive, and meaningful personal relationship with other people; it is one of the major catalysts driving human behaviour; work may then be easier (Kelly 1988). Research on social support, which is defined as the perception of others who are available and willing to provide one with emotional or instrumental aid, has emphasized the importance of interpersonal relationships in the physical and psychological well-being of man

(Kosslyn & Rosenberg (2005). Organisation theory also points out that less mechanistic models and non-rational factors such as the social relationships between staff and the culture of the organisation, have a strong influence on performance; rational planning with tight job specifications and hierarchical control is effective in ruling out human error but not productivity (Marquis & Huston 1996). Persons are believed to develop through interpersonal relationships, which include nurse-client relationships (Degnan 2000). The work team composed of school members Mary, Sue, and Daisy and parent members Grace and Fanny, have made a joint effort in starting the project. It was the first time they participated in collaborative work of this nature. They never thought of being invited as research team members. Most of the time, the school would just invite health experts to deliver health talks and parents would only be assigned simple tasks such as distributing circulars, delivering handouts, keeping student discipline, and being in charge of furniture arrangements. They were never involved in giving opinions and ideas. It was a surprise that they could participate in undertaking such a role and they were willing to try out the experience. The team members felt that innovative healthcare involvement was worth trying if the time required of them was not that much. The project team members were not sure what they could contribute as

it was their first time to participate in such a working relationship. They were regarding the labels the researcher put on them as voluntary service givers more than co-researchers. One parent participant mentioned that the experience was meaningful because she had never taken such an active role in her past voluntary school work. One teacher participant responded that if teachers were not required to attend regular meetings regarding planning and organising work that was time-consuming, they were still willing to participate.

Team building involves essential communication styles of empathy, acceptance, openness, and passion. A mutually trusting and supportive work environment is gradually established throughout the negotiated task allocations.

4.4 Outcome of school health planning

The first phase of planning involved the five levels of work practice in leading the change. Work relations were gradually established at the changing patterns of work practice towards the establishment of team relations and social intelligence. The five levels of work practice as illustrated in diagram 4.4 were delivered as (1) setting mutual goal, (2) building helping relation, (3) setting a conducive environment, and (4) framing strategic work (5) developing team relations and social intelligence.

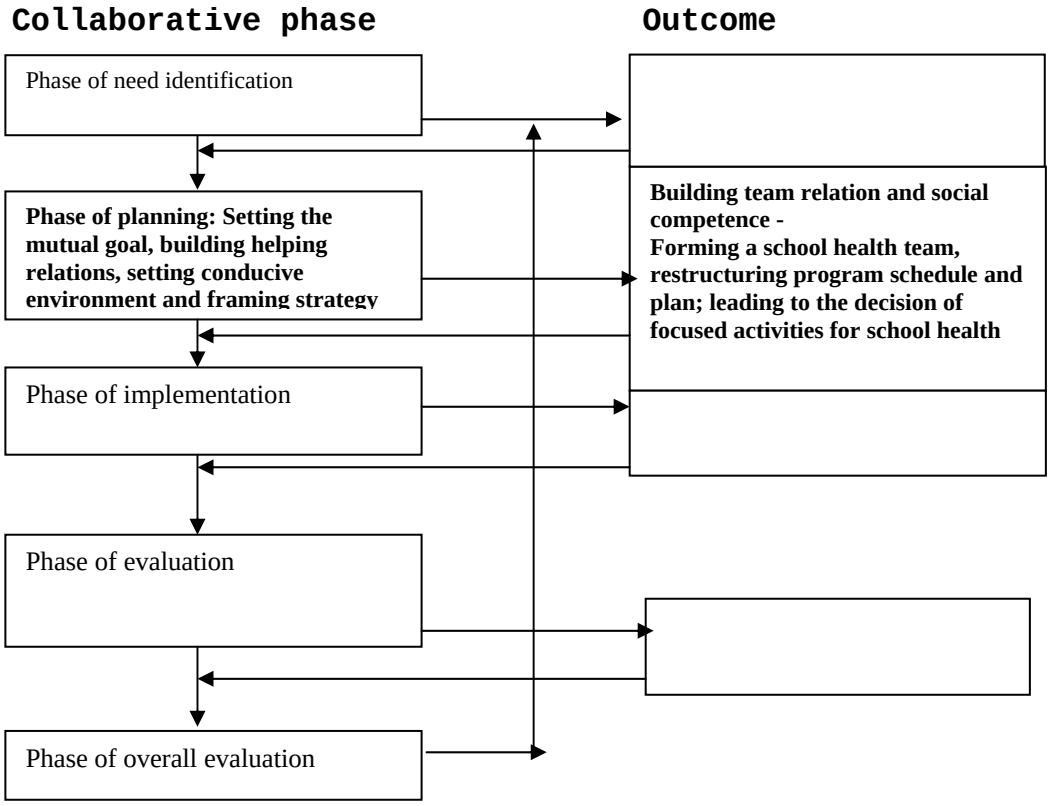


Diagram 4.4 Outcome of school health planning

The team relations are described as empathetic and supportive human behaviour in cultivating a mutual respect and openness toward one's self and others. Social intelligence is defined in this research context as the ability to communicate, understand, and react appropriately to others' feelings, thoughts, and behaviour. Social intelligence is a crucial aspect of networking and establishing team-work relations as it affects the willingness of people to work individually and in groups towards innovative change. The process of

working with a school community establishes a platform for face-to-face dialogues and communication through which people could understand each other, one another's work, and practice culture. Collaborative work involves critical, creative and integrated thinking and communicating processes. The use of intellectual skill becomes more real, practical and conscious when it is used in solving real world issues such as dilemmas, conflicts, and changes.

In the dynamic environment of change and complexity in practice, thought and action are intrinsically linked and mutually dependent (Jones 1997). When nurses learn about the world of the client, they can apply that knowledge towards a more emancipatory way of being in the practice setting (Griffin 1997). Nurses can reformulate the common reality and learn about who their clients are through the direction of their lives, the social dynamics and liberal nature of emancipation are formed in this human setting; human become more fully human (Henderson 1997). Emancipatory dialogues reinforce openness and trust in our dialogues. The first stage of planning generates insights into understanding the school's culture and concerns. The communicative action reinforces the exchange of thoughts, perceptions, ideas, values, beliefs, and other in-depth notions and perspectives.

Moreover, the school health collaboration offers a platform of interpersonal communication and team-work practice such as empathy, openness, acceptance, accommodation, persuasion, and negotiation. Finally, cooperative planning nurtures human willingness towards team commitment. Hence, collaborative work relations are gradually established in goal-directed practice towards the process of the implementation.

4.5 Process of school health implementation

4.5.1 Phase of participatory inquiry

4.5.1.1 Participatory inquiry in family health practice

The first phase of intervention started with a first research group meeting. It was held for the purpose of understanding the nature of family health practice and engaging the parents in voicing their needs and concerns. The research meetings involved the researcher, Fanny and Grace who were parent co-researchers and parent-association members; and four other parent participants who were not members of the research project but were interested in being involved in the discussion. They were Mark, May, Susan, and Apple.

The questions which the researcher brought forward in the meeting were:

How would you describe your experience in promoting the

health of your children?

How would you describe your involvement in this experience?

Fanny started the conversation by expressing her concerns about today's children who are lacking in exercise. She thought that if the society would like children to be healthy, the society should strive to achieve an environment with clean air.

Fanny *: "Making the children do exercises is difficult for some families, when there is not enough sport ground or garden nearby…….……Both my children go to school on foot everyday, they would regard it as their regular exercise but still I worry about the air quality as they walk along the main road and I feel that the air is quite polluted. I am quite hesitant whether they should continue the daily walk ….. ."*

The belief on health practice should be reinforced by an appropriate environment with clean air. In fact, this notion is well matched with Nightingale's environmental health concepts in fundamental primary nursing care. The major areas of Florence Nightingale's caring concern in the physical environment were ventilation, warmth, effluvia (smells), noise, and light (Torres 1990). Likewise, school health should also place focus on the

quality of our physical environment. This message was made evident in the dialogue.

On the other hand, Mimi voiced out her concern that the school health policy should enforce healthy eating through the sale of healthful food in the school's food shop. She said,

' The school could help parents if the food shop can sell more healthy food….We would just waste our energy if we teach our children to eat nutritious food at home and at the same time, the school and their friends were reinforcing them to take junk foods'.

Her concern was that the school should provide nutritious food rather than fatty foods to the children. This was again another factor for promoting the school health environment.

When the discussion was shifted toward family health practice, Grace raised her concern regarding the method of enhancing family health practice. She said,

"My concern is when I want to go out for an exercise on Sunday, their father will usually object as he feels work is already a vigorous exercise…There is no way [value] for him to go out on Sunday for any exercise…he said he already had much exercise at the workplace."

Her frustration in promoting exercise as a family activity was due to her husband who would most of the time disagree with her ideas and who would just want to stay home and rest on Sundays. The notion of ‘I value rest more than doing exercise’ seemed to be a common thinking of most modern people.

The behaviour of avoiding physical exercises is not only a child health issue but an adult health issue as well. People are usually unwilling to do exercise because of time constraints. Their sense of ‘comfort’ far exceeds the perceived benefit of physical exercises. Therefore, the essential step to motivate people to be active is to develop their willingness to break through their comfort zones by experiencing how exercises could give energy and result in energetic feelings. This can be an example of the use of the affective domain rather than the knowledge domain in promoting health practice behaviour.

Parents were specifically interested in sharing strategies or skills to reinforce child health behaviour rather than placing the focus on strategies to improve school health. However, if we treat each family as one cell of the school, the collective healthy cells would evidently result to a healthier school.

During the discussion, the parent participants were addressing one other's concerns and needs. They were also eager to correct one another's misconceptions. For example, when May noticed a parent regarding heavy labour as a physical health exercise, she corrected her immediately by saying,

On the notion of labour exercise, May said*: "Laborious work is different from physical exercise, you should tell him the difference and encourage him more…"* Her underlying meanings after clarification was elaborated as she learned that work exercise is different from body muscle exercise ….She knows that vigorous body muscles is important for heart functions and should be promoted in family for the children.

On the notion of guiding children toward maintaining healthy diets, they had the following shared ideas. Mark, father of nine year old son, voiced out difficulty in reinforcing his son's healthy drinking. Parents started to exchange cues and experiences on this matter which stimulated further questions in relation to other child care issues.

Mark: *I have difficulty in stopping the children from drinking too much soft-drink....*

May*: Have you tried to add more ice into his drink to make him drink less [soft drink]….?*

Susan: *…..Can anyone give me ideas on how to make children drink enough water per day?*

Elsa*: I am trying my best to make my children eat a balanced diet, though I think it is rather difficult as my daughter doesn't like to eat vegetables and fish…*

May*: Have you tried cutting them into small pieces? Children can't eat large portions of vegetables…My child doesn't like meat, therefore I help her to mix in meat with a minced texture and she likes it…*

While a parent was interested in health talks, a parent preferred to enhance parenting skill in teaching them how to keep child's self-discipline. Fanny responded to this intention and suggested*: "There are many ways of keeping a child's self-discipline, but physical assault is forbidden."*

However, Mark said*: "It's impossible for children to discipline themselves. They are born with parents to discipline them."*

Shirley*: Anyway, it depends on which kind of discipline you apply, but beating should not be allowed.*

Maggie: *I think the difficulty of our situation is how to balance the risk of danger and the method of learning. I remember a child care expert informing us that parents*

should not hit children. I accept this idea, but I also accept that we have our own emotions as parents.

Fanny: *Sometimes, I think if parents really hit their children out of their emotion, they really should not be blaming themselves too much. I would tell my child, 'I am not in a good mood today, and you better not cause my anger.' I agree that sometimes parents should not feel that they should blame themselves if they are really doing something bad to their children. Just say, "Sorry" afterwards. Of course, I am aware that I do not make it as an excuse…"*

Fanny*: I can understand the child health concerns of today's children... Parents are working, they are eager to be a good parent, but sometimes they would be too protective.*

When the discussion shifted toward their experiences in school health participation, Elsa voiced out that the priority of the school health should be to arrange more sessions of physical exercises and talks for reinforcing healthy diet behaviour. She said,

Elsa: Regarding what kind of school health activities I have been involved before……n*ot specifically focusing on improving child health, usually I will just attend the health talk offered by the school. You know, children*

nowadays have plenty of homework, and not much time for planning activities for health. The best solution is if the school can offer more physical exercises and conduct health talks for promoting children's healthy eating ……

While the issue of promoting children's healthy eating was concerned, Apply brought up another context of body image. Her explanation was,

Apply: You need not say much. If you tell girls right from their childhood that water will keep their face beautiful, they will follow your instruction…
Fanny: *Of course, if I relate an action such as exercise with a negative feeling, my daughter will dislike exercise; she would rather do other things such as dancing. But dancing is also a form of exercise, right?*

While the discussion on promoting child health proceeds, Fanny brought up her observation that when children were trying to learn good health practices, they were, in fact, also learning how to practice self-discipline.

On the notion of maintaining a good health practice, Nancy said: *"I place more attention in disciplining my child, and it already draws all my energy, leaving no mood for thinking about health…"* Fanny listened to Nancy's comments and shared her opinions of reinforcing

children’s unwanted health behaviour.

Fanny*: You know, when children don’t want to take vegetables, they still need to take it even though they may not like it because it is good for their health. Isn’t it a lesson for them to experience….when something is good for them, even though they dislike the taste, they still need to take it…It’s similar in the adult world, even though you disagree with the boss, you still need to do according to what he says. Children also need to develop a stronger will in coping with the difficult times in life; they would be spoilt if they always do things according to their interests. They must know the underlying reasons and parents need to be firm in managing the children’s behaviour if we are certain it will be good for them in their future lives…*

A parent raised the point that child health practice should also include keeping a child’s self-discipline. The discussion focus was then changed to another concept of discipline. Arguments occurred when the researcher asked them how they perceive the barriers when they want children to be self-disciplined. Mark started to talk about his views.

There were other messages derived from the discussion dialogue which, although they did not stimulate any

interactive responses, brought up two related elements in citizenship growth and caring each other. These were the concepts of ’shared health responsibility’, ’health priority decision making’, and ’hearts of caring’. These concepts were brought up when we discussed how a child health promotion activity should be designed in order to enhance child health practice at school. Nancy suggested that the school could work with neighbourhood community centres, and students might even render services to these. She responded to my question as,

Nancy said, “The health awareness program can be jointly conducted by the community centres; it may not be necessarily conducted with the parents. Children could just do some handy work and voluntary parents could give the school a hand in looking after the children. Isn’t it a cost-effective way of educating our children the hearts of caring?...”

While Fanny added her further comments,

“I don’t expect the school to provide me with the health participation opportunities, I need to create it by myself. Child health promotion should start from children’s homes.”

It was noticed that active parents, most of the time, tend to express empathy on others. Elsa, who was recognised

as one of the most active parents in our research team in preparing the project work, showed her concern regarding the school teacher's workload. She perceived the fact that health promotion should not be their roles or responsibilities. She commented,

"The school has no time to arrange the activity; the curriculum is too tight. …….Teachers already have so many teaching activities; we should not expect them to cover anything more……"

However, when the suggestion was made by the researcher that perhaps parents could be more involved in the implementation, Nancy responded and said,
" Parents could be too busy to be involved as well……..In fact, the children already have so many extra-curricular activities, how can they have time to attend such activity which has no mark added?"

The team, through the research discussion, finally came up with the final decision of certain higher priority of health promoting activities. The team decided to involve the researcher as facilitated by the team members in conducting healthy diet workshops for the children and group discussions for parents. The activities should aim at reinforcing the health behaviour of eating and

exercising in family and at school. For the activity planning, there was a need of identifying factors leading to the self-initiated change of risk behaviours.

4.5.1.2 Participatory inquiry in self-directed practice

The discussion and interview promoted an understanding of individual beliefs in health and child health practice in each family. The group inquiry in the context of child health practice contained moments of exchanging experiences, thoughts in values and beliefs, and feelings on childcare and healthy living practice. The emergent themes of the dialogue meanings were conceptualised into belief notions of explaining the self-motivated thoughts of health practice behaviour which were further categorised as (1) environmental notion: I act when the surrounding is conducive, for example, I believe that health practice should be induced by a clean air environment, (2) value notion: I act according to what I value, for example, I would rather take a rest rather than do exercise, (3) knowledge notion: I act with a cognitive reference, for example, I exercise because body exercises build up our muscles, (4) tactics notion: I act if I know the skill, for example, learning how to do it, I would do it that way, and (5) higher well-being notion: I act as it makes me feel better, for example, all ladies love the feeling of being more beautiful.

You can’t go out and teach a community to think clearly if you can’t think clearly yourself.
----------Martin H. Fischer (1879 -1962)

From the dialogues induced by the parent and teacher discussions, the researcher attained a better understanding of the school health context. It was observed from the dialogues and interaction that our health practice behaviour could be highly affected by our internalised notions of standards and values with our accompanying health beliefs. They are interrelated personal systems of thinking which influence our health-related behaviours. According to the definition in Johnson's behavioural model, behaviour is the patterned, repetitive, and purposeful ways of living which characterize each man's life; is expressed by the behavioural and biological scientists of the output of intraorganic structures and processes as they are coordinated and articulated by and responsive to changes in sensory stimulation(Barnum 1994, Conner et. al 1994). If we agree part of our sensory stimulation is induced by our inter-subjectivity interpretation of our external worlds, in brief is how we perceive our reality, the change in the sensory stimulation could imply the change of our perceived reality and ultimately changing our behaviour.

I was more able to facilitate the second research group meeting. It was focused on collecting ideas and opinions about the design of educational parenting activity as

suggested by the last research meeting. It was believed to be one kind of family health support that could enhance parenting styles in promoting the balanced diet behaviours of the children.

4.5.1.3 Participatory inquiry in family support for child health

The parent co-researcher participants were requested to recommend approaches of promoting balanced diet behaviours within families and children. The discussion was guided by the following two questions.

(1) What could be the parental concerns and needs in facilitating children's or others' healthy diet behaviours?

(2) What could be the nature of support for enhancing family practice in promoting children's healthy eating behaviour or other health-related behaviour?

Two focused discussions were organised by the research team. The total number of participants including the team members was twenty-three. The dialogue started when Susan expressed that she wanted the school to arrange face-to-face health consultation talks involving the children which will subsequently improve health communication relationships with them. This brought up

the discussion on the dimension of school nursing support.

Family communication

Susan: ……..*I really want the school to have health consultation sessions for the children. He seems to have a difficult dialogue with me when we talk about healthy eating. It may ruin our good relationship and I really don't know how I can help him …...*

While this parent considered the family health relationship, another parent talked about the need of having a particular person who was responsible to deal with particularly the child health issues. She explained,

Individual resource

Apple: …….*We seldom seek advice from the teacher. We are afraid that they will label our children as problem students……it will be better if we have a particular person, let say a nurse whom we can approach and talk about health of our children ….*

While another parent thought that teachers should know the children better. .

Joyce: …….*I always seek help from the school teacher, as they are the people who understand my child's learning skills the most……..*

Vera thought it may be too expensive for a school to hire a staff member who will be mainly responsible for child health as the service may not be found useful by all parents.

Vera: *Not too many [times of seeking help from the school]…., I believe I manage my child quite well, it could be expensive if we [she means the school] hire a person for child heath."*

Parents seemed to be more interested in debating on this point and said,

Betty: *If it is an emotional problem, I will seek help from the school counsellor. If it concerns learning, I will ask advice from the teacher, although sometimes I seek help from both.*

Marian: *I try my best not to seek help; the teachers have already have many things to do.*

Martha: *Seeking help sometimes seems to give people an image that you are incapable. I would only seek help if I really cannot manage it. Anyway, I will try my best first. For me it requires a certain amount of courage.*

Active learning in living

Parent: *The government now offers a parenting program.*

It helps us become better parents and is very useful.

Fanny: *Do we need to attend such a course to become a good mother?*

David: *There is too much bad news nowadays. The media, it seems, assumes that we don't prefer reading any good news. Everyone would like to see good news. I would let my child see two sides of the world. We have different natures (personalities) as people. Although we tell our children to care about others, we also need to teach them how to protect themselves, to be aware of strangers…*

Parent: *My child is a little shy and passive, could my child be trained? What I mean is making them more active. Do you think she can be?*

4.5.2 Phase of health communication

4.5.2.1 Communicating supportive strategy

It was observed that there were many individual and common health needs and concerns. The nature of parenting support will therefore be different. This discussion ended with no conclusion as to what an appropriate program should be, but worked toward a dimension of the nature of support which school nursing could perform within a multi-disciplinary school health team. The social role and image of school social workers and counsellors have already been well established. How can nursing contribute to the quality of child healthcare within this

professional health care team? With the different natures of caring practice in nursing, will school nursing be able to provide a cost-effective caring service which is different from that provided by other disciplines? Parents expressed ideas and opinions regarding the use of professional health resources from an economical perspective. After all, the economic factor is an issue affecting all members of a society.

Based on the research meeting records, the school raised four essential biological learning needs for enhancing self-care behaviour at child age. They were (1) body weight, (2) vision care,(3)respiratory function, and (4) skin allergy. In one personal dialogue with a teacher, seeking her ideas on how the researcher could work with the school to enhance whole school participation in child health, she stressed on the importance of providing support for the family to deal with emotional health. She said,

"Children will easily have emotional health concerns ….. *they may simply feel annoyed when they need to do things in the conflicts of their beliefs or values. Stress may come if they were not well-prepared for their examination. Anxiety can be induced by any of their life changes."*

How could children's emotional health be effectively

promoted by their own family? The researcher's education and personal belief have taught her that parents are always the best models for their children. It implies that if parents are able to manage their health well, their children will learn how to do it as well.

The school research experience informed me that most parents were interested in seeking knowledge to strengthen the physical and psychosocial health of their children, and indirectly, the whole experience ultimately affected their states of well-being. During an informal dialogue, one parent felt interested and sought advice regarding psycho-spiritual health dimensions in the context of promoting inner-self growth and establishing positive values of the self. There was a wider range of health concerns, ranging from psycho-spiritual wellness to health and diseases. Nursing claims to be holistic, being able to attend to the psychological, physical, and spiritual dimensions of health. Could this be one of the strengths the nursing profession already has?

4.5.2.2 Strategic plan of school health

Based on the accumulated learning from the school-health promoting experience, a preliminary strategy for school health partnership emerges. School health could be

mediated, controlled and maintained by the four core environmental forces: the personhood, the development of a physical and community well-being system such as the school's families, the school's neighbourhood community, and the school health service system. Nursing can become one of the agencies of the school health service system in integrating the health resources of these four domains toward achieving the nursing standards of health. The base of the systems will be integrated by these complementary forces and functions in sustaining the health needs of each stage of child growth and development. Based on personality psychology and educational practice, personal health can be enhanced through character development and health-goal exploration. As guided by the principles and practices of student health, a comprehensive school health promotion should consist of program components, immediate outcomes, short-term outcomes and long term outcomes (Wallace et. al. 1992). This vision can also be illuminated from parenting voices that say 'It is hard for children to be healthy if they lose their self-discipline', and from a teacher's voice saying 'What will be the meaning of achieving health if we do not have our life goals'?

Individual health could be achieved through the exploration of the lifestyle activities that influence

their health (Kann et. al. 2001). The focus is recommended to act on problem-solving techniques, achievement of positive self-concept, and acceptance of responsibility for those personal health actions over which the individual has some control (e.g. care of teeth and gums, eyes, ears, skin, hair, as well as balance between rest and physical activity(Seffrin 1992). These personal healthcare activities can integrate and reinforce the concepts of self-discipline, self-responsibility, and self-efficacy and at the same time participating in caring own body. Most parent and teacher participants had experiences in exerting efforts to promote child health at home or at school but rarely they would bother to evaluate its effectiveness. With the focus on promoting healthful habits at school, the parents and children's analytical decision-making skills could be enhanced through activities involving healthy food choices, inquiries on health practice, and a critical evaluation of school health practices.

Some parents have expressed views in their dialogues that health-related behavioural practice was already applied in the health service setting. What is difficult to change is its relationship with the social and personal realities of the people involved in it. During a health advice session, a mother and her child came to me for

seeking advice on healthy diet. In between, the mother expressed about the child's behaviour of not willing to greet others. The child felt being misunderstood and she clarified her underlying reasons which I included this encounter in the category of "communicating inner realities" which implies the exchange of feeling, thought and perception in relation to social norms and conditioned behaviours.

4.5.2.3 Communicating inner realities

The primary sixth grade child responded that she felt greeting teachers at school was a norm behaviour, but not in a home environment. She perceived greeting as a school-conditioned behaviour rather than a show of respect or politeness. She felt uneasy when greeting people because she cannot predict how the other person will react, and how she should respond to it in return. She however, related well with greeting her friends, as it contained the meaning of friendliness. Sometimes, parents may tend to pay more attention to what children do not do well and forget to understand why they do not do it. An adult's interpretation of the meanings of good behaviour can be different from a child's interpretations. Approaches of practicing interpersonal skills can be very dynamic in adapting to the settings and personalities and should be discussed and interpreted from different value

perspectives. Sometimes, we as professionals may tend to define the norms of practice in our culture rather than the organisational culture of practice. Tuning into the meanings of person's voices promotes our understanding of their perception of changing behaviour.

These are one of the common approaches in nursing dialogue and interaction. Sometime unexpected encounters and meanings will come up from the conversation. Nurses most of time learn our human nature in our caring conversations. Another scene also occurred similarly when we discuss about how we could reinforce the children's health behaviour in school settings. Sophia responded,

Sophia: *Most Hong Kong people are practical, if I don't see its necessity or benefits, no matter what you say, I would still insist my own way of doing things.*

Sophia's underlying meaning after clarification was she expected nurses should help families in changing their parenting styles.

Researcher: *Why do you think so, can we not change this reality, to improve the family environment?*

Teddy: *That is the social reality; we cannot change much.*

Teddy was thinking that even though nurses were involved in promoting family health, they could do only a little as individual family issues could be a complex issue.

Teddy: *How can we as the public have the power to change it, it involves the policy [service] …*

Researcher: *You may write a letter to the hospital authority, I am sure that they are willing to improve the quality of service.*

Teddy : *No way, I won't do things which will cause no effect. You better not be so ideal…*

Researcher: *Then, how about if it happens again the next time?*

Teddy: *Let's see, if the condition [hospital care] gets worse, it may be better to write.*

4.5.2.4 Changing social realities

Another dialogue also in the similar context of changing the reality when Clark recalled a dental health service experience. Her children was found to have a toothache but was dismissed by the dentist as he said the free dental service only cover the screening but not the treatment. He advised her to seek further treatment from the private. She was frustrated because even she was willing to pay for the service, since it was a free government service, the dentist was prohibited to have extra paid service for the public.

Clark: *I remember bringing my child to a dental health check. The dentist informed me that my child had tooth*

decay, but that their service will not cover that as it was free. He advised me to seek treatment from a private dentist. [The government offers free annual dental health check for children].

Researcher: *Were you satisfied with it?*

Clark: *How can I not be satisfied as it was free, I just felt frustrated that they were not willing to do it for me even if I am willing to pay for the cost, that I needed to go to the private practitioner. I didn't mind paying; I just wanted to save time. I just cannot understand why they cannot do it for me even I am willing to pay.*

Talking about the quality of dental health service, Novel shared with Clark her opposite experience. I perceive, with Novel's message, Teddy's reality may be changed to a certain extent.

Novel: *Yes, I think it depends on the region. The service I receive is quite good. They even let me make appointments through the phone, which I think was impossible in the past. Anyway, I think the service is improving.*

Researcher: *It can be the policy. However, perhaps you can write your experience to the department reflecting on the situation. It is one way for them to generate money as well. Perhaps nobody has initiated anything and they dare not try a new system of service. Public hospitals*

many years ago won't accept private patients but now, we can have both. There is a need for someone to initiate a change somewhere…

Teddy: *You are too ideal. Just get the work done and just leave the rest to God.*

4.5.2.5 Communicating the best value

Novel: *I am ideal, as I think it is where my energy comes from…to drive myself towards being a better person…*

Researcher: *Thinking of doing it in an ideal way and thinking of doing it in a realistic way may not necessarily contradict each other. It is only when time and opportunities come that you select the approach that suits the situation. Don't over-exhaust yourself; people have limitations. We just try our best hoping it will be the best way we could do it……..*

Novel: *How can we know if we have done our best? I always say to myself, I will give the best to my children, but in fact, I am not certain what should be the best for my child.*

Researcher: *Talk to other parents. Their ideas may be a good reference. But as each child's personality is different, talk and communicate more with your child regarding your child's interests and feelings. Sometimes they are able to tell you if you have done the best for them. If you are available, attending parenting talks and*

other related talks may give you insights, too. As long as you have the heart for caring for your child, you have already been acting as the best parent to your child.

Nurses will act as public advocates most of the time as well as reinforce clients to become self-advocates as a strategy of developing individual capacity of expressing own needs. Most of time, nurses use knowledge in day to day dialogues and in communicative intervention of behavioural reinforcement. Nursing role is fulfilled through dialogues may not be conscious. The same situation also applied to the researcher. Without the reflective practice in writing, she was not aware that the role concept of the 'nurse as a client-advocate' was indeed guiding her to such verbal responses.

Nursing uses many types of knowledge to achieve its goals; the development of knowledge has its main goal of empowering nurses in professional practice and empowerment of clients to care for themselves to take advantage of the resources available to them (Meleis 1991). With an understanding of the social relations that shape the professional practice, the nature of knowledge in facilitating the nursing roles and functions within a social care setting can become more visible.

Regarding school as a client, the clientele will include the school staff and the school children and also their family members if needed. As a community health practitioner, we most often take the role of empowering the public with health information and relevant health support channels. Public health education teaches the public about their right to access equal health, as well improves the quality of the healthcare system in health participation and self-health promotion. In fact, public and health professionals are in the same boat (of health), so to speak. Public pressure on public services could sometimes bring about changes if people's collective voices made sense. The quality of healthcare and how it could be shared within the population satisfactorily is a non-ending debate dialogue in Hong Kong and perhaps in the global community, in general. Healthcare in the economic context was found to be a common interest as it affects all of us as persons, citizens, as well as health professionals.

The discussion of the cost-effectiveness issues lead to another observation of health participation. Public are more interested or eager to be involved in the discussion if it involves their loss and benefit. Nurses from our history of education are less involved in health policy studies or criticism. Quality of nursing service is not

sustained purely by nursing knowledge. With the complexity of the healthcare environment, health promotion nursing practice ought to be involved in the broader dimensions or issues in human-health context such as economic, political or policy health issues. The social health environment is affected not only by an individual health but also the health policy of shaping the equity of health services. Should the type of knowledge that advances nursing practice be including this dimension of social health knowledge for empowering the profession as well as for the facilitation of the public health involvement in service evaluation.

Referring back to Novel's question, how can we know if we have done the best? Although we cannot be certain of what is the best for our children or ourselves in the future, we can be certain that what they or we (if we reflect from our childhood experience) need most right now is parental love, support, appreciation, and knowing the moral relationship of getting along with people. It is more important than just placing emphasis on knowledge, although it is also important in boosting our confidence. They do not contradict each other. I notice that many children who are conscious of moral values appropriate for their age of growth and social interaction have much confidence in learning and can get along well with people.

There were assumptions and beliefs from teacher and parent based on their experiences and observations that if children have a set of moral values, they are more able to understand the purpose of communication, respect, empathy, and others that promote positive social interaction. This observation and assumption are worthwhile to be tested in further research on its valid truth.

4.5.3 Phase of intrinsic reinforcement

Another discussion illustrated that parents would like to learn reinforcement techniques of health related behaviour. The researcher labelled its underlying context as intrinsic reinforcement which corresponds to the previous observation that the public would be self-motivated in promoting their health if they know or understand its underlying meanings, tactics, or techniques. Daisy, a mother of seven year old girl responded that she felt exhausted when trying to reinforce her child on healthful diet and exercise.

4.5.3.1 Supporting healthful diet and exercise

Daisy: *"Sometimes I really feel exhausted with persuading the children to eat healthfully. I lack data. I am not too sure of the number of exercise hours that children must do to encourage growth. They may think I*

am only a teacher; will my speech be powerful enough? I did try to encourage children to participate in more physical exercise activities, however, when they were given poor results in school work or got injured during exercises, I am the one who is blamed. I personally do not like doing physical exercises; therefore I do not see any benefits of it which implies no feelings of fun."

Being a novice implies having no ability to be critical; one can only receive or process what has been given. Humans are more conscious and critical of seeking tactics in order to attain a better or the best performance when we are offered more choices. From the dialogues and human interactions with the school's different representative groups, some parents became engaged in identifying and elaborating their perceived best strategies. Many times, the ideas would be connected with actual experiences or visions of expected outcomes. Diana, who had been participating actively in voluntary school work, expressed her opinions in designing activities to promote school health in a family-school cooperative approach. She said: *"School is the second home of our children. I think the best way is to set up a family day at least once per week or initiate interactions through which families can have regular meals together, gather around and just engage in chit-chat. It will be good if we could have*

family support groups from the school."

4.5.3.2 Supporting parenting skill

Diana, as a parent, expressed her initiatives of holding regular parent meetings which will provide an opportunity for parents to gather and talk. The school, as she experienced, was the second home for the children. This seemed to be truer if the school can provide the warmth, caring, and supportive environment that the home provides. This idea is worth seeking and promoting. From a social support strategy, positive relationships among families help strengthen the family network and resource support. In the focused group dialogue, there were some instances in which the participants were asked to recall their past health practice experiences and share their health beliefs and values for such behaviour. For example, there was an encounter in which a mother gained new insights from another mother. The dialogue started with a parent who expressed her interest in learning new ways to reinforce her child's self-management behaviour regarding homework.

One parent said, *'I have already tried out many different positive reinforcement strategies of rewarding him with the things he liked when he could achieve the expected behaviour. I felt exhausted when I recognised that many*

times, I needed to think of new ways of reinforcing him. My son also started to negotiate and associate school work with rewards'.

Another mother participant responded, *'Have you ever involved him in finding the personal meanings of learning? I seldom reward my child for school work as I always tell him that it was his responsibility and he would be rewarded or punished by the school according to his school performance'.*

This researcher expressed her own views at this point and said, *'Sometimes, it is difficult for us to decide which approach is the best for our children's learning behaviour. Both rewards in the nature of being physically observable and spiritually sensible are essential for behavioural motivation. Similar to adults' work behaviour, we may seek extrinsic rewards such as the salary and the promotion for the work, but we may also be eager to seek for the intrinsic values or rewards of the work that may have personal meanings. My ideal is having both rewards if possible'.*

When we are being questioned regarding the underlying intentions and purposes of certain habits (habitual practice or repeated behaviour at work or in living), we

as individuals are spontaneously being invited to express values and beliefs about work and living. For instance, when the participating parents were sharing their perceived effective parenting skills, we were not aiming at seeking which were the best or correct techniques but learned to be open by actively listening to each other's underlying beliefs and values attributed to the practice. There are no right or wrong parenting skills because there is no standard model of parenting. Parents, in general, are able to capture the better technique for personal skill improvement. Parents who were seen as more able to reflect critically and sensitively on social and life observations were recruited as the school health team members, making the team bigger and more supportive. Most parents learned childcare practice from their own families, evaluating these using cultural and moral values and standards. For instance, a parent made a strong argument that parents should not physically hit children because she had gone through such negative experience in her childhood. This expression generated an observation that negative role modelling experience sometimes could be transformed into a positive force of behaviour. Furthermore, it can be mediated by individual ways of thinking and interpretation.

At work, when we are made to justify our proposals, we would try our best to lay out the presentations as

worthwhile strategies most of the time. In academic research practice, we are conscious of learning approaches on gathering data in an objective manner, but in this case, subjectivity is inevitable. We have to acknowledge the human tendency to become biased. However, these are two different mindsets of learning to achieve different purposes and are equally important for intellectual development.

During the course of this research, we unexpectedly found that a focused group discussion that was originally aimed at working out a framework of activities for implementation also became a parenting support group. The school-parent association in the past had not really thought of organising a practice support group of this nature. With the involvement of a healthcare professional, parents found this support group useful in clarifying conflicts and doubts during the discussion or even afterward when a professional was no longer present.

4.5.3.3 Supporting peer talk

A focused group discussion was held for children to share their experiences regarding healthy diet behaviour. In their dialogues, it was observed that the children could also support each other and exchange skills or cues in taking food healthily. A child told us his feelings about

taking vegetables as he said:

“I feel the difficulty of overcoming the unpleasant feelings of taking vegetables…….I did not like the texture and the taste of vegetables when these were being put into my mouth.” Another girl at this moment suggested,

“You may ask your mum to cook vegetables in different ways. That could help make them taste better, such as cutting the vegetables into pieces, mixing the vegetables with eggs, or boiling them in soups…..”

“Is it really? …..I would try ….”

This scene lively demonstrated the effect of peer support in child health practice. Later on, when the researcher followed up on this boy’s eating behaviour, the mother said that he really had told her to change her cooking methods. She tried and his diet was improved by taking more vegetables. Although it was just a single case demonstration, the researcher believed that a peer support group can be a very effective tool for reinforcing health eating behaviour. ‘Peer’ is a concept implying similarity in age and generation. Peers could understand each other better. Since mutual concerns will be more easily shared and understood, peer empathetic response could therefore come through very naturally. Should we need any evidence to prove this natural effect in human

dialogues? How could peer support be put to good use as a school health resource?

4.5.4 Phase of integrated education

Integrated education is meant to introduce a concept that health knowledge indeed can be applied and integrated in daily activities besides the school programs such as food choice, approaches of learning as well as interpersonal communication at school or at home. A girl told the researcher that she would behave differently in school such as greeting teachers at school but not the parents in the family. Why should there be a difference? After further clarification, she perceives greeting as a social manner rather than respect. And she thought she needs not to greet parents as they are so close to them. Even though, they are impolite, their parents would not matter. However, at school, greetings are regarded as politeness. Teachers may dislike if they do not greet. It was a dialogue for the researcher to understand the inner world of thoughts of a child and learn the context of integrating society's value in child's value.

The following dialogue illustrated different teachers' perspectives in viewing the possibility of change in their teaching schedules.

Ann: *It will be difficult for us to teach health. We are not taking any special lessons for it, even for sex education. We only have a few hours and this time is not even enough for health which covers so many areas.*

Ivy: *The school calendar has already been planned. It will be difficult to fit it into the schedule. The earliest availability will be next year.*

Daisy: *It might not be. Perhaps it can be integrated with the after school activities. Some parents might be interested. We can help distribute the notice in class for children to inform their parents about their interest in joining the program. I think they may like the idea. We have never arranged such a thing before.*

Daisy: *Ideals direct positive and active ways of thinking and reacting to teaching.*

School principal: *Our school emphasizes holistic learning. We strengthen our students' will, which is a right moral will. We also strengthen their thinking, as well as their artistic and scientific talents.*

Researcher: *All these elements are really important for today's children to learn for their future!*

Teacher participant: *It is most difficult to teach children's attitudes.*

Mary: *I think the students' good characters and positive thinking are most important. If we can educate them in*

that, then in the future, when they work in society, they will know how important it will be.

Macey: *I think your model sounds workable, but it takes time. It could be initiated in my physical education session. I won't mind trying it if it has support…*

Rannie: *We had organised a "bandaging" workshop, and it seems that the children and parents liked that. We may think of activities like that. Parents are very practical; they will be more interested if the research contains some survival skills development [bandaging implies learning how to care for joint-wounds after an injury].*

Fanny: *Isn't it that last time the principal expressed that the project can start off with a health fun-fair? We can hold a health fun-fair, with a health-screening check including the lung and obesity check. Is it a good idea?*

Researcher: *Yes, that's right. You have reminded me about that meeting. We may start off in such a way as to involve more participants and staff. Would you all be willing to help in this way?*

Mabel: *It is possible. Anyway, we as parent-association members will help in that function.*

Researcher: *The school promised to let me have the store room near the playground as my temporary office.*

It was brought to my attention that the school personnel

and the nursing team perhaps can start with a complementary mode of health education service. We could make full use of each other's strengths and expert knowledge in teaching health. Teachers should have a better knowledge and technique in teaching the other contexts of health-related skills in their areas of responsibilities such as music, physical exercise, art, religious studies, and integrated studies. It can be a worthwhile plan to move forward if we acknowledge the philosophy or the concept that health has biological and inner-self growth dimensions. One's well-being can be affected by perceptions regarding oneself. For example, a person who perceives that he or she is able to care for others will add a positive feeling or value to the self as a caring behaviour most of the time which is being valued by people and the society. Appreciation of music, art, learning community resources in integrated studies, and the ability to express the self in compositions are all considered as personal health-related learning activities. This idea came into the research dialogue when a teacher, Ann felt hesitant to integrate health topics into the school curriculum.

4.5.4.1 Supporting integrated health practice

Teachers seemed concerned about how they have been doing when we discussed about how the future plan can be

implemented. Health promotion activities that could better fulfil the educational philosophy and their role commitment seemed to be more appropriate. Tuning into the school curriculum was not easy as it involved curriculum changes. Owing to the tight curriculum, extra arrangements or substituted classes for health education classes were difficult. After talking with the teachers and taking their words to heart, their practical concerns became easier to understand. Most parents and teachers made suggestions on what children should be taught. A teacher participant, Phyllis brought up an insightful thought in a group discussion.

Phyllis: *Contents that were relevant to immediate life experiences would be more interesting. A health promotion activity involving active voluntary work participation which offers people opportunities to experience active living and caring will be seen as a meaningful activity. Each active life-story reflects on an active life meaning that brings people to further thoughts, to a more critical sense of understanding living. For some people, attitudes or approaches to problem management are consistent across life settings. People may reflect inwardly and compare whether their ways of managing problems at work, for their health or in family life.*

Rannie: *Would you give us a talk on improving children's memory?*

Researcher: *Why would you like to learn this topic?"*

Rannie: *I notice that children, and myself too, have lots of things to remember. If we have a good memory, we can learn better, am I right?*

Researcher: *That sounds logical. However, memory is not taught, it is a kind of practice, of course. There are theories of memory that generate principles for guiding us to capture, categorise, and store data or information that we perceive in daily life.*

Macey: *How about the skills of problem-solving, decision-making…other higher order learning skills, there are so many theories now, but exactly what I need to learn are not the theories but the practice and the ability to develop the skills for daily decision-making…I just think my thinking is rather slow…and also the decision-making ability to choose quickly…Even while shopping for things, I need to think for quite a while before I can decide what I would buy….*

This discussion called to mind this researcher's experiences in nursing. Nurses need to make very prompt clinical judgments and give treatment to patients. Is there time to think systematically? Perhaps it is only when we are learning that we could have time to learn how

to think logically, systematically, or theoretically. In the reality of the health service profession, there is a need to make very prompt critical diagnostic judgments most of the time. Nurses, at moments, need to be judgmental in our clinical diagnosis; but on the other hand, nurses are always reminded to be non-judgmental in considering the psychosocial dimensions of a patient's circumstances. What is integrated learning for ? Will part of it be enhancing our daily decision-making and judgement? We may think of integrating our knowledge, how about our thinking? Do our modes of thinking or practice facilitate our integrated learning?

This researcher is certain that if people work with a deeper layer of thinking, that is higher cognitive order of thinking, they are at the same time optimising their brain cells and stimulating their intellectual growth. Biological and educational theories approve such an explanation, but the point remains whether we are willing to optimise our brain cells to work vigorously and make an effort towards deeper learning and acquiring deep knowledge. Should we need to wait for a scientist to tell us how to lead an efficient and integrated learning process? Should students nowadays be given courses to learn how to learn? Would learning become more self-directed and intellectual if learners have a better

knowledge of the mental process occurs while we are learning? If positive life experiences could promote positive thinking, would the storage of positive experiences help promote confidence or resources in managing negative life situations?

4.5.4.2 Supporting school health activity

The health bazaar was the health and fun day mainly organised by the school and the parents, co-organised by the nursing students and the nursing teachers, including this researcher. It involved the participation of the whole school with the external support of tertiary healthcare students and was considered the biggest event of the project. As confirmed by the school, it was the first time for the school children to take part in such an event. Four themes were emphasised, including healthy diet, visual health, respiratory health, and emotional health. The school, the teachers, and the parents were involved more in designing health games and coordinating the overall program rundown. Health-related messages were integrated into the themes of each booth.

For example, nursing students prepared questions and answers for children to exercise their health knowledge learnt from the booths and in previous classes. Right

answers were given if the students said the wrong answers, but the activity helped reinforce the right concepts about balanced eating, obesity, and other simple concepts of biological health. Children, from their energetic behaviour, seemed to enjoy the quiz competition, more so because they received prizes.

Delivery of program activities

Nursing students manned booths/counters through which children generally asked questions regarding health. After each session, the children were given a stamp. The accumulated stamps were later exchanged for prizes. Other nursing students held health talks and quiz competitions with the school children. The student nurses, for their part, were themselves able to practice child health communication skills
in this kind of health promotion activity.

Promoting child health at school was more relaxing, dynamic, and creative rather than having done so in a hospital environment. It was a new experience for all of the research participants to work for the promotion of school health. Group photos were taken for records, as well as for sentimental reasons (appendix).

The nursing students were thus able to apply their

knowledge in a variety of areas. They applied their knowledge in the counters for health information giving and healthy eating talks (appendix, photo 1,2), obesity screening (appendix, photo 5), respiratory health assessment (appendix, photo 4),health quiz competition (appendix , photo 3).

Health concepts were integrated in the games. For example, at the counter for smart vision and articulation (appendix, photo 8.1), children were allowed to throw a ball into several holes and read rhythmic phrases within five seconds. The game stall for healthy choices (appendix, photo 8.2) required students to work out a health slogan puzzle within a particular time and say it aloud. The “building blocks” and “blowing balls” games (appendix, photo 8.3) encouraged children to use their fine-motor skills, steady hands, and breathing to blow a table tennis ball into holes to score points. Other games like “moving hands and limbs” required players to use body skills in manipulating the four limbs into touching random ground-spots (appendix, photo 7.1), the “ping-pong marathon” required participants to use chopsticks to hold ping-pong balls (appendix, photo 7.2), and the “unpredictable fortune” booth made the children use their sensory skills to guess and feel what was in a bag or box (appendix, photo 7.3).

Delivery of workshop activity

(1) Invite the children to interpret their ideas about the food pyramid model and, as a team, plan their own balanced-diet meals and take them home for practice (appendix, photo 10). The underlying assumption is that children need ideas and health information to modify their health risk habits.

(2) Involve the children in sharing their choices of food in their living practice.

(3) Invite the parents to learn child health communication and promotion skills and to practice these at home (appendix, photo 12).

(4) Involve the children in making health decisions through electronic health games. The use of available e-health resources can lessen the preparation time and work of a health

educator in this activity (appendix, photo 13).

4.6 Outcome of school health implementation

A research group meeting was held one week after the bazaar. Some parent association members were also invited to the meeting. Representative dialogues were extracted to understand the participants' thoughts and feelings on the health promotion activities.

Ann: *I would rather like to join [health talk]. However, I can't join owing to the busy teaching schedules…*

Dick: *Last time, when I noticed that there was a high-blood pressure measurement, I really liked to join. It is expensive to have it done in the clinic, but we cannot attend when we are on duty.*

Fanny: *I think the children are really enjoying.*

Shirley: *The children are really eager to learn. Maybe because it is new to them…….I remember you had plenty of prizes that day, my child told me he got a lot of gifts.*

Mabel: *I like the activity of respiratory health check. Can it be offered again for adults? My husband is a taxi driver, and perhaps he may have a poor lung condition. I hope he can also receive this kind of free check.*

Researcher: *My students also learned from this voluntary service. It was their first experience to work with such a great team and school. Do you think this kind of activity can be continued in some way?*

Fanny: *We really cannot be sure. What I know is the school will hold an annual new year function for fun; its original aim in the past was not for health. Health knowledge was usually only learnt in class.*

Mabel: *I think the health screening will be useful. You know, in the current service, they only offer one annual health and dental check, and there was not much time to ask questions about children's health problems. If*

complete health screening can be offered regularly at school, I think it will be useful.

John: *My child and I were both considered obese under your scale. I think under the standard it will be considered as fat. I would prefer the school to arrange fat-reduction activities. I have no time to do exercise with my child. If the school can arrange more of this, my child will at least benefit from it. By the way, where can we have a more accurate obesity measurement? There are plenty of them, which is the most accurate one, can you give us the better one for reference?*

Researcher: *How about some sessions for children to share healthy eating practices? Does it sound good?*

Fanny: *That may be a good start to listen to children's words. I notice that some children seldom have such kind of social activities. I think it will be useful. Children like to hear adults talk, not about themselves. By talking about other people, they learn from other people ...*

Maggie: *I think teaching us more common knowledge about children's illnesses will be good.*

Researcher: *There's a lot of available e-resources. The information is very extensive and some are very comprehensive. I can introduce you to some. Perhaps next time I will prepare for you a list of quality health websites…*

Barbara: *Yes, I remember your last talk about healthy*

eating. Have you got any pamphlets that I can use to teach my child at home?

Susan: *How about information on low cholesterol, may I have an extra pamphlet? It teaches us how to differentiate between high-cholesterol and low-cholesterol cooking oil. I want to get another one for my mother as she takes care of my children. It will be good for her reference too…*

Apple: *[Information about] caring for asthma is also useful. May I have some copies as well?*

Researcher: *Perhaps I would bring more copies during my next visit. I will put the copies in the shelf which is placed in my office, but it will be locked in my absence!*

Apple: *"You may place them in the storybook shelves. They are in the playground and we can get them easily."*

Researcher: *"That is a good idea!"*

The school health team recommends that the healthcare professionals should also focus on the general public's health interest and concern rather than just focus on disease prevention orientation. This statement expresses the fact that any health/disease knowledge, an objective kind of knowledge, needs to make sense of individual subjective meanings in order to interpret the change of behaviour or habit as meaningful.

The transformation of health information into persuasive

learning contents can be brain-draining and exhausting. The translation of health concepts from English into Chinese was difficult because the meanings were rather different. We seldom ask in Chinese “What is your concept of health, health participation, or community health participation?” How was the researcher able to persuade or convince people to work with her in this action project? It was also the researcher’s first experience in ‘selling’ these health concepts to the public in such a manner. There is much discussion about health promotion, but what is the meaning of health promotion? Does it mean the advancement of health? What is the mental state beyond or above health then? Health knowledge is a resource for restoring and protecting health. It needs to be translated to self-constructed knowledge rather than remain an external indirect deliverable. Health promotion concepts and skills can be framed and reframed through individual successful and failed living experiences. There can be many different health promotion models in achieving various purposes through a variety of tools and means and health promoters need to be familiar with the knowledge or principles in practice to achieve success and understand the failures within. Health promotion methods, therefore, can be very diverse and dynamic in response to individual and/or group cultural needs within each social setting. Health

promotion participation can be regarded as a valuable learning experience for nurses to be able to conceptualise total healthcare strategies, from wellness to a diseased state of life. Nurses are educated to promote, preserve, and protect public health from the individual to the community settings. In addition, healthcare learners will feel more relaxed, and have more time and space to practice skills in health promotion in a non-hospital community setting.

Consulting the teachers and parents before the project started was useful in bringing up a cooperative school health practice. Foreseeable difficulties and barriers could be resolved in this stage. Examples were the ideas of turning new initiatives into an annual school plan and/or into extra- and co-curricular activities. Potential team members and how they could contribute within individual capacities can be evaluated and communicated. Behavioural health education is more than just learning a health concept, illness, or disease. It involves interpersonal communication skills, healthy living cues, and psycho-spiritual wills in achieving health goals. To make health education an effective method of reinforcing long-term living practice behaviours, teachers, nurses or other healthcare educators are required to expand the field of health

promoting practices and attain a wider scope of knowledge preparation.

From practical experience in real-life settings, people gradually develop a sense of willingness if they are given the chance to discuss and transform the concepts that they originally perceive as the sources of conflicts. For example, the teachers or parents had originally thought that health professionals should be the best persons to teach about health. They did not recognize that health promotion can also involve public parties. They tend to associate health with disease prevention and rarely think about other aspects or alternative perspectives of child health. A teacher responded that she has never thought of a word that expressed concern over the promotion of students' health. The status of health can be promoted by positive emotions and caring support. It can be a common fact that all of us know, but sometimes forget to practice it intentionally. Through self-reliance, people increase their confidence by succeeding. Humans feel comfortable when being adaptive and tend to avoid external changes. A willingness to try new things is nurtured by reinforcement, encouragement, and more importantly, support in the process. The nature of support can be different from individuals' needs. No one would like to fail themselves. An internal motivation of

change is highly driven by a sense of self-reliance. Adults are more interested in knowledge that can be immediately applied to their work and personal lives. This observation sounds logical if we believe in the adult's world where an ideal life goal is attaining satisfactory work, family, and living conditions. Knowledge will be highly valued and interesting if it can have such a function. If we believe that children as human beings will have a similar state of thinking, they should have a correlated learning interest in those knowledge that can promote their skills in play, learning, and peer relationships. Therefore, the more effective health teaching strategies, if aiming for an immediate practice, must involve the learners' thoughts and verbal responses on its practicability in relation to their living worlds.

The implementation of health promotion activities involves the essential skills of imparting health information, providing health advice, and sharing life experiences and ideas about healthy living. Imagine a health teacher who is required to teach the basics of a healthy diet to two population groups which require different teaching techniques to meet their appropriate cognitive levels. It is challenging as the health teacher will be required to design two sets of teaching materials with one set of learning resources. It is a fact that one

set of health information can be transformed into different types of health teaching materials and learning resources. The paradigm of health-promotion is shifting the mindset from a prescriptive, rigid state of prevention to a descriptive, dynamic state of advancement as illustrated in the following framework (diagram 4.6).

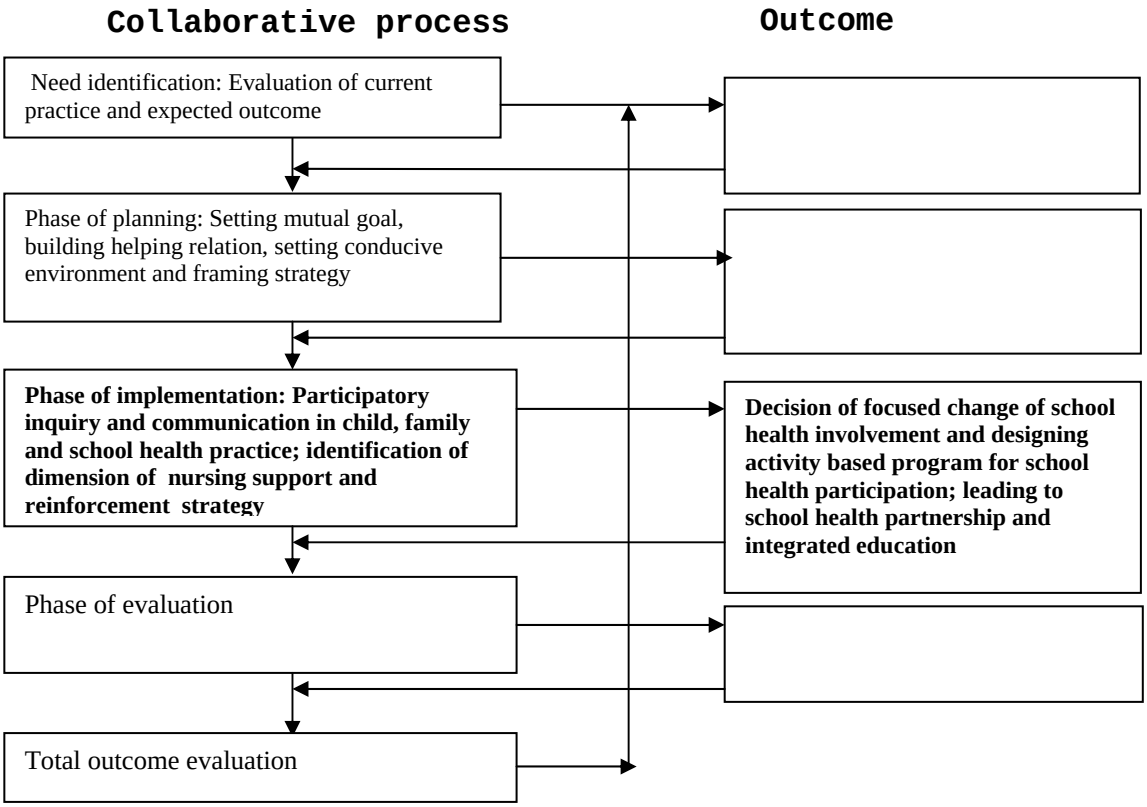


Diagram 4.6 Outcome of school health implementation

The participatory inquiry and communication in child, family and school health practice introduces multi-paradigms of thinking, understanding, and knowing. The nature of the school health partnership in engaging family health practice was identified to be composed of empathetic communication, peer talk, parenting support.

While integrated education was involved in supporting healthy life-style in diet and exercise, health activity learning and practice learning. The practice settings are not linear and static. They are evolving in dynamic approaches throughout the school health collaboration. Each change of the focus of collaboration will direct new issues, enquiries, and perspectives toward the next phase of new learning.

4.7 Evaluation of collaborative child care

The researcher conducted a post-intervention evaluation meeting. Issues arose in relation to the teachers' roles and the level to which they should be committed in school health. There were one teacher and four parents shared their views about how children should be cared for or taught. Ivy, a teacher exchanged her beliefs and values of caring practice for child health.

Ivy: *We need to deal with a lot of projects, teaching, preparation of materials and so on, we really will not purposely plan for the children' health, but more for their learning. That kind of child health promotion will usually be left for the parents. We have parent-teacher associations that can help in such a way by organising school picnics……..Teachers, if they really care about the children, need not be very knowledgeable. Of course*

they will need that special knowledge for their subjects, but from what I have learned by teaching here for so many years, I have observed that the most important thing is whether we have the heart to teach well. If we have, we will have the intention to search for more knowledge and thus, teach better...

When the researcher read this conversation, she was moved by the teacher's words because the researcher also shared her views regarding arts of caring. The researcher also thought that it is an important part of nursing knowledge. Psychosocial theory will only remain as text if nurses work without a heart or an art of caring. However, how could we nurture our hearts of caring? If this is an essential professional attribute for the professional nursing practice, should it be one of the mandatory components for nursing practice? We do not have a focused caring practice session in our current field practice, but we have an assessment component of professional behaviour. The researcher believes and it is evident in life that nurses learn and practice caring ultimately is not solely a professional obligation, meanwhile it is enhancing our inner-self growth and development.

There were other dialogues which highlighted the nature of school based caring practice for child health could

be.

4.7.1 Caring is a practice of love and hope

Fanny: *"Caring for our own children is easy. Caring for other children may sometimes be difficult. As when they do wrong, you cannot punish them or scold them. You need to control your emotion and be patient. But whether we are taking care of other children or our own children, we need hearts. I think that is the most important thing why some people care about other children……Whose children do not like to be loved? Even adults need love. A lot of effort is exerted, but if it can help other parents, it would be worth it."*

Ann: *Sometimes, just by observing their uniforms, their faces ……you already know a little bit whether their parents are caring for them properly or not.*

The desire to care for one's personal or other people's health is internally motivated and not externally demanded. Health-promoting actions are belief- and value-based, and are self-creating. A spontaneous healthcare practice is therefore better reinforced by our inner hearts. The health-promoting efforts become more desirable when they are related to people's innermost interests such as beauty, esteem, richness, and happiness

than when they are associated with disease prevention. Our team members voiced out their views that beauty is closely related to health, and that beautiful health to them means beautiful life. Health promotion can be experienced as a creative, spiritual, and active living process because there are many ways of promoting healthy lifestyles. This concept is evident in our common living experiences. Health promotion induces a higher psycho-spiritual effect on human behaviour when being self-realised as a process of self-promotion rather than as a process to perform preventive measures.

4.7.2 Caring is mutual concern and participation

There are people who treat the experience of helping and caring for others as self-promoting. A parent said, *"We feel that if we can help care for other children whose parents are busy at work or not that able to care of their children, then the children who receive our care hopefully might not turn out so bad when they grow up. How can a child learn with an unhealthy mind?"* We ultimately end the dialogue by having the common feeling that health and parental love are equally important for a child to grow and develop as a totally well being.

Human thinking is dynamic. Non-judgmental, trustworthy, and respectful relationships facilitate a welcoming

communication setting. A wide range of thoughts, ideas, and concepts are stimulated in discussions, and a relaxed manner of free talking, sharing, and expressing of views gradually occur. It may be seen as being non-effective since we could not make out any conclusions. In the end, however, we all feel satisfied with learning some insights from the experiences of others.

4.7.3 Caring is intrinsic practice

From the dialogue, it brought up our common knowledge that mothering care is intrinsic based on the natural mother and child bonding. How about the caring character of a health care professional? Should it be nurtured through nursing education programs since it contains universal social values as well as professional value? It is to the researcher's beliefs and evident from practice that if a learner can understand the related social context of the knowledge, he or she can recognise the meanings of the use of knowledge in making a difference; he or she will then practice it. For example, when we understand how empathy can make a difference in human relationships and social integration such as promoting peer, work, and family relationships, it will increase the motivations of learning. Adults are motivated to think and interact reflectively if the issues being focused on are related to common conflicts and dilemmas in the context of

personal experiences such as myths, misinterpreted health facts, emotional behaviour, work conflicts, life conflicts, and current social health problems. It is not surprising that people have misconceptions or misinterpretations of perceived realities, if we agree that real concepts that have been felt are actually constructed by individual experiences. Knowledge to a learner is difficult to experience as real and true if they have never experienced the effects of its application. Learners might feel powerless if they find that the learned knowledge could not be realised in real practice. Relatively, they would have an eagerness to try and test it if they could mentally figure out a positive outcome of it. This prediction was evident in some dialogues between co-researcher parents and this researcher who were discussing about the appropriateness of child health activities. The meeting started with the question “What activities could we propose and implement at school for the purpose of promoting child health practice?” The following quotes were extracted from the dialogues of a parent group. These phrases were reflecting on the belief of behavioural practice for health exists in life; the senses of living.

4.7.4 Healthcare is in life

“Every healthcare activity would be good as long as it is fun. I can’t think of any person who would not value health, with no health, nothing can be done……..”

“Children have learned a lot in class about balanced diet in health. The point is how they can do it at home with their parents…….”

“I think health professionals should draw more attention to the visual stimulants in their health teaching. You know, children like to see the effects immediately. If you place some fat meat on a paper, let them see the oil on it, they will believe the high fat content in it and eat less……...”

“My child once joined a visit to a poor Chinese village arranged by the school. They know that there are many poor Chinese children who are starving with not enough food to take. After the visit, they seemed to value food more…….”

“I am keen to know more about health rather than disease prevention……..”

“Learning the causes of and preventive measures about diseases are good but what about ways of promoting health? Does it mean that a balanced diet and physical activities are enough? There are so many different health advices on the web, how could we select the reliable source? I am rather confused……..”

This set of response was reflected by the research participants when they were invited to evaluate the effectiveness of health information and project activity. From the collective comment, it reflects that a healthcare practitioner to be prepared not only with physical health science knowledge but also be sensitive in making the best choice for one's health. Individual life is unique but part of it is common. The success of solving practical daily concerns can be shared with the community for the enhancement of other people's lives.

The participants were more interested in sharing their healthful experiences from their personal life experiences, when compared with the scientific data, which they had just a slight idea of.

4.8 Outcome of school health collaboration

4.8.1 Leading to school health partnership

Partnership implies a long term work relationship for the benefit of all parties. Based on the cultural and experiential differences, we should all have our differences in health values and beliefs that determine our definition of health and life. However, when we talked about the meanings or reasons of health practice, its underlying health goal, it might be as simple as we really

make it as our second if not the first living priority. The most useful health information or knowledge that may lead us to a change of our practice will be related to our own experience or life context rather than purely the knowledge. It can a statement applied for all human beings including the health professionals. Reflection on lived practice invited us to be more conscious of what we learn from living and be better prepared for our future life. Action research skills and reflective techniques involve higher social sensitivity. I am aware that my interpersonal skills and action sensitivity simultaneously develop during the process of school health partnership. From this research experience, it was realised that from reading the text theory, we only in fact get the concept, only when we apply it in a real world, we could interpret it in our language and become our knowledge for independent practice.

Co-researcher participants are offered opportunities to experience the school health practice in reality. From a common sense, we all could attain a better understanding of the concept if we have applied it in realities. Through the experience, it was observed that the project not only gave opportunities for the school to lead a school health practice change, but also teamed up some parent members to mainly focus on child health promotion. The

school-parent association is now having a new session focusing on children's well-being. Toward the end of the project, the researcher noticed that indeed, the association members in the past did try to improve the school health environment by improving the snack-shop and school bus service. However, they would not regard it as child health promotion. Now, they realise they could also think in this perspective and add meanings to their actions. The wider concepts of health promote a wider scope of health participation among individuals. Enhanced living and life management skills such as stress-coping and health risk awareness are common areas of interest. The positive school health climate will be important for all children and would likewise boost staff morale. School nursing techniques and knowledge are found to be both essential in facilitating school health practice change. Possibilities for translating the research activity into educational parenting practice or teaching practice tools are worth investigating and testing.

4.8.2 Leading to resource mobilisation

The parenting education strategy of mobilising resources from a parenting group and professional caring support in sustaining the team or social spirit of a school in

promoting a child's well-being could be further implemented and evaluated. Participants perceive health needs more in social, physical, emotional, and behavioural dimensions within an external and internal experiential context. These four dimensions in fact could be common experiential concepts if we reflect on its meanings in life context. Our psychological state of being is highly affected by our social and human relations. Our way of relating self to others and to the world affect our self-esteem, self-confidence, self-understanding. It is not just a belief but a truth that can be tested on ourselves. If we could be conscious of our state of emotion, we could understand self and other more. Do we really need emotion theory to interpret or understand human emotions? Reflective practice indeed is helping us to learn through our own practice and be aware of our inner self-affection; the matter of thoughts that affect our decision and behaviour.

Health can be interpreted from the narrow physical environment of health to a broader mental environment of life.

What is health related to? This is a good question for people to reflect on while relating individual conceptual meanings of health to a philosophical view of life. Most of the time, health knowledge is viewed as functional

knowledge learning for work or service application; for illness and disease care. It serves as the service practice knowledge of helping caregivers and other people in order to understand and manage diseases and mental health problems and concerns. Health knowledge is rarely derived from the wellness practice experience of working towards a healthier public, caring for healthy growth and development, and promoting the understanding of functions of feelings such as emotions, affections, and spiritual feelings. Most of the time, a healthy body is taken for granted by some people. No effort is done to sustain it. Similarly, family relationships should be highly valued by all people, but most of time it is easily neglected by not committing time and effort to nurture it. If we assume that health is not merely the absence of disease, but includes the elements of psychological, social, and spiritual well-being, then such paradigms of thinking and learning should also be integrated in nursing practice while developing the behaviours and attitudes of appreciating, valuing, and performing any social care work. Participating in promoting neighbourhood health is well-citizen behaviour that can also be regarded as health practice events. The integrity of caring practice in thinking and actions has been shown to produce positive psycho-spiritual feelings. People who have experienced the process of helping or caring for

other people would all agree with the Chinese saying “More wellness is felt in giving than receiving”. This researcher has also seen many children willing to help and share things with smaller children if they are guided by adults. It may imply that the internal motives of being able to care for and help people could be a basic human instinct, but like other talents, it requires external reinforcement, invitation, stimulants, and practice for them to grow in dynamic systems.

The intentions of caring of others, caring of health, caring of the quality, caring of human life seemed to be based on the same notion of thinking of a well-being, a person, an active being. The values are felt from the same heart. Caring moments are inviting people to care for others, not for self. Caring moments can be self-enriching and rewarding. Human has a basic instinct of caring. It is a matter of whether we are willing to response to this caring instinct or being offered opportunities to practise it in realities. To experience ways or skills of sustaining caring desires or a healthy human relationship can be equivalent to developing an intellectual way of thinking for living and working.

The evolving discussion focus later on was shifted to more philosophical issues in adulthood learning. For example,

a parent has a life attitude of being open and respectful towards others, which then leads to a feeling of work conflict when people are not with this belief. Another parent expressed that *“being honest to one’s self and others makes one’s self feel good and trust what one feels*.” If interpreted in a human context this feeling may imply a concept of integrity. Human would love to practise in what they believe in. A learning experience of enabling people to translate their ideas into visible action according to the researcher’s experience is educational as well as spiritual, enabling people to feel with the sense of self-achievement and success can be a self-enhancement program.

Group communication for parents to express their parenting difficulties and concerns, empowering their confidence and abilities in becoming capable parents is observed to be one of the family health enhancing skills that school nurse could learn and practice in the school health settings. Confident children need to be nurtured in positive caring families. The school nursing settings could share part of this role in building strong families.

4.8.3 Leading to integrated paradigm in school nursing

Theory of nursing can be described in many different forms. In this school health nursing context, nursing can be

interpreted as a holistic life practice and it is so dynamic that we could not apply solely scientific paradigms or a particular paradigm, model for the understanding. Without a holistic understanding of health and life, how could we feel competence to communicate our clients with health and life issues?

“Nursing’s greatest vulnerability may be its tendency to rely heavily on other disciplines for its structure and methods of intervention and practice (Barnum p278).” The history of nursing knowledge is depended on research tools borrowed from other discipline such as philosophy, medical, psychology, sociology. When nursing could have her own paradigm of knowledge construction purely derived from nursing practice? Different discipline will need different school of thoughts for enhancing the real practice at work. If a theory is for practice, that theory needs to be constructed by the practitioner so that body, mind and spirit could be built in and for the life-long practice. Could there be a nursing research methodology purely derived from the practice? In reality, the psychological setting and relationship of nurse-client is different from psychologist. Could the theories generated from other discipline can really be transferable to our practice settings? It can be doubted.

Holistic explanation in the new forms seek to organise a wide variety of human phenomena that cannot be comprehended through models based on linear relations among elements for its indivisible totality as necessary; can be interpreted as simply a matter of carving up the whole in a different manner for a particular purpose(Moccia 1986). Through this mental activity, the nurse researcher learns how to be holistic. Holism, is a human way of thinking, it is learnt through applied practice and was experienced by the nurse herself within the context of interconnecting her nursing experiences into a visible and life-logical text leading to a researchable nursing paradigm.

Human beings are holistic persons who have multiple interacting subsystems; permeating all subsystems are the inherent bases of genetic make up and spiritual drive leading to body, mind, emotion, and spirit as a total unit and they act together as a whole (Stanton et. al 1990). This statement may denote that human beings have the potential intelligence of being holistic, however, I would reserve it as only if there is an external facilitation or invitation of making this mental process becoming a reality. Otherwise, this natural intelligence, like the notion of caring, will just remain in thoughts rather than being interconnected as a wholeness being.

The research process was ended at an understanding of the nature of caring practice, brought forward another scene of what is collaborative nursing care. I would regard only through this stage the nurse researcher would find out the role of nursing in difference to other psychological, social or healthcare discipline.

Whole is greater than the sum of the parts. It would make sense to those nurses who have the experience of holistic nursing practice. Holistic is a sense rather than a concept. It needs to be self-experiencing and understanding of its context in order to become our practice. Holistic practice is not solely for the benefit of nursing care, it can be a good internal resource of promoting self-consciousness and understanding through the integration of one's beliefs, values and notions in practice. Based on this research experience, holism is not just a philosophy or theory, it reflects a life value and meaning, notions of human's potentials and intellect. Some people may not bother to know the whole meaning of life or work situation, I just bother how I live in this moment of life. However, when we give a second thought to the meaning of a holistic initiative, a desire of seeking the whole meaning of what we observe or experience, it may reflect a way of how we respond to our psychological

state of life. If we believe all human has a curiosity sense, why don't we bother to look deeper into our lives? Will it be a matter of life priority? If one of the main role of nursing is to care about human's self-understanding their states of life, should holism be developed in nursing practice for the higher sensitivity about life? Human experiences affect each other. I experienced that if nurses could be able to appreciate life through a holistic paradigm, our conceptual power is gradually increasing. Holism invites people to seek not only the external matter or knowledge, but also the inner relationship of oneself. The integration therefore may come through the mind naturally. It could be one of human's natural paradigm of thinking. Holism is not purely a cognitive ability. It involves the intellectual capacity of relating objects from at least three different perspectives.

The connection of separate practices phenomena to an integrated concept is an intellectual process of merging parts into a body of knowledge. It is a mental process of inner-outer patterns connection. Health in the context of life, illness and death will generate different paradigm of thinking, thoughts and meaning. Body in the context of knowledge, size, shape again will induce different meanings or images. If we believe the key

function of language is to promote human's mutual understanding for the common good of each individual as well as for the society. There should not be a language gap in our living world. Similarly knowledge should have a language context, especially if it is an applied knowledge. Knowledge application in school health promotion settings may include communicative dialogue (intuitive knowledge), skills of thinking (cognitive knowledge), skills of acting (technical knowledge) and problem solving (intellectual knowledge). Each of the knowledge therefore should have a context of function for its learning. Human mind is shifted towards its inner source of understanding in practice. Therefore, more important will be how much we understand rather than how much information we know.

Life has its uniqueness and commonness in nature. Life process is both critical and creative. Life contains universality as well as singularity in relations. An individual life interpretation may not always make sense to other people, but by having the chance to understand its elaborative and deeper meanings, the common concerns and needs of health practice could be recognised more fully.

From the discourse of the research experience,

participatory reflection on health-promoting living practice has provided me an insight that most people prefer self-reasoning and making a decision toward change. This may not be surprising if we believe that people typically value their own freedom of choice the most. We may all have come across a feeling that we do something because we intended to, and not because of being informed. People are eager to have a sense of autonomy when it comes to living and making decisions. The participatory inquiry setting provides active opportunities for people to communicate and share with others their thoughts, ideas, and opinions through voluntary group participation activities for the purpose of reflecting on the participation experience and making recommendations. The participatory reflection on the school health practice and personal living practice seem to offer people opportunities to express personal values and ways of living. The participants sought their preferred styles of living practice through personal clarification of uncertain concepts. Individual styles of health practice were respected. During the process, the researcher was able to reflect on the public's styles of thinking and interpretations. Humans are social, experiential, and functional. Thus, people felt satisfied and saw meanings in long term health practice if they experienced how the intention can stimulate better ways of doing, thinking,

and living.

Reflection becomes a highly abstract concept without experiencing a reflective learning process. Reality practice settings promote a conceptual understanding of interpersonal relationships such as communication, interaction, conflict, empathy, trust, respect, love, caring, and other interpersonal concepts. Text theory may provide an outer body framework of its conceptual existence, but actual social application provides the inner muscle substances of sustaining the individual ways of long term practice. The social dialogues contribute channels for participatory communication in enabling people to express and share concerned thoughts.

4.9 Proposition of innovative nursing care

In our professional practice, we are always reminded to keep time-control at work, during interviews, in communications, and in other work and service settings. A non-focused group discussion, on the other hand, can become a relaxation strategy for people if we can get rid of such rules of obligation for work productivity, get rid of all work or practice rules and regulations and just talk about what one would think, not worrying whether it is right or true, and just being allowed to express oneself. When this non-focused activity was done, it

seemed to be non-effective if there was any aim at having a conclusion or something that can be held onto. On the other hand, it became a therapeutic moment of giving everyone the ability to express happiness, affection, emotion, anger and frustrations about child caring.

“How can a child develop common sense?” “How do we stop children from talking while they are eating?” These two questions came up unexpectedly when this researcher asked for interpretive meanings of an earlier observation, that parents were frustrated with their children for having no common sense and initiative, when they were doing very little housework themselves. Parents expressed worries about how children are required to rewind all the bits and pieces of every message. They shared approaches on how children can be well disciplined and trained, triggering their self-inquiries on whether they were performing correctly or not, and the appropriate methods to deal with them. It turned out to be a common concern among the parents. Few could describe in a very detailed manner how they interacted effectively with their children, but reinforced other parents to try theirs, in a very encouraging sense.

If we agree the notion of human beings are by nature judgmental, biased and self-centred. These behaviours

can also be seen as a natural human response in protecting self. Bias, in general, gives people a sense of 'being too subjective', but when tuned towards something that is of valid goodness it becomes socially acceptable. In this way, the topic that really matters is whether or not we can be conscious of the nature of subjectivity bias, the reasons for our own nature of growth and behaviour and be able to further reflect on the meanings of these behaviours with respect to our innermost thoughts. The success of changing an unwanted behaviour can be a therapeutic or spiritual feeling. We may ask ourselves about our innermost needs after we are satisfied with the material ones. What would be most valuable to us?

A parent asked whether we could or should buy children a Game Boy, and an electronic virtual dog with voices. She asked "How long should we allow children to use the computer?" and "What is the suitable weight of a school bag for children to carry?" and many other issues related to living and health. At that moment, this researcher was not necessarily able to give any response, but just dropped their questions of interest and concerns which may be useful for future interpretation as it was their interests or needs that motivated them to attend the discussion sessions. This researcher did not really engage in the dialogues, but what was noticeable was that

the parents were exchanging their values and principles with one another, talking about money values, learning values, human values, and other ‘human communication values’ in justifying whether they should or should not do one thing or another.

Parents sometimes blamed their children for misbehaviour such as “using foul language”, “hitting his brother or sister”, or complaining that “one is jealous of the other”. Some mothers shared similar responses, and some inquired about the skills in managing such situations. Some senior mothers said that it was a natural occurrence and there was no need to worry because when they grow up, this kind of behaviour will gradually disappear.

This researcher seldom interrupted their discussions unless there was dominant conversation or out of the focus of discussion. This researcher usually took a passive role in answering questions, mostly putting the question back for other parents to respond to rather than have them influenced by the researcher’s own comments. Parents were keen to share strategies on managing children’s behaviour. When this researcher went over their questions in the transcripts, a follow-up thought was how the parents interpreted the term ‘misbehaviour’. If they can recall an image of ‘misbehaviour’, that means inside their

thoughts, they should have certain references of ‘normal behaviour or good behaviour’. At that moment, the researcher did not ask anything. It may have been better if the parents were invited to talk more and share amongst each other their different interpretations about what the difference is between misbehaviour and its opposite interpretation, or good behaviour. It may have been a good sharing moment for thoughts on values, norms, or other culturally based issues in their experienced context that might not be realised by others.

The parents ultimately may have lost focus on what they will learn or lose from the research programme. This researcher did not stop them, though it was a bit of a disappointment as they talked very briefly about what they gained from the programme, and hardly reflected very closely on what they felt they had ‘gained’. Their most common expression is that they felt they had gained knowledge, that the programme provided them more varieties of choices for health participation, that they could talk to each other more, that the programme gave them more chances to share parenting skills, that they were now more conscious about health and that they would try certain ways of communication and self-caring skills – just very brief statements and short phrases.

Does this count as outcome achievement? Though it is not the main focus of this research, with the knowledge of this research experience, perhaps a more focused set of structured statements may help parents reflect on personal child caring strategies pre- and post-programme participation. That may help them realise their personal change or unchanged behaviour in their parenting styles.

4.9.1 Paradigm in school health practice

From the repeated school health support and research, some emerging patterns and concepts of human practice are constructed. “When description of phenomena in the observable world unfolds, ideas about how variables seem to be related are formed in the mind of the researcher; the theory or insights about the phenomena of interest comes through reflection on accumulating evidence, intuition, and introspection (Powers and Knapp 1995 p86).” It becomes an integrated knowledge rather than separated variables.

Practice is reflective, intellectual, and developmental in the transcendence learning process. Reflective practice engages people into focusing on the purpose and meaning of action goals. Work in living involves critical and creative thinking skills such as problem-solving, decision-making, and management of conflicts, dilemmas,

and changes. The intuitive desires of better work create hearts and contemplative minds of feeling, thinking, and acting. Conceptual integration in the forms of notion, information, ideas, or knowledge is the inner resource of practice in behaviour and action, and the satisfaction of action experience produces motivated thoughts and energy for the continuity of health practice (Diagram 4.9.1).

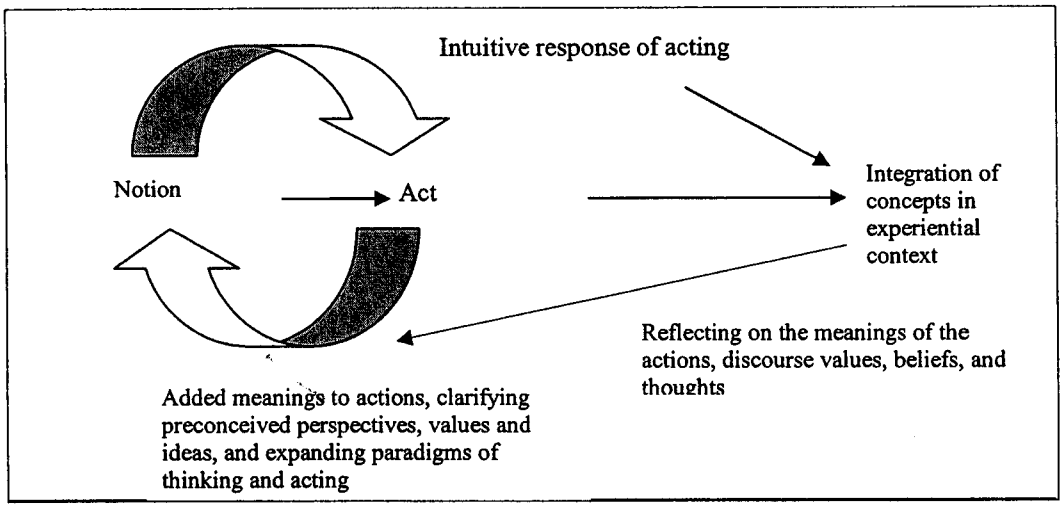


Diagram 4.9.1: Theory of practice in the context of school health

Practice refers to committing acts of improving, enhancing and promoting effects based on the standards and values of the outcome goals. Practice is based on a conceptual plan, which is reflective and involves changes and behavioural reinforcement strategies. When people think of better or best practice in health-promotion, beliefs and acts are connected together in a

stimulus-response mode with the positive experience recall to further confirm the methods of action practice. For instance, when a parent shared with others the joy and success of maintaining children's healthy eating habits through family involvement in the process of cooking and preparation, it involves a belief that a healthy diet should not only focus on balanced food but also on behavioural motivation factors, adding a sense of participation in preparing the meals. Other parents voiced out that they developed their children's attitudes in eating such as not wasting food, taking turns in dishwashing, and cleaning tables. When people were focusing on better ways of acting, participants were motivated in recalling all sorts of experience that proved to be successful or possible strategies such as those in cooperation with the school's food store, and making full use of the existing reading books corner, the Sunday schools, and the parents' interest club. The personal interpretation of possible practice can create an inner force of overcoming the barriers and constraints and seeking alternatives of achieving. Positive feedback acts as catalysts that add meaning and energy to the thinking process, promoting positive senses and feelings to the action meanings. Negative feedback tends to create withdrawal feelings of taking further steps, reinforcing a negative feeling of meaninglessness in participation,

and unwillingness. The continuity of action and reflection behaviour regulates people to seek deeper and wider meanings of the practice and ultimately construct patterns for independent practice. Reflection on practice can expose the hidden sight of one's unconsciousness such as reaction, emotion, affection, perception, thought, and feelings in relation to the practice. Reaction is an unconscious and non-rational human response or behaviour. Emotion is an example of reaction behaviour. Its impacts on human thoughts, perceptions, and judgments are unconsciously influential unless we are conscious of its existence and genesis. Being conscious of self-emotion and its sources can help us avoid its influence on our objective observation and judgment.

Practice may involve emotions and may not be self-manageable. It requires communication and support with other people. In the project group reflection, some parents started to reflect on the differences and commonalities of their emotional responses to children's misbehaviour. There was a situation where a parent recognised that her emotion was stirred whenever her child could not follow her instructions. She felt uncertain whether it was influenced by her childhood experience as her mother was very strict with her. She

was more aware of it and was more able to think of ways to improve this behaviour.

Practice in the context of mental development involves reflections on the self and social practice. Reflection refers to a deep thinking process of seeking social and personal relations and meanings of practice experience. Reflective skill is self-experiential rather than a taught concept. The theory of reflective practice can be highly abstract without experiencing the process. Reflective thinking and learning is induced when a learner exerts efforts in seeking the inner values and meanings of lived practice experiences. Reflective theory in text could generate objective meanings but may not be able to guide an individual world practice. Reflective practice is a self-directed behaviour. Meanings and approaches on reflective skills ought to be understood by a practitioner through practice to deepen one’s skills and thinking habits.

Practice in the context of health behavioural promotion requires the integration of knowledge into educational activities and sound health messages of preventing or improving health risk behaviours and promoting school health culture. The school is expected to perform the social function of providing a caring environment of

developing brains for social wealth and development. The morale and active learning culture of a school is essential for teaching and learning. The process of integrating healthcare activities into the school's practice needs to be gradual and participatory. To sustain it as a long-term practice and integrated school resource development, genuine communication and reflective practice of seeking personal and school meanings of the collective school health promoting efforts are thus crucial.

4.9.2 Dimension of school health nursing

The last project research meeting was organised to evaluate the outcome of the school health practice. There were comments on how future health promotion plans could be enhanced and improved for future child health needs and practise if the collaboration proceeds. Three major interventional foci were summarised as (1) effective parenting (2) active learning and teaching (3) resource and integration and (4) health curriculum planning

4.9.2.1 Effective parenting

Fanny evaluated that we should place more emphasis on moral or legal parenting issue such as preventing child abuse behaviour. She found it as important and explained.

Fanny: *How about a talk on child abuse? I am strongly against parents hitting their children. I have seen a child being hurt by parents [in fact she has not really seen it, but she has seen the wound or bruise mark on her skin].*

Nancy: *Yes, I agree with you. I have observed some parents who really are not parents. They would just let their children eat what they like. Children should be taught to choose healthy food right from their childhood stage. In our time, we didn't have so many food choices, but now there are too many choices, too much temptation. I think it would be good to hold some parental talks that might be useful for parents to share their child caring experiences with…*

Shirley: *Last time, a father told me that the most effective way for a child to learn is to make him learn from the mistakes, but I tell him it really depends on what mistakes it will cause. Would you accept a child to play in danger? Also, we are just human, too much work sometimes will make us feel frustrated…*

Mabel: *How about for parents, will there be some workshops for parents about caring for their children's health? I noticed that a child's asthma is serious here, I am not*

too sure whether it is because of the recent renovation work near the school. The school's air environment has become worse since the buildings' construction started.

Maggie: *I think sometimes parents would like to talk with you as an individual instead of a group.*

Researcher: That's possible, if it does not clash with my school work. Anyway, I also intend to talk with some parents about their parenting experience, how could we arrange it?

It was observed that the dialogue was becoming more vocal about what parents need as compared to the previous focused discussion. It may not be a surprise as once we have practice experience, school health promotion will become less abstract, and we would know how to make it improve.

4.9.2.2 Active learning and teaching

Some parents were more concerned with improving the teaching methods and designs, which I give it as the context of active learning and teaching. She explained, Elsa: *"I think the teaching should be visual. You know children will not believe it if they don't see it. I would suggest that we bring a piece of high-fat pork, diffuse*

the fats on a paper and let them watch how fatty the food they have taken in is."

Nancy: *"That may be of major interest, but we need to work out something that's active. You know, children nowadays will not feel satisfied with just sitting and listening. They will rather like you to play with them. Have you ever thought of arranging some workshops or creative activities?"*

Learning by action-inquiry can be a good tool of enhancing active learning. Action learning is well documented by literatures as a teaching strategy that can promote active learning and teaching for students and teachers. This action research project unexpectedly generates an action-in-life practice model that could be taken as reference for its framework and methods of action research and learning. Each outcome of action research and learning will be unique in consideration to the difference in social settings and human contacts.

4.9.2.3 Resource and integration

Throughout the research process, the nurse researcher's concepts of health were changed by the public dialogues and health intervention practice. Although the co-researcher participants did not express any

developmental change in the evaluation dialogue, they were eager to have another opportunity to introduce another health event for the school and for the children. Based on a three-year school health participation and practice experience, the researcher would argue and assume that if nurses were trained in a pluralistic and philosophical paradigm of viewing health in a real life context, our life enlightenment and intellectual skill of conceptualising life and death from the social and spiritual dimensions could be much easier. It could be a worthwhile educational intervention research to further seek validation for this observation.

We as nurse educators might, from the history of our learning, be well-trusting on our existing knowledge and repeated teaching with similar contents, inducing similar ways of thinking. We may tend to teach in the way we were taught. Our current nursing program is shifted toward a philosophy of education in the context of professional and personal development. Nursing students and educators are now aware of putting nursing knowledge not only in the professional context but also with the global view of knowledge conception. For example, students understand that the theory of health promotion will not fully help them master health-promotion skills until they really apply the knowledge and understand its

meaning in the professional context. Thinking from a student's perspective might make it difficult to interpret what is the best learning approach. As a teacher, reflecting on my own effective ways of understanding and learning might make it easier for me to understand learner's needs. Despite of personality influences, our conceptual modes in learning are similar such as common logic from common knowledge, common sense from common culture, and common perception from common experience.

It is essential for children and adults to learn about health by experiencing the energetic feelings that come from living an active life (Seaward 2001, Berg & Sarvimaki 2003). Healthcare concepts and theories are not deliverable knowledge or bolus dose knowledge that can be infused one at a time into the mind. The ideas come from the participants' responses based on their learning needs.

The research experience informs me that children and perhaps adults like to talk, like to share any of their happy, successful, or somewhat feel-good experiences, and their observations. In today's world of knowledge, public are no longer novices. They are now able to lead some discussions on interesting topics. We would know the relations of human environment settings simply by

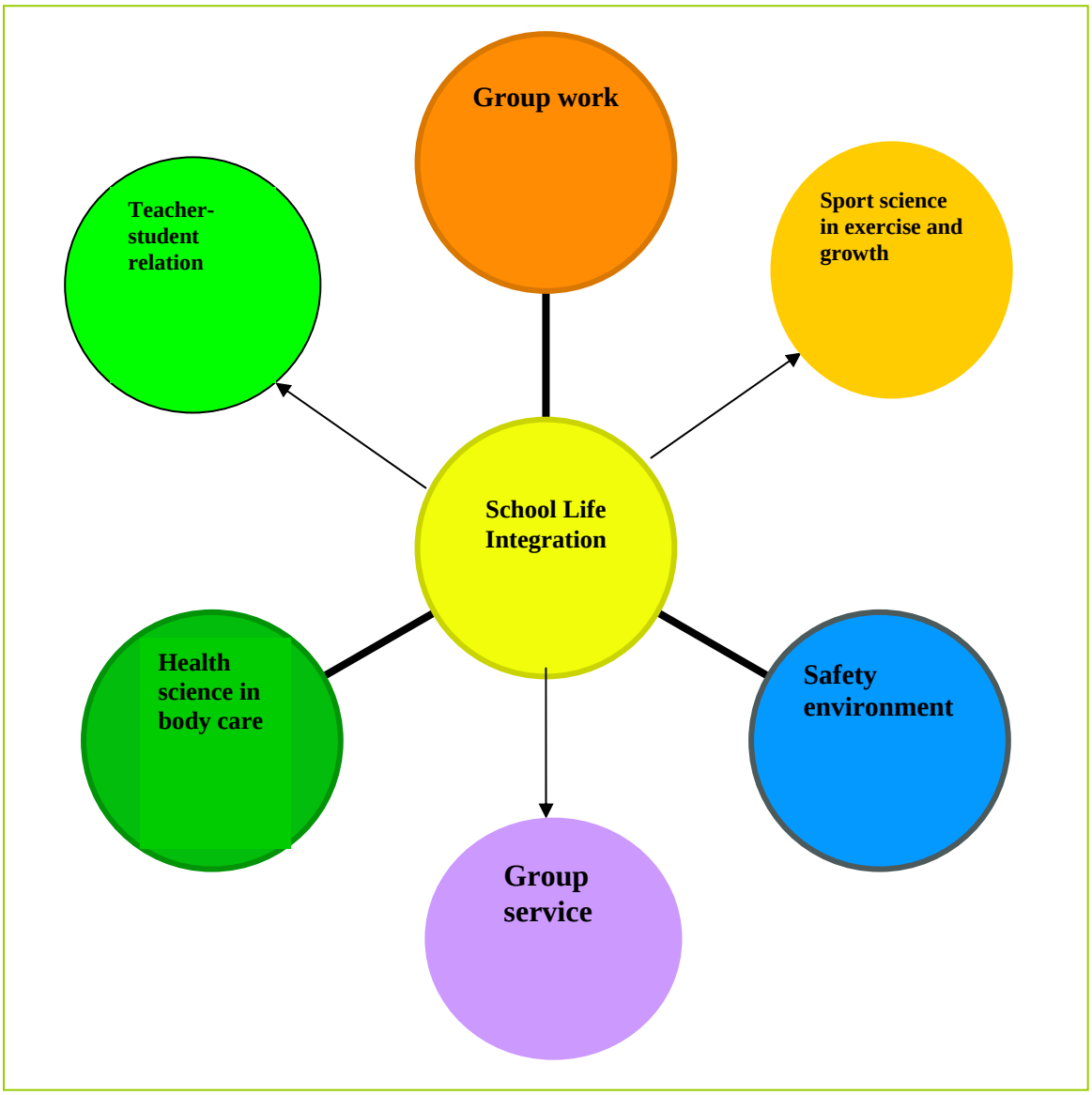
participating within it. I experience the effect of how sometimes we can just be active listeners, clarifying misunderstandings and trying to understand their inner worlds of thinking and expression without making judgmental comments. Being participating in this genuine openness makes oneself grow within.

Children like to hear adults talk, not talking about themselves, but talking about other people; that is, how they learn from other people's lived experiences and about life. Social issues can arouse children's living concerns, not their parents' living concerns as there may be a great difference between the two. A child's life education context would involve real child risk incidents that arouse learning interest and health awareness.

4.9.2.4 Health curriculum planning

At the end of the project, another framework as shown in diagram 4.9.2.4 was designed for the health curriculum planning which integrates health and wellness concepts in school activity and learning.

Diagram 4.9.2.4: Curriculum plan of school health integration



The underlying framework was based on the philosophy of health and wellness as a personal system of interacting with body and mind through art work and scientific studies. The collective memory of our school lives may generate some consensus in effective strategies of school based teaching. The framework plan was designed to serve the purpose of interacting with teachers in future action research project. I failed in engaging teachers in

integrating health in the subject curriculum. With a concrete plan and realistic goals based on the existing school curriculum activity, health learning hopefully can be more naturally integrated within the school system. School health practitioner may collaborate with schools to research further on the development of evaluation tools for each of the health teaching activity.

The plan of promoting school life participation for the purpose of child health growth and school health development was recommended for the future focus of school health curriculum study. From the confirmation of the school principal, the framework matches the existing school activities. Enhanced growth and development were considered as the common value for both children and the school.

4.9.3 Strategy of school nursing

School nursing strategy can be demonstrated as a framework of systematic plans for engaging child health stakeholders in the steps of introducing behavioural change in school health participation and cognitive evaluation. Researching lived experience according to Van Manen’s theory (1990) is action sensitive pedagogy, developing teachers’ intellectual paradigms of designing effective learner-centred teaching strategies. Similar

concepts when being applied in nursing context, researching caring experience becomes an intellectual process for nurses to develop knowledge and concepts of understanding client's needs and concerns.

A parent expressed that she never thought that it might be better to swim with her child; instead, she just waited for her child to finish her swimming lesson each time, and then brought her home. She didn't even notice that her daughter might like her to swim with her. She herself could also keep fit through swimming even though she may not be interested in swimming. This message came to her mind when we discussed about what activities families could do to promote health to their children. From program observation, some parents were not conscious of the fact that while they promoted health for their children, child health activities in the family setting can also be treated as individual health promotion activities. Although her motivation to swim was because of her daughter more than her own health, it is no more a matter of concern as far as she is willing to interpret it as a participatory swimming activity with her child, rather than an observer or safe keeper.

Conscious health practice can be driven by self-expectation, or it can be cultured by responding to

repeated social or environmental demands in personal settings (Kwok & Wong 2000, Engebretson 2003, Chiu 2004). Every conscious action practice should ultimately be able to constitute personal knowledge that engages an internalised paradigm of understanding. For instance, when we reflect on our unconscious empathetic dialogue in our daily nursing dialogues, we will not be conscious of using it. The consciousness of applying this concept in the conversation was known by the practitioner only when the dialogue was evaluated. Empathy skills are not attached to knowledge paradigm solely but also to hearts of caring. We learn empathy but may not apply it in our social context in particular when there is a conflict of interest. It is a decision made between our value of personal interest and optimising the empathy skills through dialogues.

4.9.3.1 Empathetic dialogue

After working with the teachers, the researcher noticed that most of them were very sensitive and observant with regards to children's health behaviours. One teacher expressed her feelings of being powerless in persuading the children to eat healthily.

"I lack data. I am not too sure of the number of exercise hours that children must do to encourage growth. They may

think I am only a teacher. Will my speech be powerful enough? I did try to encourage children to participate in more physical exercise activities, however, when they were given poor results in school work or got injured during the exercises, I am the one who is blamed. I personally do not like doing physical exercises. Therefore I do not see any benefits of it which implies no feelings of fun."

Initially, the teachers were rather reluctant when requested to integrate certain health concepts into their subjects, or to integrate the concepts in their subject context or in an activity trial. From face-to-face dialogues, we shared ideas that in fact, they might be the better person to teach school children these health concepts, as they were the people who were most available to the children. Children, most of the time, learn from their teachers' role modelling if they respect the teachers. That might be the same for youngsters. Individuals have a phase of admiring people, observing how they act and react to the same behaviour if they found that ways of interacting, behaving, or doing could work in respect to achieving what they want. It can be a very simple rule in life if we really can have closer observations on how people act. From children to adults, while they may feel ignorant of the ways of doing things,

would be eager to search for practice references. The intensity of eagerness will be higher if it involves a quality survival skill.

Another context noticeable was that teachers and parents showed great interest in exploring the key principles of enabling children to feel interested in health conversations. Some simple rules such as short life messages, same language level, and rhyming were generally agreed to be workable and considered as successful strategies of communicating health messages (Grotberg 1995, Whitener et.al 1998). When teachers and parents felt that they could interpret health in such broad dimensions, they became more willing and able to try more methods in their daily lives. Schools and homes should be a lively place for children to grow and develop their social and individualistic characters in. When this researcher shared with the parents and teachers this point of view, they seemed to agree with this value and belief.

School, when focusing solely on educational standards and achievements, may place less emphasis on helping students develop their inner growth. Children are generally more sensitive to feelings when compared to adults. They are more interested in play, stimulating sensory images, and

touchable objects. People are most interested in knowledge that is related to their experiences or enhanced role functions. Age-appropriate teaching methods will promote learning. Self-understanding activities such as expressing views, ideas, opinions, or dreams can promote self-confidence and values. This nature of mental activity may have a potential effect in developing human capacities of reflective learning and perceptual powers. Creating opportunities for a person to express cultural-values, life values, and beliefs in a non-judgmental atmosphere can be a setting for people to share with each other their thoughts and choices in life.

Practical thinking is related to approach of acting. It is normal for both professionals and lay people to have conceptual differences because their work culture and work environment are different. Moreover, theoretical concept and practical knowledge are constructed by two different paradigms in modes of learning. When the researcher compares her concepts in between theoretical reasoning and practical reasoning, certain conceptual differences become observable in the language as shown (table 4.9.3.1).

Table 4.9.3.1: The conceptual difference between theory and practice

Theoretical reasoning: World-wide view of reality *Reality cognition*	Practical reasoning: Life-time world of reality *Reality perception*
Interested in observable, testable and theoretical constructs such as *Scientific, aesthetic and philosophical paradigm*	Interested in visible and perceivable concepts such as *Understanding, feeling and knowing*
We believe what we research and experience, taking data from worldwide literatures *Evident belief*	We believe what we see, do, and experience in social realities *Visual belief*
Being involved in systematic logics in building blocks and patterns of words, languages and concepts e.g. l*ogical thinking and analysis*	Being involved in visible, intuitive and sensory patterns of symbols, signals and constructs e.g. *intuition and synthesis*
Thinking of past, present and future *e.g.* *Based on the past success and planning for present and future practice*	Thinking of present, past and future *e.g.* *Thinking of presence from past experiences and planning for the future*
Adopts pathways of problem solving, plenty modes of solution *e.g. The strategic choice of doing it includes*	Adopts personal style of problem solving, limited solution *e.g. My way of getting it done is*
In search of plenty possibilities; from research realities such as *Possibility thinking*	In search of possibilities; from experienced realties *such as* *Feasibility thinking*
Every road has a turning point *The road has no end*	The road has no turn *I have come to the end*
Dual thinking Your body gets diseased, but not your mind; body can control mind and vice versa You can do it if you want; It depends on your internal command	*Self-centred thinking* I am diseased and my mind feels sick. I can’t do it I know I need to do it but cannot make up my mind

Cognition is constructed in word, language, context and evidence	Perception is constructed in symbol, metaphor, pattern and meaning
Do it in rationalised value	Just do as they do
Becoming internalised being	Becoming socialised being

4.9.3.2 Mutual participation

A participant said, "Sometimes the more knowledge I learn about the possible causes of diseases, without being taught how to manage or prevent the risks, the more nervous I felt."

The provision of relevant health information and self-caring knowledge are two common nursing intervention strategies for enhancing personal health. After receiving more of this knowledge, the public will become less anxious. Emotional support and positive reinforcement are always needed for continuous long-term practice. The strongest motivation should emanate from an inner self-willingness to participate and apply health knowledge into actual practice. As evident in modern living, we understand that the time and intention to practice healthy living are the strongest internal barriers. Both constraints of time and intention would not be changed by health science knowledge but could be transformed through a self-reflection of habits and work practice to match one's life goals. Most people told this researcher that either they had no time to do exercises or they think they have enough, however, when they are requested to layout how much time they spent on doing other things, they would admit that they in fact could squeeze the time to have regular or occasional family exercise activities. People would be more willing to

take up more physical exercise if they learned more about varieties of leisure activities that could also be classified as good exercises such as cycling, table-tennis, jogging, and walking. For people who have no regular habit of doing physical exercises, persistent encouragement and provisions of choices are essential for persuading the practice.

Methods of health practice can be learnt or experienced. In health communication, it was noticed that if people could be sensitive to the use of a common living language in understanding each other's life situations, we could be more ready to understand and correlate each other's perception and thoughts with ours. A parent felt annoyed with her child's unwillingness to greet people. When the parent was requested to experience the situation again, only this time she imagined that an adult was in the position of greeting a stranger whom she did not know so well, she found out that their feelings of uneasiness would be similar. The parent seemed to understand the child's world better once she focused on the social human's behaviour rather than her child's politeness or social manners. Concentrating on the latter may further justify her judgmental arguments and conflicts with her child. In this researcher's days of schooling, we were not consciously taught social skills or interpersonal

relationships. We learned them through social experience, natural conversations, and interactions. Nowadays, children could be tuned into an artificial way of socialisation, attending social skill training sessions, learning table manners, and all other social skills that are conventionally taught by families and parents in daily living. A satisfactory social relationship with others highly affects the quality of the psychosocial state of one's well-being. People may try to maintain a consistent but also adaptable view of themselves, depending on their role in a situation as a self-motivating system of promoting a positive self (Deckers 2001). It can be regarded as functional way of enhancing interpersonal skills. However, this is different from a genuine interpersonal relationship which is built on a natural and trustful environment rather than social status or authority.

No matter how advanced technology is developing within the society, it can never replace the values of face-to-face human dialogues that human beings mostly need. Open and empathetic communication is a powerful tool for establishing trust and rapport with others. Communication can be in the forms of verbal, written, telephone, gesture, electronic, and other aesthetic ways of delivering thoughts, information, and messages to

others. It is evident from practice that child health can be reinforced by family communication. A family that is more able to conduct intimate talks and have non-judgmental attitudes with their children will be more able to build up supportive and trusting relations with their children. Some people may think communication tactics are part of our common sense and need not be practiced. People may also think of learning communication techniques for their work and clients but seldom relate the skills they have learned to establish family and human relations. For example, empathy as applied in the context of nursing is also a powerful inner resource, as it implies the possession of personal qualities and abilities to help a person deal with difficult social situations while establishing interpersonal relationships that disregard any settings. All people love to be understood. Empathy skills are learned through reality practice although some people may be able to acquire it through reflective living practice. Empathy reflects the willingness and ability of a person to understand matters from the knower's perspective.

Furthermore, dynamic communication skills are acquired through face-to-face practice and are different from Internet or cyber-world communication. If being a competent communicator is one of the social expectations

we have of a healthcare provider, one's ability or mastery of face-to-face interpersonal communication skills should be developed and practised in realistic environments that are conducive. Communication is a form of mutual interaction, a social value, and an appreciation toward understanding one another. The ability to communicate involves an attitude of willingness to listen, to understand, and to trust, and involves the art and science of empathetic hypothetical reasoning. Genuine communication in interpersonal work relationships is a psychosocial human desire. Moral behaviours are equally important for an individual to prosper and grow as a psycho-spiritual well-being. The connections of inner righteous thoughts to external practice as one becomes a person of integrity can produce a feeling of inner-connection, and a sense of attaining the will to develop and actualize one's self.

4.9.3.3 Personal health integration

"Would people value their own health without necessarily being informed by others?"

Grace felt curious about whether we needed to learn about health for promoting personal or child health. This was consistent with her thoughts and another common belief that each parent should have their own ways of caring for their own children. Are parenting talks needed to develop

a caring parent? Being a caring parent is not learned from a programme. Caring hearts of parents come from an inborn bonding, the intimate relationship between the child and the parents who gave birth to the child. Parents who were observed to have a strong ownership sense to the child might be tempted to overindulge the interests of the children. On the other hand, the ownership of the child gives parents a sense of role responsibilities to nurture and develop the child using their best efforts.

We have learned many core concepts of health and some fundamental theories on it. We have also learned to widely interpret what a comfort health could be on paper. How does it apply to real human lives? How should people behave in a healthy life can be viewed as a private issue, but when the behaviour has a health cost of society, it becomes a public concern. It is a simple rule of placing the principles of how we as healthcare professionals can intervene in people's behaviours. How do people react to the needs of a 'social life' or a 'personal life health'? Is an individual's need to learn disease-related knowledge in order to take an active role of promoting personal health justified? Is an eagerness to protect one's own health a natural human response? It is equivalent to basic human instincts of seeking survival or quality living. It is true that even a baby

instinctively feels that he needs to cry for his first breath as soon as he is separated from his mother's placenta, and that he needs to breathe independently? It was noticed that the public was more interested in knowledge that might help them prepare or equip themselves with functional social roles, the ability to cope with social conflicts, improving family relationships and social communication. Their areas of concerns mostly touched on the aspects of living, learning, and working situations. Transitional and normal changes of life such as the change of schooling stages, change at puberty stage, change of social roles, change in mental capacity, and change of physiological life according to age-degeneration, and so on. These are normal yet uncertain life changes. They perceived that parenting programmes would be more interesting if they could focus more on the practical health information that they can immediately apply to their daily lives. Information including biological and sexual health changes, nutrients aiding in growth and developmental needs, and health and moral behaviour reinforcement skills should be available.

People, in general, are eager to attain a wellness in living. Parent participants were not only focused on their physical state of life, but were also looking at

the psychological, emotional, and intellectual needs of their children. The parent participants felt glad if they were enlightened by wiser ways of doing things or reacting. Most of them focused on the knowledge content that may help them solve their current observable life issues and problems. They might not have been aware that in fact, the most essential core elements also include life-value attitudes and family lifestyles. It was also a common observation that parents would seldom see the need to revisit their own family setting problems rather than directly and unthinkingly focus on their children's behavioural or emotional management. The participant discussion groups would sometimes be shifted towards the issues in their home settings and parents were then alerted to certain unconscious living cues as they revisited these situations and sought ways to improve them. Participant parents in general were eager to give the 'best' to their children and have high expectations in providing better care to their children. There could be a good topic discussion about the definition of 'the best care to give to the child' and 'what is the best environment for family participation'. This researcher feels that it would be an enriching discussion if model parents can be identified and invited to share their experiences in these forum discussions. PAR settings can be transferred into a community inquiry setting where

members of the public can participate in a discussion, sharing and revisiting individual family situations. Initially, this researcher assumed that parents would not participate actively in child health promotion and therefore assumed that the action research model could enhance their participation. Surprisingly, most of the parents who attended the focused group discussions were participating in many different ways. Most of them thought the programme useful when they were asked to recall and reflect on their past child health participation experiences and compared those experiences with other parents' parenting skills rather than the programme experience. We might identify action reflection as a systematic action and practice process but in fact, it can also be defined as the natural reflexive human response of a person who has a desire to refine one's own performance. The difference might be that the former is based on an external stimulant while the latter is driven by an internal stimulus. One of the questions raised by one parent participant was, "Do we all value our own health without necessarily needing to be told by other people that we need to value health?" This voice came through when the participants were asked for their learning needs. The point was how to maintain good health and how to react to poor health when it comes. We all value it so much, of course, that no one wants to

lose good health. However, we may have insufficient knowledge to protect it fully.

Ann felt the need of people with diabetes during a research meeting and said, *“A restricted diet can make people feel uncomfortable. You may take diabetic people as an example.”*

Researcher: *“There are many different diets especially designed for people with diabetes. They can now eat healthily but also have good choices in ways of cooking and eating. I could let you have some pamphlets of that nature if you need them.”*

Another parent also raised a concern. *“We receive many health risk information, informing us how we should eat. Some may help, some may be too alarming, such as the current news of preserved sausage that may induce cancer. In fact, what they mean is that these become dangerous if we take a lot per day, but it may not be a matter if we take only a little of it, things may happen like this. Would the health scientist impose too many unnecessary worries and inaccurate information on the public?”*

The parent also told this researcher that sometimes, the more knowledge learned about the possible causes of diseases, without being taught how to manage or prevent the risks, made them feel more nervous. That may be a

similar human response for some patients who choose not to be informed of the operation procedures. Should people have the right to choose not to know and still be allowed to sign the consent form? It is an ethical decision for patients to be fully informed of the operation but the healthcare provider should assess the readiness of patients to receive pertinent information. This researcher has personally experienced the situation in which a patient is threatened by unclear information or instructions, which further induced confusion and anxiety towards the operative investigation. It is a work attitude of whether or not we bother to have things done uncaringly, or to have them done in a humanistic way. It may be so in similar situations where we have observed in some cases that patients were only informed of the investigation procedures but not given enough time to raise questions and have them answered. It was also one of this researcher's experiences that a junior nurse was asked not to explain too much about the patient's post-surgical condition and the underlying illogical reason was that the patient was perceived as difficult and would complain if he knew more of his disease status. Would we impose too much unnecessary worries and unwanted thoughts onto our public? This can be a critical question for people to ask, which allows people to think in a different situational context or for nurse students to

discuss and argue about their inner ethical concerns and dilemmas.

The following two dialogues expressed by two parents demonstrated the learning process of child caring through self reflection on lived experiences.

"How would you feel if you have just been scolded by your boss and got home very late and when you got home, your husband, with an unpleasant tone, asked you why you were so late tonight and everyone was waiting for you for dinner? How would you feel? It is similar to a situation where your children might experience some unhappiness at school, and they expect you to understand their feelings rather than hear "You shouldn't react in such way!" How would you feel if you were the child…?"

"If we just look at the children and their siblings, they can play together very quickly after a quarrel. Sibling quarrelling with one another is quite normal. We could make use of that situation to teach them communication afterwards, not during that moment when they feel frustrated. Children need to grow through the process of social experience, this can also be the home experience for them to learn…"

The ways for children to develop their interpersonal skills are similar to adults. The socialisation process of learning involves the mental process of psychosocial growth, changes, and development in the social culture settings. A major part of our child and adult world differences could be caused by the generation gap, a natural cultural gap as the society and the human beings in it evolving and develop at the same time. Our living and internal worlds are two close systems that are hard to separate, we naturally interact in such a process.

During parental group discussion, the researcher recognised that at certain moments she was trying to change dysfunctional thoughts or negative feelings expressed by parent participants. The responding conversations reflect the researcher's notions of health related thoughts and concerns. Examples were illustrated as follows:

Notion: Help-seeking is mutual action

"You shouldn't think that seeking help is shameful. Imagine, if you don't use the social services, they would have no clients and their service will not be sustained. In fact, you are helping them to maintain the service, especially after considering the government budget cuts"

Notion: Health is a shared responsibility

“Although we have responsibilities to our own health, the society also has a responsibility to help us.”

Notion: Be your self-health advocate

“We should be more aware of self-advocating and optimising personal and family health.”

“Health resource awareness may redirect people to associate life crisis with external supports rather than the lonely way of self-coping. This infuses people with a sense of participatory action rather than perceiving it as a lonely act.”

“You have the right to use the social resources. Don’t over-exhaust your energies.”

Notion: Many ways to life problems

“You would just stop thinking further if you think that it is impossible to work out”

“Problem-management styles can be changed by being more aware of the possibilities and paths of problem-solving approaches.”

Morris: *I feel rather relieved that I am not the only emotional mother.Yes, I do agree sometimes I may be too anxious of my children’s behaviour rather than focus on*

their inner thinking …...

Researcher: *Every person has emotions. What is important is whether we could control it when it affects our abilities and performance. It is not worth it if it ruins human relations or family relationships.*

Eva: *The problem still cannot be solved after the relaxation exercises. I have tried it out before ……*

Researcher: *Doing something just for fun is already a kind of stress-relief management, sometimes our senses tend to be too tense to think positively and wisely …….perhaps after relaxation your ideas will come through …*

Eva: *Do we need to classify for ourselves which strategies we need to use? Sometimes I will use multiple strategies depending on the situations*

Researcher: *Yes, you are right, and it is good that you can understand your ways of self-caring [caring is attached to an affective sense of feeling and doing, care is treated as a cognitive concept]*

Parental inactivity strongly predicts a child's inactivity (Fogelholm et al. 1999, Francesca et. al. 2002). Moreover, parental influences are early determiners of food attitudes and practices in young children (Wood 2000). Based on this observation, a

healthcare professional may try to design a reflective sheet for a family to write a family diet pattern, providing them with the opportunity to reflect on personal family diet, and to discuss ways to modify it if necessary. Attitudes are developed through daily practices that we have never doubted, whether these are right or wrong. Parents, through being actively involved in the health-in-action process, will gradually develop their own models of health for themselves as well as for their whole family. Some active parents may even volunteer and be eager to share and promote their healthy living skills, such as cooking at school. Healthy families create more healthy beings for the society in general.

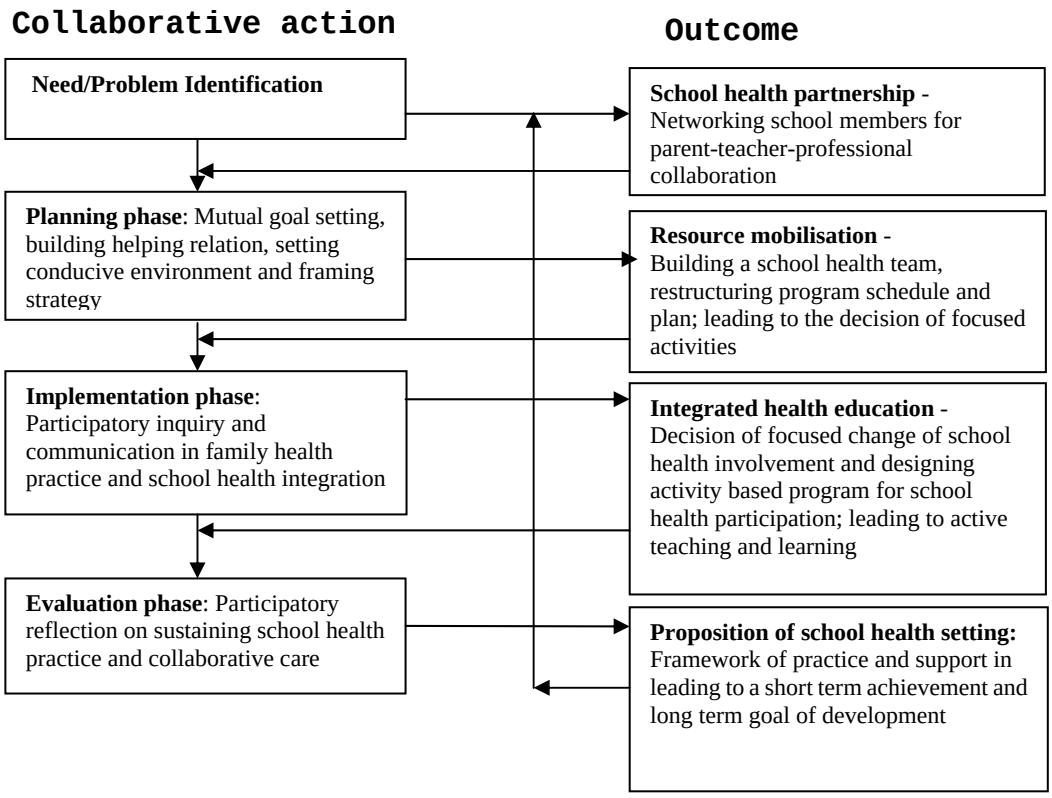
It is believed that people will be self-motivated to take an active behaviour in caring for their own health if they are able to realise the reasons for their health concerns and problems. People who voluntarily participated in the programme, most of all wanted to learn a practical skill and bring it home for immediate practice. Parent participants were interested in sharing empathetic skills in life context. The shift of focus in learning reinforces an understanding of psycho-social development and behavioural learning besides focusing on preventive measures. They enlightened the researcher with an

understanding of the importance of integrated health learning for life care practice. With an understanding of bio-psychosocial growth in children and social spiritual growth in adults, the psychological world gaps between children and adults might be more easily bridged.

4.10 Proposition of school health collaboration

Healthcare practice involves not only the biological health issues but also the day-to-day problems and concerns about living matters such as family relationships and emotional health concerns. “The rational control of life’s surfaces is an aesthetic and not merely an intellectual or political issue; the surface of the experienced world is the field of the aesthetic (Achinstein 2005). Cognitive and behavioural intervention skill such as communication, caring, and therapeutic support are trained and developed through the application of integrated knowledge of textbook theories, personal beliefs, and experiences in practice. It will be unrealistic for a practitioner learner to perform therapeutic caring skills without providing a practice environment which is conducive. The model of school health collaboration as shown in diagram 4.10, generates further concepts and strategies for the construction of school health settings for collaborative care and learning.

Diagram 4.10 Model of School Health Collaboration



Scientific nursing theory is a knowledge tool that helps nurses to reason logically and thinks more widely in a reality setting, being capable of making a prompt and accurate decision in a clinical or social situation (Leddy 2000). Coherence and integrity among professional or personalised values, theory, actions and outcomes are essential for a professional or self-directed theory practice model (Mitchell &

Bournes 2000). The values of objects including the spiritual nature of aspirations are meant to expand and extend existential relationships to a broader life meaning.

4.10.1 Nature of the collaborative nursing care

School based collaboration integrates the contextual elements and relations of the phenomena of caring practice. “Life was squeezed out of human experience when we attempted to make sense of it in a numeric and non-contextual way (Morse 1997, p89)”. Reflection on the totality of collaborative care and research experience generates a secondary meaning of the collaboration that can be shared and referenced for future healthcare practice.

4.10.1.1 Synergistic nursing care

Synergistic means a psycho-spiritual effect of gaining extra energy, power, and success through team effort that is achieved by more than one person’s strength and will. Brodt used the notion of synergism in relation to goal achievement rather than in relation to a nursing process; it is always the combined action between the nurse and the client that change the process not the process structure itself (Barnum 1994). It is generally agreed

that healthcare practice is not solely based on knowledge. We worked together with different aims, perhaps, but with the same goal of enhancing community wellness.

Teachers were not actively involved in the programme activities. They served as very good resources in playing the role of the programme's communicators and student-discipline managers. This researcher sent messages to parents and the children and they sent messages back through the teachers as they placed the slips in the letter-box placed in the teacher room. Though no e-services were offered as a means of communication, it would have been a more preferred pattern and efficient channel if the school health coordinators had a communication homepage attached to the school homepage. As the researcher could not commit to such extent, the kind of support was not requested. Otherwise it would have been a good opportunity to build up a sense of belonging as a participatory school health team, through an easier channel for dialogue as some parents could have preferred to communicate through email or ICQ.

Concepts of health are integrated with individual human senses, concepts, and experiences of health in living. Concepts of health reflect a life value. For example, participants in general related to ways of promoting

health such as diet, exercise, and social activities. They were not aware of learning community facilities near their schools, which could also be considered health-promoting activities to increase our social awareness and allow us to be more able to seek help or health resources when needed, in convenient and confidential areas. When this idea was shared with the teachers, they did not recognise that ‘health’ could be related to community environmental learning. Health practitioners are more ready to think about ‘health’ in a broader sense as they apply or practise health knowledge or related language more consciously or frequently than the public, developing the expanded concepts of health in a wider, more practical sense. Being able to accept ‘seeking help as a courageous action’ rather than ‘a shameful or incompetent form of behaviour’ can be a persuasive tool of communication for the clarification of the misinterpretation of help-seeking behaviour. These clarifications can further reinforce the belief or value that ‘self-sought help’ is a correct attitude for helping one’s self and family even though the society has a shared responsibility of supporting people. Information on the accessibility and appropriateness of health services can be one of the first important steps for people to take to be more aware of self-advocates and optimisation of personal and family health. Health

resource awareness may redirect people to associate life crisis with external support rather than the currently solo way of self-coping, empowering people with a sense of participatory action rather than perceiving it as a lonely act.

4.10.1.2 Therapeutic nursing care

Therapeutic as experienced in this research context, means an awareness of more of the possibilities and paths of problem-solving approaches of life and self-enhancing capacities. Emotion can be felt or defined as an internal resource gap to external demands such as work, conflict, diseases, and can cause mental disturbances such as anger, anxiety, fear, and worries. Negative emotions can be dissolved by positive affections. Engaging people in therapeutic comfort such as feelings of support, being understood, being concerned and involving people in group activity for no other reason than purely for fun or play that are of interest to the client, will help people temporarily relieve stress and settle their emotions. A cognitive appraisal of seeking appropriate ways of problem-management becomes more possible after settling the emotions. Both emotion-focused and problem-focused techniques are common resources or tools for life coping. Other relaxation techniques, like the ability of ‘letting it go” and freeing ourselves from rigid non-rational

principles, as well as re-engaging our self with hope were observed to be useful tools for self-care practice. Caring practice actualises our inborn or artificially internalised values cultured by living environment or work practice. Health promotion is experienced and created through life. Health promotion knowledge will be more appropriate within the context of understanding the biological and social sciences of happiness, joy, excitement, and spirit. Could it be more useful than understanding helplessness, sadness, or other negative emotions? What creates a human being's commonality? What creates a human being's uniqueness? What are the differences between people? What will be the social differences among the practice of individualism, socialism, communism, and other philosophical beliefs? Does it make any difference to a social culture and the qualities of its people? A human being's ability to make a decision towards a responsive action can be very complicated as well as very simple. Action is based on meanings that may be seen as non-rational by an outsider but may sound logical to the actor wishing to achieve a goal. The spirit of collaborative practice is connected with common hearts and intelligence of caring health. That the caring spirit can be selfless translates the difference with teamwork spirit or other nature of social spirits. Caring practice actualises the intrinsic

hearts and extrinsic wills of human beings. Mental heart and will are equally important for a healthy person to grow and develop as an intellectual and caring being. This belief is evident in life-world practice.

4.10.1.3 Moral nursing care

While parent participants always discuss about their learning desires of promoting the moral attitudes of their children, their conversations recalled past memories of a dialogue with an adolescent health researcher. She shared one of her findings that most adolescents rarely relate the word ‘moral’ in their retrievable memory or mind. This observation may have several interpretations where adolescents did not think of it as avoiding compliance with a moral behaviour. The concept of morality does not exist as it may be replaced by another concept of integrity with the meanings of consistency in one’s internal and external behaviours. Adolescents may also take it as a social sense of mutual respect in their peer world rather than in the adult world which contains more complicated social relationships. Being moral is logically not much of their concern when adolescents have not yet experienced the broader social dilemmas compared with their simple peer and social group conflicts and dynamics. Values and concepts of human respect, dignity, life values, and other life and

cultural context issues might be perceived as less abstract concepts if the related contents could engage them in the reflection of their social experiences and family lives (Tappan 1987, Yau & Smetana 2003). Will the concept of morality be more valued by adults than children or adolescents who were less involved in the socio-political situations? Orem, one of the famous nursing theorists, has a strong belief that the nursing practice has a moral dimension founded on concepts of goodness, love, agency, and personalism, which are all essential human qualities and capacities required to take care of another person (Taylor & Godfrey 1999). Moral character development is seen as an important attribute of a healthcare worker as well as for a total person development. Contemporary Western medical ethics focuses on individual rights, autonomy, and self-determination, while traditional Chinese societies place greater emphasis on harmony, responsibility, and respect for parents and ancestors (Ip et. al 1998) as part of the moral and community values. The moral dimensions can be diversified and controversial when interpreted differently from various practice settings and cultural perspectives. The alternative approach of developing moral attitudes can be based on the emphasis of practising positive human relationships and re-experiencing its values and purposes toward a personal intellectual and

social development. The settings of healthcare collaboration in this project produced many practice opportunities of community partnership skills. They include relationships of co-inquiry, rapport, care, education, co-worker, and co-practicing.

4.10.1.4 Rapport nursing care

Rapport involves trust, empathy, and support in establishing therapeutic human relationships in caring. Rapport practice deepens a human being's sensitivity, and intelligence of health and life care needs. When we are thinking for others but not ourselves, our internal selfless world will expand. Today's society expects people to be aesthetic or spirited thinkers - creative, positive, and dynamic thinkers for problems and creations. As part of the total development of being a person or a professional, aesthetic, philosophical, and scientific paradigms of learning seemed to be essential in an education curriculum of health professionals. If it is believed that health has biological, cognitive, social, and spiritual dimensions, then health education must also cover all these paradigms of knowledge. Through our sharing, we came up with ideas for health teaching plans. Although it was not a grand or scientific model, it was a reinforcing framework for trial practice, and that was all we wanted to achieve. Thinking skills are critically

important for later success. Supportive strategies of facilitating parents and teachers in fostering children's thinking as a process are essential (Lam et.al.2003). Healthcare practice is not purely based on scientific knowledge. It also uses internal resources and tools such as intrinsic values, lived intelligence, and perspectives. The quality of life values become complicated when they need to match diverse human interests. However, it could be very simple in terms of core beliefs as evident in living. They comprise the '4-F' acronym, which means 'family', 'friendship', 'fairness', and 'freedom'. These four intrinsic needs bring out concurrent elements that empathy (being able to react in an empathetic manner) is a tool for people to sustain these four basic human values. A teacher once shared that being a good or excellent school teacher may not necessarily require a person to be very knowledgeable, but, more importantly, it is whether they can or are willing to have a heart that pleases other hearts, the hearts of other people's children. Hearts affecting other hearts can be an abstract concept for people who have never experienced or observed how people's positive thoughts, minds, and experiences can touch and affect others' negative perceptions, beliefs, and behaviours. Students' bad behaviours are more easily affected by kind reinforcement than strict rules and instructions. This

rule that applies to children also applies to adults and seems to be a life-long workable tactic in building up an initial stage of rapport relation in trustful, empathetic, and humanistic natures before further focused intervention can take place.

4.10.2 Researching holistic care

Caring for individuals as whole people implies a caring person is sensitive in understanding factors affecting the totality of a human being. Holistic care incorporates the meaning of dynamic, creative and tendency of nature that cannot be explained solely in mechanistic concept of environment but should be in the wider settings, extended towards a body of knowledge (Laura & Cotton 1999). The valid account of lived experience can become a theoretical construct of human practice originate from human action; a lived experience in nature (van Manen 1990). Human experiences can be unique as well as universal in nature. Perception of realities is affected by social contacts and its interpretation of the experiences. Hermeneutics anticipates the values of human intelligence in logical investigations, perception, recollection and imagination, and has a sense and meaning prior to expressions of knowledge, concepts and theory propositions (Lester 1998). Theory proposition

of nursing knowledge is informed by the theories of discourse, the language that provides meaning to the world (Gray & Pratt 1991). Hermeneutic ways of understanding human thoughts, feelings and behavior allow a humanistic, sequential and real life experience of interpretation.

4.11 Conclusion

There are many different categories of knowledge contributing towards the school health nursing practice. Knowledge can be generated from practice and feedback to replenish the known concepts of knowledge. The phase of evaluation generates a new philosophical view of school health and research strategy. Systematic inquiry into new phenomena is adopted to advance humankind's ability to dominate nature (Maxwell 1997). Underneath the capacity of dominating, it involves the power of understanding the relations of realities around us and living within and beyond. Nurses as caring professionals, have been well informed and conscious of caring-in-practice. We are rarely involved in self-inventing ways of developing theory from practice. The roots of each practice theory grow from social encounters and experiences. Theories are changeable and are regenerated by a new angle of viewing and perspective. A physicist will admit that there is always a possibility of error in interpretation; that the

moment we change the angle of observation, an object may generate another theory of motion in physics. Professional practices are culturally constituted and thus have to do with shared meanings that are culturally dependent, constantly developing, and evolving (Maxwell 1997). Nursing, a signature of professional caring, claims to have a unique paradigm of professional practice. With its professional uniqueness, the nursing practice paradigm should at least involve the elements of values, beliefs, purposes, and principles for guiding cognitive practice in the specific cultural setting.

The hermeneutic inquiry guides researchers to seek further inner meanings of collaborative healthcare practice towards an innermost meaning of acting in life. The inner self-concept, self-values, and self-consciousness rise from the frame of reflective practice. It is the researcher's belief, developed from this practice experience that reflective action practice is not merely for professional intervention but also for human growth and development. Reflecting practice has intangible intrinsic values for individuals and healthcare practitioners to re-value or evaluate past unconscious caring acts, behaviours, values, beliefs, and thoughts and seek meanings in their values of doing and acting in social, personal, and life-time contexts.

A learners' consciousness of an action practice promotes self-understanding of independent strength and capacity and intuitive intelligence needed for action. The social standard, organisational culture, and individual values affect the participation levels of practice behaviour. The theoretical development of healthcare practice ought to have contexts and applicable concepts of guiding independent professional practice in interpersonal, interventional, and life goal settings. Indeed, conscious theories-in-practice are not only a moral or professional obligation. More importantly they generate intuitive intellectual resources, visions, and directions to ways and cognitive structures of acting in response to dynamic practical demands; without the need for long sophisticated thought process to initiate a reaction.

Caring theories have philosophical and methodological roots in their evolved settings. The science of nursing care practice will be non-realistic if caring practitioners could not reflect wholly on the total care or intervention practice to repute the contextual elements of caring practice in real life settings. The school nursing collaboration which involves team-building, empathetic dialogue, mutual participation, integrated education and curriculum

planning were regarded as the driving forces of school health partnership, resource mobilisation and school life integration. The realisation of these changes takes place in not only the physical environment of the school but in the psychosocial nursing process of communication, support, caring and education.

Chapter Five

Implication to school health development in Hong Kong

School nursing, as an advanced community nursing practice, its body of knowledge developed from a real world research ought to have a function of formulating plans for professional advancement, community partnership and service intervention. Many researchers may not understand the needs of the school health practitioner, research and evaluation have become a vital part of providing effective school health education (Lee 2004 et. al, Clark & Brown 2006). This chapter aims to recommend future policy plan and implementation strategy for school health development in the context of professional advancement, school health partnership and service intervention. The following discussion summarised the framework of planned change of school health practice which includes (1) policy plan of professional advancement (2) strategy plan of school health partnership and (3) service plan of school health intervention. They are considered as necessary elements for creating a collective and integrated force for the positive movement of school health collaboration.

5.1 Policy plan of professional advancement

According to Clark and Brown (2006),members of the school health subcommittee research council of the American School Health Association, which is an international school health association, school health research topics should start focusing on school health research agenda, school health nurses, research issues, and how to create partnerships with universities. This indicates that school nursing research, which enhances the quality of nursing intervention, is still needed. Research-based school health data for practice are recognised to be inadequate.

Evidence-based practice is the contemporary aim that nurses strive for in their practice. If we reflect on the current nursing services, role commitments, and the process of nursing activities, we would see that there is a wide range of nursing activities occurring in the clinical and community settings nowadays. Nurses take an active role in attending to human self-caring interests in sustaining personal health with a comprehensive understanding of body and mental functions. Caring is the essence of nursing, and nurse-practitioner students should learn how to provide total-person care. The shift of research

approach from mere controlled intervention to a collaborative intervention could be a challenge for nurses as they develop new schools of thought and practice. Thus, research on a practicable model enhancing the local practice will be significant.

Health promotion practice, as experienced in this research, engages people not only in the pursuit of scientific knowledge but also in the art of integrating health knowledge into a visual language for promoting health understanding, thereby influencing behaviour. The philosophical enquiry is in place when the school health practitioner decides to discuss and communicate with the public about their individual lifestyles. In order to prepare for this dynamic nature of professional roles, school health education ought to include at least three paradigms of learning, practice, and integration in the course curriculum.

School nursing is at its new field of research in Hong Kong. Wallace and his team (1992) recommended that a comprehensive health promotion plan would serve to guide and integrate health promotion efforts. Professional discussions and implications on future plans, directions, and action strategies for

developing an integrated school health care will be needed. Moreover, a holistic agenda for advancing generic nursing education ought to be recommended in the national and international levels (Anderson et. al. 2000). Holism involves understanding and appreciating the inherent wholeness in life, and accepting wholeness as a reality and not as an ideal (Lynn 2000). What would be the effect if a disease-, illness-, and health-oriented nursing philosophy could be complemented with a wellness and health paradigm in school nursing science? Nurses in hospitals and community settings are currently facing a role shift from that of being a clinical nurse to that of a practitioner nurse who requires dynamic and systematic ways of decision making and organising talent to manage controlled and uncontrolled practice situations. Moreover, nursing service is a socially demanded caring service and a major part of it is customer oriented. Thus, with social development, the nature of nursing service demand is evidently changing. In line with the current higher educational reform, the design of general nursing practice is now undergoing a parallel reform through nursing research in the place where the public health demands will be integrated.

5.2 Strategy plan of school health partnership

There are many documented findings for the development of school health partnership. For instance, Rienzo et. al. (2006) did a study and found that promoting understanding and tolerance in a school environment can result in reinforcing universal values of acceptance and openness . The work engaged in the collaborative healthcare illuminates strategies for school health partnership (Table 5.2), as well as reflects the cognitive and behavioural strategies of facilitating the changing practice process in the phase of planning, implementing, and doing research.

Table 5.2

Paradigms in school health partnership

I. The Planning Phase

Prescribing principles ----------Describing activities ----------Transcribing strategies
The phase of setting values, designing steps, and developing goals and outcomes

Socialising with people----------Interacting in groups---------- Communicating with individuals
The working together phase

Framing plan----------Reframing work ----------Framing practice
The action strategy of working out a feasible plan in real settings toward a knowledge-based practice

Stimulating notions ----------Exchanging ideas ----------Translating meanings
The strategy of talking with the people, exchanging plans, and understanding the meanings and notions in their voices

II. The Implementing Phase

Performing ----------Reforming ----------Transforming
Performing a reform in gradual transformation phase within a participative and genuinely open communication setting.

Starter---------- Partner ----------Owner
The role is evolving when the partner becomes gradually independent.

Struggle---------- Challenge ----------Settle
The psychological readiness when facing uncertainties, receiving challenges, and seeking relations of social behaviours.

Loser----------Accommodator----------Successor
The psychological readiness of social objection, social accommodation, and learning from the differences.

III. The Researching Phase

Learning ----------Bridging ----------Transcending

Taken for granted as well-trusted principles of practice	Seeking applicability and clarification of the practice	Integration of learned knowledge in practice

New Practice ----------New concept----------New knowledge
Knowledge from new practice forms new concepts leading to new knowledge

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5.2.1 Strategy of collaborative planning and implementation

Collaborative care activities introduce collective work and thinking, as well as facilitate the work completed in each role performed from a group and an individual perspective. Moreover, the related school health activities could be critically reflected on for their individual meanings. Tinsley (2003)

advocates that parents should be the healthy-eating models of their own children. Sharing family health practice experiences helps deliver a cost-effective health promotion dialogue within a school community. In this project, the participants engaged in activities to address the needs and issues of child health. The communicative activities helped them acquire an in-depth understanding of these problems, and sometimes, the parents were able to lessen their worries when they shared common experiences during the open discussions which enabled participatory reflection among them. The participatory evaluation process gave the public opportunities for collaborative problem solving as they search for solutions, and strategic decisions.

Nursing does not only focus on caring for other people but is also concerned with how people care for themselves. The nursing value of self-care strengthens the philosophy of optimising an individual capacity to manage personal health change. Transcultural nursing reinforces the concepts of respecting individualised belief systems of cultures and lifestyles.

Giving a client a feeling of being listened to and

understood is one of the less expensive but most effective therapeutic treatments. Healthcare professionals, aware of transforming knowledge into a mutually conscious consensus, enable the service relationship to be therapeutic to both parties. For instance, Woolley et. al (2004) proposed a constructivist model of teaching which they say helps a teacher grow and develop by reflecting vigorously on personal beliefs from a self-experiencing construct. In the same manner, this nature of reflective practice helps a practitioner reconstruct personal beliefs from a shifted paradigm (Hoffman & Burrello 2004). Healthcare professionals usually undertake reflective practice without being conscious of it, and acting this out through practice comes with intuition. Moreover, the reflection on the unobservable personal practice knowledge in writing helps organise and structure the contents into observable concepts. Three modes of intelligence were identified in effective performance which includes analytical intelligence, creative intelligence, and practical intelligence (Gerrig & Zimbardo 2005). These three intellectual skills are involved in the process of collaborative action and the phases of research inquiry.

Throughout the phase of researching, the school health practitioner, with a basic notion of working together with mutual participation toward a common health goal, ought to be very conscious of being non-judgmental about responding to participants' concerns, even though their ideas might seem to be different from their professional views. In this way, participants would be more able to communicate with practitioners in identifying practice difficulties, concerns, and barriers. They also receive enlightening feedback and emotional support from professionals and fellow participants as they share with each other their respective notions, feelings, and experiences. These days, however, recent school health research is more concerned with teacher, family, and professional intervention collaboration in school health (Catalano et. al 2004, Brener et.al 2006), and rarely is the focus trained on the effects of family or parental involvement in the patterns of school health participation. Data for justification of family patterns of involvement in school health is still lacking. Thus, intervention based research for increasing levels of parental involvement in school health participation is needed.

Nursing consists of experiential learning and living

dialogues, and its goal is to expand knowledge about human experiences through creative conceptualisation and research; this knowledge is the scientific guide to living the art of nursing (Parse 1999, p275). For instance, Florence Nightingale's success came after she experienced tremendous psychological and spiritual anguish (Calabria 1997). The total discourse on the process of planning, implementing, and doing research could eventually work out a developmental model for the school, the practitioner, and the profession in general. The total research process in this practice paradigm therefore, involves not only cognitive development but also social interaction techniques that promote public health participation.

5.2.2

Praxis- Closing the gap between knowledge and practice

Knowledge can act as a resource for the production of cognitive thoughts and the widening or advancement of the capacity for conceptual and logical reasoning. Knowledge, if applied to practice such as in nursing practice, needs to be made sense of by learners

before it can be intuitively recalled or applied for use in action or practice.

Furthermore, knowledge is not deliverable. It requires the involvement of learners in reconstructing it into concepts through practical activities. Self-experience reflection serves the therapeutic functions of promoting. It involves the inner self-consciousness and awareness which come from one’s personal strength, limitations, and potentials, as well as the detachment of negative emotional bonds through reflection on emotional experiences. For example, teachers can learn effective teaching skills by reflecting on their personal learning experiences. We can conceptualise better teaching techniques by observing an effective teacher’s verbal and non-verbal behaviour and style of presentation. Effective practitioners do not understand why they are effective, but they possess directly observable evidence. Moreover, effective action requires the generation of knowledge that crosses the traditional disciplines, which is a difficult but is otherwise exciting and intellectual task when one integrates thought with action (Argyris & Schon 1974). Teaching and learning are both

cognitive mental skills and techniques that are learnt by action, reflection, and conceptualisation.

The following are statements of human relations that could be evident in our living worlds. The extent to which we agree or disagree with these statements reflects our beliefs and values which affect our choices in our daily life action and practice within our surroundings.

The following statements are considered as health and social facts evident in life:

- The health of residents from neighbouring cities affects our lives;
- The stability of social economics cannot be sustained without a mentality of public collaboration;
-Every subject that we are observing could become an object observing us;
-An educator ought to open minds with bases for thinking rather than set boundaries for thoughts;
-Individuals love the feeling of being listened to and understood;
-People in families love the feeling of caring for others and being cared for by others;

-People in a society love the feeling of being concerned for others and being the focus of others' concerns;
-People in the world love the feeling of being related to others;
-People are affective with thoughtfulness and persistent messages; and
-Selfless critical thinking is a powerful tool for personal and social development.

Knowledge is for us to explore, verify, and communicate to the best of our ability, and people without beliefs may act like children without dreams. Thus, lay people need healthcare professionals to help them build self-convincing beliefs to deconstruct their misconceptions. Professional education is meant to induce a self-directed action strategy to integrate learning from education to the workplace (Oliver 2004). Engaging clients in a mental construction of a competent and intrinsically desirable action is necessary for sustaining long-term behavioural practice. This is a general application of motivation principles that exists in common human life.

Moreover, it is also essential for health professionals to exert extra effort in transforming

health knowledge into visibly explicit and practical messages for learners to capture easily. To ensure that professional voices have more influence on public health behaviour, healthcare professionals need to acquire knowledge and skills to deliver related messages in a mutually understood language culturally sensitive to client life experiences. To most people, this may not be a taken-for-granted skill. Furthermore, effective communication techniques can also be developed from self-evaluation and reflection on a daily 'trial and error' basis. It may not be the programme structure or design that contributes to the success of a successful health service, but staff commitment and incentives also play important roles. A realistic evaluation needs to consider that the process of implementing or managing an intervention is as important as evaluating the outcome of that intervention (Pawson & Tilley 1997). Reflective practice, which shares the same vision of a constructivist approach in engaging people's self-realisation of the constructing frame, serves as a self-directed vehicle to drive a professional toward public concerns. Professionals can enhance their abilities to be more sensitive observers of public concerns through dialogues. This process helps a healthcare provider visualise clients' feelings and

notions in service needs. Through this, a service provider would be more able to close the true service gap with the data and observations generated from daily practice. Identified innovative change, if necessary, can therefore be directed toward satisfying genuine community demands.

Lived experience under a vigorous study becomes a valid account of a theoretical construct of human action (van Manen 1990). This extends the conception of social realities, allowing people to be more able to capture the philosophical notion of life into a conscious comprehensible language and knowledge.

5.2.3 Context of therapeutics

Therapeutic feeling exists when people attain a sense of being understood, and when they find positive life meanings with a sense of hope for the future. Therapeutic relations can be reflected in the following experiences of feeling and knowing.

Balance

People enjoy the balance of being helped and being of help.

People appreciate the balance of caring for others and being cared for by others.

People are concerned about the balance of being related to and relating to others.

People treasure the feeling of loving and being loved.

Primacy

The primary function (Primary nature) of the family is to nurture and support rather than to teach.

The primary function of the school is to inspire the mental growth of learners for the next stage of life.

The primary function of schooling is to connect thoughts rather than to set boundaries for thoughts.

The primary function of language is to communicate with others about what they experience and observe.

One onto another

Knowledge is rooted in living observation and can be related back to observable meaning.

Every *subject* that we learn becomes an *object* with which we can reflect on ways of thinking.

Social stability cannot be sustained without a mentality of *public collaboration.*

Mentality is cultivated by *thoughtful minds and hearts and the intrinsic values of kindness.*

The health of *neighbourhood societies* affects the lives of the members of these societies.

Local action has the potential to empower creativity in developing a *universal being*.

Our memories contain many of our lived experience of formal schooling, work, and everyday living. For example, we learn how to cook and how to care by observation, knowledge input, and practice. Every person, before his/her formal schooling, may have already developed his/her own personal knowledge system that he/she has derived from personal experience in living and working. People often talk about ‘mind’ in the sense of ‘heart’s thinking’. For example, in a train we might see a sign that says ‘mind your head’ or ‘mind the gap’, which indicates consciousness and gives people a sense of ‘being careful’, ‘being sensitive’, or ‘being conscientious’. The ‘mind’ is a bodily sensing term that involves feelings about thoughts. It is a paradigm and a model of thought, as it reflects people’s spiritual and social connection to the phenomena of life. Mind contains the intuitive, the perceptual, the cognitive, and other memory-related senses. Humans engage in self-directed behaviour and intentional acts using senses, and the mode or patterns of thinking will be set through repeated practice and actions in response to external or internal demands. Our mind is

therefore cultured in our lived experience, social or work practice, and ultimately, our personal lived reality, rather than the object realities.

Mental disturbance can be easily caused by feeling a loss of coping capacity, sense of security, sense of personal control, and sense of interpersonal support. People are often unaware of the fact that acknowledging other people's feelings and concern is an important start in any kind of constructive communication, such as therapeutic, effective, or interactive communication. The key ingredients for mobilising public participation in a self-directed manner are: engaging people to revisit their own situations, encouraging them to find their own ways to sort out a problem, giving them recognition and support, providing them with needed information, offering them opportunities to practice logical reasoning, and encouraging them to re-conceptualise the meaning of their lived experience. Meanwhile, practitioner research is triggered by taking on the active cognitive roles of an enquirer, listener, information giver, interpreter, and knowledge seeker.

5.2.4 Approach of internal conflict

The diffusion of conflicts between an individual belief and value in life practice through

participatory evaluation and reflection on individual lifestyles in relation to personal health promotion can be considered to be an approach in bridging gaps in healthful living practice and knowledge. These are mainly achieved through group dialogues and the transformation of people's experiences and ideas into a reconstruction of their self-conception. Health practice dialogue reinforces public adherence behaviour, and can act as an approach to bridge professional and public practice and language barriers. Moreover, a health practitioner putting one's self in a layperson's shoes to understand the feelings of the general public helps build rapport with the latter.

Gaps in personal and family health practice can be identified through the expression and sharing of health participation experiences and observations. The people's concept of health participation and the frames of reference they use in making decisions about health participation are highly affected by individual life values, beliefs, and emotions. Our sense of self-efficacy – the belief that we can succeed at something we want to do, helps us make assessments by using a wide variety of information and knowledge that we gain from our experiences

throughout life (Sarafino 1990). Sources of incompetence in relation to health participation can be related to practice opportunities. The public's response to health varies according to the frame of reference that is used, and practice gaps can be natural gaps that are created by different levels of activities. Gaps, therefore, may not be real gaps but thought gaps that can be easily closed by exchanging and sharing thoughts and ideas for creating possible alternative ways of doing and practice.

With the concept of balanced living, the public may perceive that eating healthily means eating all kinds of food to achieve a balanced diet, which can be further reinforced when one acquires more information about various types of nutritious foods needed to maintain a balanced diet. Furthermore, the public may perceive exercise to be equivalent to doing housework or labour work, and thus the correct interpretation of the meaning of exercise, balanced diet, and other concepts that are related to primary healthcare need to be introduced to clarify such misunderstandings.

With the concept of living skill, the public may be aware of what constitutes healthful behaviour, but have no idea of how it can be applied in daily living

practice. They may be missing ‘skill’ knowledge and feel unable to transform the idea into action. They may seek appropriate and acceptable forms of action that fit into their lifestyle or choice, or be unwilling to change their current living practice. However, once the healthful living skill is identified or designed, it can fill in this gap, and a complete mental health picture can be conceptualised more easily.

With the concept of habitual practice, people may perceive that ‘ways of practice’ means daily habits or routine patterns that are perceived to be unchangeable unless a believable reason or fact is given to justify such changes. Ways of living require certain ways of thinking, and patterns of living practice can therefore be widened and restructured through the introduction of shortcuts (less effort or money) and more cost-effective (time or money) ways of reinforcing change in living patterns.

With the sense of comfort concept, people often associate a change of practice to an uncomfortable feeling, and affective language is required to break through this feeling. Affective language refers to language that expresses an understanding of other

people’s concerns and feelings. For example, a practitioner might respond with ‘I understand that you are worrying about…’ and ‘from your expression, I notice that you feel anxious about…’. Enhanced living strategies associated with the concept of ‘less effort, great reward’ can reinforce adherence and willingness to affect behaviour. People can be encouraged to capture and remember certain short synergetic language perceived to be meaningful by the individual for self-encouragement.

In terms of lived reality, the possibility of practice channels is perceived differently according to different experiential contexts, and each person has a conscious or unconscious frame of reference about the boundaries of reality in accordance with individual lived experiences. Reality can be regarded as lived knowledge, and can be conceptualised in daily living and social practice habits. Gaps in lived reality can be bridged by sharing the lived experience, views, and practices of others to formulate a new reality of the wider world. Life experience sharing can act as a powerful internal energy to extend life meaning, and participants will feel that they are not the only ones who think that way as they find out that experiences may not be as

bad as one thinks if one reacts in a certain way. In this way, they may come to perceive a wider social picture, rather than just focus on their present lived reality.

The human body is a machine which winds its own spring (De La Mettrie 1748). If reinforced with a sense of need to enhance their current state of living, people can be motivated to recognise the need for health behavioural change. Adherence behaviour can be encouraged by giving advice about steps that can be taken toward change, which lessens the chance of refusal to receive new ways of practice. Thus, as a health promoter, it is important to be aware of the fact that every individual has a conscious or unconscious intellectual living knowledge. Intellectual knowledge can be generated from both living and thinking aside from formal learning. Meaningful lived experience is worthy of sharing and being reinforced in a public health talk, and may act as a health teaching resource for practical demonstration.

5.3 Service plan of school health intervention

The American School Health Association (2006) has the following comments in its recent on-line report, it states,

*"Students cannot learn well and are not likely to behave well in difficult school environments.... School climate is the learning environment created through the interaction of human relationships, physical setting, and psychological atmosphere. Researchers and educators agree that school climate influences students, teachers, and staff members and affects student achievement. Yet many school improvement initiatives primarily address school structure and procedures and virtually ignore school climate."(*http://www.nsba.org/cube/WhereWeLearn)

This paragraph generates the clear message that school health intervention ought to include the psychosocial dimension of any learning environment. However, school climate intervention seems to be a neglected area which school nursing scientists have not yet explored.

The dimensions of school climate intervention are diverse, and the core intervention strategies as experienced in the research process were conceptualised as mental health support, which enhance living and learning, as well as the ways with which we communicate inter-realities.

5.3.1 Mental health support

Mentors need to be sensitive and conscious of learners' affective states and stages of learning needs, especially when the knowledge is expected to be transformed into action or practice knowledge (Biggs & Moore 1993). The expression of feeling belongs to an affective paradigm of understanding. People may not be conscious of the need to learn or do something for their psychological state of feeling well. We feel joyful when we read an interesting story and feel love when we are cared for. We may have a spirited feeling when touched by another person's good thoughts or words. Intrinsic values and needs of feeling well or feeling good achieved through an enriched life could be hidden in our minds, but could be recalled through a process of self-reflection. Participatory reflection on health practice experiences would involve moments of recalling our affective feelings and thoughts into self-conscious senses whilst promoting our understanding of our inner feelings and thoughts.

Concepts of love, emotion, affection, spirit, and other affective ideas are more easily understood with their underlying life contextual meanings, rather than understanding them from a theory-based

interpretation. We may experience a moment of internal force driving us to move forward, act independently, intellectually, and proactively toward a self-informed choice in living and at work. Moreover, the source of our spiritual feelings reflects our individual intrinsic values and beliefs.

Statistics from the Central Registry of Drug Abuse point out six reasons for current drug abuse (Leung 2001). They include (1) peer or partner influence, (2) avoiding the discomfort of the drug's absence, (3) curiosity, (4) seeking sensory satisfaction, (5) relief of negative feelings such as boredom, depression, anxiety, or stress, and (6) self medication. The delivery of health knowledge is a minimal part of influencing human behaviour. In fact, aspirations gained from an interactive concern, therapeutic communication, peer, family, and other affective support can all act as a spiritual dose to empower one's mind to act positively in life (Sellers & Haag 1998, Mcleod & Wright 2001).

The human emotion is a complex and critical factor that affects our mental functions. It is an experienced feeling, a word that represents people's awareness of a strong attached feeling that causes our inner motions. From the observation of healthcare

service and human life in general, we may realise that most of the time, emotions are related with inner values, beliefs, and life expectations.

5.3.2. Active living and learning

It is generally believed and agreed upon that active living is one of the core elements for people to lead a healthy life. People gain a good sense of active living by being able to participate freely according to their interests and by acquiring the freedom to speak, live, and act. School psychology experts, Wallace and his team have, since 1992, recommended that social competence be included as a core domain in the school health promotion programme; social competence is meant to be a goal for responsible family members and productive citizens. The act of enabling of a supportive social environment in which people freely share and express their desires, anxiety, emotions, love, and affective thoughts could be a powerful tool in promoting health. People will be active if we provide them with the opportunity to talk about their lived experiences, their concerns, and their values. This can also be treated as emotional support therapy. Humans, by nature, want to have the freedom to act and think, and by interacting actively within a group, their mental functions would

be stimulated. We may not be conscious of the fact that participating actively in life helps us attain intellectual growth, but emotional problem-solving skills are transferable, and thus one way to manage stress, conflict, illness, and other human responses is to share common strategies in dealing with such problems. The basic principle of such a strategy is to revisit the roots of our thoughts and concerns. Moreover, the mastery of logical reasoning skills enables people to establish logical and sensitive conceptual living. Knowledge, if taken for granted, may decrease a learner's curiosity to think further. Most truth wellness health concepts should be self-experiential and be felt by the person himself/herself. It has been observed that if knowledge is put into a more cultural living context, such as stories of others that learners can reflect on, participants would be more likely to engage in a more active mental process.

5.3.3 Communicating the social realities

Different types of knowledge serve different paradigms of thinking and learning, and a mental construct of wellness needs to be constructed by the individual self, rather than by a health provider. Health providers should only act to inspire and

facilitate this mental construction of wellness through guidance and advice in order to help independent knowledge seekers understand the meaning of health participation and the health learning process.

Learning styles directly affect a learner’s way of thinking. The way we think determines the way we act, and our minds are often immersed in critical and creative enquiry in seeking meanings to our surroundings. Thus, humans need to balance knowledge of nature in order to understand the core values of a human being’s world.

The real world is ambiguous, riddled with paradox, and is often impervious to its technical wizardry (Hunter 2000). Science-based knowledge promotes a sense of perceptual certainty of informed social action. In social or cognitive research, theories generate aims for people to further test in order to refine the theory for social and cognitive development. The body (bio), the mind (social), and the spirit (human) are the core paradigms of a being. Social science knowledge is aimed at providing social references for practice, experience, and development of knowledge. Giving people support and

understanding human emotions as a whole are the core mental techniques needed to build a relationship with clients and communicate with people in general about their lives. Thus, in order to promote a good sense of health, practitioners need to start by matching their efforts at promotion to the concerns and interests of the public, rather than focusing on professional interests.

Health in action requires individual willingness and commitment in participation. The disease-based prevention paradigm may focus on providing people with the knowledge to prevent disease and health risks to reinforce health behavioural changes, but in reality, people may be more interested in healthful living practices to enhance their lives. This is because based on the basic instinct of human survival, the human response to focus more closely on one's current stage of life is normal for every human being. On the other hand, health practitioners tend to perceive matters in terms of evidences and facts as it is how we were trained to survive in our professional functions. As professionals, we always tend to guide people to think logically from past events toward the present and the future, whereas the public is more concerned with its current state of

living. Psychologically, we all prefer to acquire immediate knowledge for the improvement and enhancement of our immediate future rather than logical prevention for the distant future. This may well be the major psychological gap between the public and professional worlds of practice.

Scientists often disagree about the extent to which evidence counts in favour of a theory because they operate with different concepts of scientific evidence (Achinstein 2005). If nursing advocates clients' health participation needs with personalised beliefs, values, actions, theory, and outcomes in practice (Mitchell & Bournes 2000), could the former statement still be applied to the nursing sciences? There are many psychosocial health intervention strategies, models, cognitive techniques, and intellectual skills that we can apply. What approaches should we adopt and practice? What would be the core principles, attitudes, skills, and values that would act as professional benchmarks in our assessment, planning, intervention, and evaluation? Humans are social beings who value social harmony, stability, and integration; thus certain practices are driven by social norms in public behaviour. Strategies that reinforce human health behaviours

should reflect the way in which human routine or normal behaviour is nurtured. Practice behaviour can be cultivated by repeated internal reflexive responses to an external condition stimulus, such as work practice behaviour or family practice behaviour. Behavioural reinforcement communication thus requires the use of persuasive language with an understanding tone and gestures to engage human interest to give the feeling that one is listening. It should also be remembered that feelings of behavioural change may cause feelings of mental discomfort in relation to perceived changes in daily practice patterns that are interrelated with life values, attitudes, and meanings. Therefore, encouraging people to reflect on their lived experiences as they relate to personal, family, and work practice may help them draw upon their understanding of themselves as socially connected beings, as well individuals who could have their own control in personal health out of the influences of the social culture.

Hence, if focused reflective practice serves as one of the ways to bridge theory and practice gap, the interpersonal space designed for interaction between practitioner and public in real-life settings needs to be further explored and studied.

5.4 Conclusion

The accessibility of school health data and knowledge-based framework affects the approaches of partnership practice. School nursing research has the role of delivering the primacy of school nursing knowledge for prescribing a professional intervention or service, where nurses have a more discrete role in promoting and sustaining well-beings. Each health discipline, being educated with different forms of knowledge under different paradigms of language and skills training, should have differences in values, principles, and foci in terms of health care practice.

Theories derived from other non-nursing health disciplines or non-reality based data may oversimplify the knowledge implications and use in nursing. Humans take action in the form of intuitive thought and intelligence, and inner resource or knowledge requires a conscious cognitive state of mind to recall. Thus, reflective practice and learning are most essential for a nurse practitioner to help him/her evaluate his/her work practice and facilitate the integration and synthesis of learned knowledge with one’s life philosophy of knowing, one’s personal knowledge, and his/her becoming self-

conscious of the integrated knowledge of guiding his/her practice at work. This enables a conscious sense of knowledge application in interventional settings such as health counselling, health teaching, as well as cognitive and behavioural reinforcement.

The sources of nurses' stress are commonly observed in work overload, quality work conflict, human conflicts, and work incompetence. Nurses are educated to work harmoniously with team spirit, but we seldom focus on the educational aspects of how to achieve skills such as the application of interpersonal communication skills in real-life. We know the need of being socially competent, but we rarely emphasise the need to conduct an in-depth analysis of our social communication process.

Reflection is the observation and evaluation of one's own actions through a conceptual framework which leads to changed decision making; this process turns a novice teacher into an expert (Biggs & Lam 1997). Learners may learn a theory without knowing how it could affect their existing modes of reasoning, perception, or conception. It is thus important to engage learners to reflect on the existing concepts that they attach to reality and its contexts (Barnum

1994, Hagg-Heitman 1999). Reflection on social practice, which is highly influenced by experienced values and beliefs, helps practitioners be self-conscious of their perception of social nature or reality.

Researchers who have not mastered the necessary language and knowledge need to be guided to reference readings in conceptualising the language and terminological meanings that are the foundations of constructive functional thinking in cognitive analysis and interpretative synthesis (Haag-Heitman 1999). Broad reading extends the width of fields of thinking and practice. Moreover, being able to understand the human needs as an emotional, social, spiritual, and physical affective being helps people develop their preferred ways of living (Black & Matassarian 1997, Buddeberg-Fishcher et al. 1998). Since, social talk and sharing are common needs in social living, structured, facilitative inquiry and communication can become a kind of therapeutic communication in which people can share thoughts and feelings.

School health nursing engages in a more self-directed and initiated behaviour in health participation and in undertaking voluntary involvement in sustaining their health status on a personal, family, and school level. Such health participation often reinforces positive living practices when involved in group dialogues, communication, and individual health consultations. Openness to fantasy, feelings, ideas, actions, and values are motivational factors to life (Deckers 2001). However, feelings about commitment, continuity, and consistency are common emotional barriers when clients are forced to make decisions to modify behaviour that carries a health risk. Nevertheless, school health interventions that can achieve both the immediate impact of making appropriate changes of school health practice and the long term plan of developing school health partnerships between academic nursing institution and community schools, from the researcher’s view, comprise a realistic and desirable model for future professional intervention and servicing research.

Chapter Six

Limitation and Strength

It has not been the intent of this research to suggest that participatory action research of studying school nursing phenomena is the only or best approach to conducting research in school health. It will be too early to confirm any concrete professional practice model. On the other side, this pioneer research could undoubtedly provide certain insights, methods, ideas and techniques of enhancing school health. With this intention, the generalisation of the research findings are inevitably limited by the small sample size which involved only one school with a limited number of participants and informants.

The parents were the most accessible and willing to take part in the school health involvement. The participation of teachers who were commonly identified as accessible healthcare partners were not fully optimised in this study. Due to their tight teaching schedule, they took minimal roles in the project. Nonetheless, if we take a broader definition of health, the teachers already have a part in

promoting healthcare with the health-related curricular activities they teach. However, they did not fully understand the broad meanings of health until they got involved in this project. Because of this, the researcher perceives that the teachers' participation may be more relevant if the research focus is shifted to enhanced teaching, replacing the context of health practice with teaching practice. Therefore, action research in the context of teaching experience could then be considered as a teacher development programme. The same strategy of focusing reflective sharing and communication dialogues of teaching experiences may then enable an exchange of thoughts and ideas to promote enhanced teaching methods.

The data generated might be perceived as biased due to the dual role of the researcher which could be deemed to affect the level of inter-subjectivity of the data interpretation. However, from a philosophical perspective, we may also argue that what we have developed was a more scientific paradigm of qualitative practice research, since the action researcher's involvement in the quality change process and the research process could be perceived as the most accurate source of data and

interpretation. In addition, bias is only induced when the researcher has expected structures of outcomes. In action research, no structure is expected, but the patterns evolve in practice. The researcher, adopting the holistic and hermeneutic view, is consciously open-minded in viewing the world-relations.

The diversity of the collaborative action research settings reflects dynamic social skills that the researcher needs. Much more effort, work, time, and commitment had been put in the preparation, activity planning, and implementation of the research process than in the reporting of outcomes. The logical sense of interpretation also became difficult due to the dual role assumed by the researcher. Likewise, the level of mastery of research skills may have also affected the quality or the logic of data interpretation.

Despite of the limited generalisation of the action research data and may not be adopted as the general practice; this action research project can further confirm and complement our understanding of the effects of an applied participatory action research (PAR) in Chinese community. PAR was treated as a

research tool as well as a collaborative health intervention in this research. This dual nature of adoption is rare. If we believe research of innovative caring practice should have a main role of enhancing the nurse practitioner to develop knowledge for improving and promoting the quality of care practice, this dual role of conducting nursing action's research may be essential. The nurse practitioner's social sensitivity, cognitive, reflective, and hermeneutic research techniques were enhanced and sharpened in the research and intervention process. The paradigm evolved from the real life nursing practice in school settings, may open another dialogue to the real nature of school nursing and practice should be. Future preparation and development of Hong Kong school nursing or other societies in similar culture settings could be shared and exchanged with further research experiences. Other values and functions of this project were to address other concerns which will be discussed in the following paragraph.

Clarifying core nursing competence and values

The debate regarding the definition of nursing has been known to exist for long. Despite the fact that

every nurse may interpret nursing from various perspectives and act differently, a profession ought to have at least a solid foundation of philosophical framework as regards core values, beliefs, and principles to base on that will guide the practice, research, and education. From the researcher's view, the complexity of the professional nursing structure is hard to exist and be visualised in our common nursing profession if the nursing profession does not have a universal or local paradigm of nursing beliefs, values, and research-based principles that guide professional practice and development. Many nurse theorists argued that nursing is a science, art, or both. In this research, we argue that from the research practice in school and community nursing, it involves not only science and art, but also philosophical paradigms of thinking. More importantly, it wholly depends on the life context of the nature of caring.

Technical competence is only part and parcel of the whole nursing context. Social and intellectual competence is another eminent professional attribute. The most valuable of nursing knowledge involves its correlated ideas, concepts, and theories which are sharable, exchangeable, and transferable for the

broadening and deepening of the human mind and practice. Visions and ideas for promoting healthful actions can be shared and diffused in a natural, non-dominant and unchallenging relationship. As nursing scientists, we may tend to focus more on the scientific interpretation of causal factors of disease or observations and the provision of justifications that give objective principles and valid reasons. These are the characteristics of a health professional. Moreover, we should also not neglect the important step of relieving the client of concerns or problems to achieve a good outcome. Internalised energy transformation is likewise essential for human understanding and self-enrichment. In the same way, energetic and spiritual activities can generate synergetic relaxing moments that ease tension and pressures in life. This can be evident in our living experiences.

Hegel (translated by Emad & Maly 1988) interprets the phenomenology of the spirit as the science of the experience of consciousness. Synergetic health communication, in this research context, is described as the inspiration of life’s meaningful messages and thoughts in dialogues. They are kinds of interpersonal skills that reinforce a positive

feeling as a form of encouragement. Health promotion requires many intellectual skills of knowledge integration in aesthetic, scientific, and philosophical paradigms. Although affective language is most often the context of our day-to-day conversations, it is sometimes not recognised as an essential language in health promoting communication.

Advocating the life-integrated healthcare practice

Healthful behaviour reinforcement is a life process. People interpret health from a subjective body sense and from their own experience, rather than solely from an objectively classified definition of health. Human attributes features to the world that it does not possess (Chalmers 1982). The feeling that one is living healthily is a functional and meaningful state in life which involves biological, aesthetic, and life-intellectual paradigms of thinking and acting.

Value awareness of the spiritual or non-physical elements helps us to reflect on deeper meanings of our present living focus, and to work toward our preferred lifestyle. This cognitive process encourages people to reflect on the hidden values,

beliefs, attitudes, and expectations that underlie their unconscious actions. Caring is a social process of attending to a person's needs that are subjectively experienced by the body and mind. Bearing in mind that one's success can be achieved only by oneself, caring professionals ought to manifest reflective and active listening skills, using the eyes and ears to understand the client, expressing empathy, and acknowledging the layperson's abilities of interpreting personal feelings about health, well-being and life experiences, and current, past and future living expectations. This approach, as experienced by the nurse researcher, could help us to re-orientate their minds toward more hopeful and interesting events.

It is non-scientific to exclude subjective experiences of life from the science of health. In a similar vein, it may be non-scientific to label practitioner's personal action knowledge as non-scientific. If a nurse researcher must only be the detached observer, could that caring nature still be regarded as nursing care? If the praxis knowledge must only be informed by text theory or research data, will it be fair to a practitioner who may already have developed a set of knowledge or theory from own

practices, and adopts competently with self-evaluations. In consideration to the social dynamics that are involved in nursing practice settings, would the nursing practice model be more logical and fair if it is evolved in a real world setting by a nurse herself?

Feelings and notions of love, freedom, power, health, caring, and other human's life values are experienced in active living and practice. These notions belong neither wholly to science, art, or philosophy, as they exist in our intellectual minds before a formal paradigm of knowledge exists. Universal human values might be the cause of knowledge seeking for sustaining a quality survival, serving the fundamental values, and principles in knowledge formation for the well-being of each individual. Meanwhile, life, health, environment, and caring are integrated paradigms in holistic nursing interpretation. The integration is fluid, non-static, creative, and enlightening. It evolves meanings of nursing acts in life's moments. Social or life intelligence, wisdom of knowledge at work and in action are all belonging to non-scientific paradigms of thinking and living. However, they are good resources for promoting human health.

Piepenburg (1998, p186) has written the 12 signs of Spirit Wisdom for promoting self-understanding and social well-being. He wrote,

“A shifting of trust to internal instincts & intuition
An appealing sense of personal lightness
Feelings of inner clarity & freedom
A sense of being at home almost anywhere
Repeated occurrences of gratitude & generosity
A persistent presence of Spirit everywhere
Desires to contribute to the common good
Heightened sensitivity
Greater sense of humor
Unconditional caring
Rapid acceptance of change
Increased creativity”

The unconditional caring was recommended by him as one of the worthwhile practice for self and others.

The theory of nursing practice will be more understandable and comprehensible if it is with its evolving context. Health practice knowledge becomes

more conscious when practice experiences are felt and interpreted in a life context that makes sense of ordinary and extended life meaning. Life values are also embedded in the nursing practice. Nursing practice theories and models, because of its complexity and high conceptual and experiential nature, are preferred to be learnt through self-practice and research. The discourse of the theorising process helps nurses to realise the integrated principles or applied strategies of the healthcare practice.

Professional care judgment on human needs and concerns is a must, but such judgment should be constructed from non-judgmental and non-biased data. Nursing knowledge developed from professional practices is always considered as valid data references. It should be subjective and non-scientific as it excludes more than the scientific data and scientific interpretation. The cognitive interpretation of personal unique life experiences may induce illogical sense to readers who did not have the similar participatory life research experience.

Common beliefs and values leading to practice change

action, as experienced in quality nursing practice, may include beliefs such as the following:

Making good use of the knowledge we own.

Making good use of all available forms of social pressure and support, including families, friends, and colleagues

Making good use of what we have performed and transformed

Present and past experiences that affect interpretation of action choices

It may also include the following values:

Space in relation to oneself helps one to reflect on one’s conception of life

Reality as an extent to which an individual relates the self to the external meaning of the world

Transcendent learning phase which is essential and should be reinforced as it will lead the learner toward a new vision, transforming the narrow scope of reality to a world of self-renewal

Assigning a positive meaning to the world helps in the development of a more positive character

Understanding oneself in relation to the world, which helps individuals to understand their own potential, strengths, and limitations

Summary

The dual research methodology used in this project acknowledges the legitimate position of the layperson in contributing to the scientific interpretation of social data. It may help caring professionals extend

and interpret the conceptual meanings of life evidence and realities that affect our interpretations of the conception of health sciences. ‘Science and rigor to research means readers can reach and learn something about the meat of the experiences of my informants (Morse 1997, p53).’ By the conventional definition, science can be illustrated as a process of seeking a relatively valid answer to an understanding of a phenomenon that is felt to be uncertain. If we agree that knowledge of health science should be applied to the promotion of human health, thus the scientific inquiry process that comprises data collection, the finding of correlations and interpretation of the health implications and meaning cannot simply focus on structural relationships, but must also look into the practice settings. The description of a school nursing intervention and its evolving thinking pathways where data emerges as a sensible construct, or where paradigms complement the knowledge gap between theory and practice in school nursing science. Applied qualitative practice research can be viewed as a research paradigm of searching practical knowledge of an innovative intervention through the systematic organisation and reframing of data into knowledge context and language. It involves an

artistic thinking process of seeking intellectual ways of enhancing quality work. It also devises a sensible conceptual integration of the knowledge in personal and professional contexts. Science, art, and philosophical thinking paradigms serve to develop human knowledge in apprehending internal and external relationships in the world. Knowledge developed from these legitimate research tools will induce more authoritative and powerful types of thinking that are worth developing to professionalise the nursing practice. The complementary findings from a qualitative practice research can generate new meanings, values and ideas on universal human assets and development rather than the outcome. Because of this nature, qualitative life based research will have its subjectivity and may not be easily generalised. Despite this limitation, the data will provide a real life picture for humans to take reference for the similar work.

Chapter Seven

CONCLUSION

This research is a pioneer healthcare project for enhancing school community collaboration in child health promotion. The project aimed to generate practice knowledge in the form of framework goals, strategies, concepts and paradigms for the promotion of health and nursing practice in life context through collaborative research programmes. Reflective and cognitive discussion of social observations and personal experience are effective channels for family and personal health reflection and learning.

Discussion with the community was likewise necessary to achieve people’s active involvement in solving their health problems and concerns. The participation of voluntary laypeople may be sustained through persistent social support and encouragement from healthcare providers. This should be one of the core public health strategies for bridging the gap in community collaboration.

The development of missions for schools that envision health as being related to learning will facilitate

the process of implementing school nursing. Policies and structured teaching schedules within public schools are the greatest barriers to the implementation of change in the school curriculum. Schools in general have a preference for programmes that ultimately develop learning capacity, as this is their perceived primary functional role. However, an effective and successful health promotion programme should involve channels of cognitive participation, life experience reflection, and emotional expression. Life reflection is an experiential learning behaviour that requires health practitioners to guide participants. The public, in general, is not conscious of the value and role of personal and social intellectual growth, despite the fact that biological, emotional and spiritual health awareness are core learning needs for fundamental health protection.

Cognitive thinking can be very dynamic, but there are common patterns, methods or language in life and health perception that reflect the life-long logical response to universal healthcare needs. A sharing environment enables individual participants to express their inner thoughts of the personal meanings of deeply attached desires, interests, values, and

beliefs that are cultivated by experienced living and work practice. Events of participatory action, evaluation, and reflection provide collaborative opportunities for the public to work with a practitioner researcher to create an active channel of social participation, action, and learning. Public involvement in life experience research motivates participants with a natural sense of curiosity to discover their own unconstructive logic, deconstruct the existing patterns of perceptions, and reconstruct their thought concepts.

The hermeneutic inquiry in the participatory action research (HPAR) process applies dual research methodology of formulating a double research loop for active practitioner researchers to integrate their evolving reflections in the research process, instead of coming up with a distant and detached observation. It also enables a more holistic and genuine disclosure of social research findings, as the researcher is also a part of what is being researched. Similarly, it creates the social process of action and participation. Nursing espouses the belief that clients should have the right and autonomy to participate and make decisions about their own health. However, people could have more choices to

participate if they were better informed or have acquired a better understanding of their conditions. Through this research, the researcher has come to recognise that conducting a PAR study without the hermeneutic inquiry is similar to a situation in which a person is involved but restricted to share insights regarding cognitive change and learning throughout the process.

The nature of the mental state of the researcher can be described as the stage between cognitive conception and critical reflection, where non-directive thought is transformed into directive focusing, being from a world-wide view to a holistic end. The key feature of this action research is that the researcher and the researched are equal partners in experience sharing, exchange of concepts, and the construction of systematic practice knowledge. It may be that the mental process involved is something that nurses have always employed in their work practice, but they fail to recognise it to be a mutual intellectual growth process. We tend to be more focused on the external cognitive function of relating the association of facts or truths to external work relationships and practice values, and rarely appreciate that the meaning of our internal

thinking and practical reflection can indeed be transformed into a self-directive tool of self empowerment.

After conducting this study, it was realised that PAR strategy could act as an interactive intervention in leading an innovative change in school health practice. Participatory communication environment was reinforced throughout the collaboration process. Most of time health professionals may think that they know best what the public needs, and a similar accusation could be levelled at educators who are confident in saying that they know best what their students should learn. However, lay experts, or committed members of the public, can be the ones who really know best what the public needs as they are with the similar culture of practice. Nurses may find our common ground and common values more easily when we are working with the healthy people, through the journey of understanding each other feelings and thoughts, nurses may ultimately understand what nursing is and learn what nursing is practising for.

The development of nursing leadership needs to incorporate the spiritual dimension; the purpose of living and acting in life (Schweitzer et. al. 2002).

It is noted that instead of focusing on the concept of health, health educators shifted the conventional disease-prevention paradigm to a bio-social-spiritual paradigm in life context. The process of bringing together aspects of one's body-mind-spirit to a deeper level of inner knowing leads toward integration and balance of the whole being (Murray & Zentner 1989, Struthers 2000). Reality perception including inner-self view and world-view, can only be changed by self willingness. People tend to work out change gradually and most preferably in their desirable ways. A direct way of undertaking change is to work it out as a new experience and to reflect on its process and meanings. Life, health and work cannot be taken for granted, and they require efforts of learning from it and sustaining.

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