Faculty of Economics and Management Sciences

The effectiveness of School Health Services delivery related to the Care and Support for Teaching and Learning (CSTL) and Integrated School Health Policy (ISHP) in the Western Cape's formerly disadvantaged schools

Mini-Thesis submitted in fulfillment of the requirements for the degree

MA Development Studies,

Institute of Social Development at the University of the Western Cape

Presented by

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DECLARATION

Herewith I, _____, Student Number 9510175, declare that the mini-thesis entitled: **School-health effectiveness in formerly disadvantaged schools in the Western Cape Province** which I herewith submit to the University of the Western Cape, Bellville Campus, in compliance with the requirements set for the degree, Masters in Development Studies:

- Is my own work, has been text edited and has not previously been submitted to any other university.

- All sources are acknowledged in the reference list.

- This study has been approved by the Ethics Committee of the Institutional Office of the University of the Western Cape, Bellville Campus.

- This study complies with the research ethical standards of the University of the Western Cape, Bellville Campus.

_____

Menziwa Mzwandile

Date:

DEDICATION

I dedicate this piece of work to God Almighty; thank you Lord; you have given me sufficient grace, strength, perseverance, good health and wisdom from the beginning, through to the end of this MA journey in order for me to realize my dream. Although the journey seemed tough, your grace has kept me strong.

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My late, dearest parents, Victoria and Michael Menziwa who struggled to give me a foundation for actualizing my potential. You have been a great source of inspiration for me.

To Nomthandazo Mnene, I thank you for opening your home for me so that I could be nearer to schools in Khayelitsha.

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ABSTRACT

Provision of effective school health services is fundamental to learners' health and learning**.** It is obvious that ineffective or absent school health services would ultimately jeopardize the health of learners, core school activities and results. Hence, it is vital for the government departments and schools concerned, to ensure effective school health services delivery, for the benefit of all learners and to alleviate health problems in schools. The purpose of the study is to understand the effective provision of school health services related to the Care and Support for Teaching and Learning (CSTL) and Integrated School Health Policy (ISHP) frameworks in the selected Western Cape formerly disadvantaged schools located in both the Metro East and Metro North Districts. A qualitative research procedure was chosen utilizing qualitative research methods, individual interviews, focus group interviews and non-participant observation. The study focused on three schools, including two public primary schools and one public secondary school that were purposefully sampled to participate in the study. The research concentrated only on the views of the parents, educators, and principals. This investigation revealed that parents, educators, and principals find themselves incapacitated and helpless in addressing health issues due to inadequate school facilities, information, and support for effective school health services delivery in their schools. This study concludes by recommending that principals, teachers, and parents should be carefully trained on how to deal with learners' health problems that may arise either from home or at school.
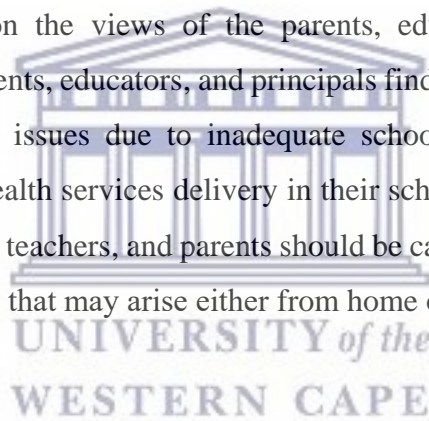
DESCRIPTION OF KEY TERMS

School Health Services - are parts of the school health program provided by physicians, nurses, dentists, social workers, teachers, and other skilled health personnel, to appraise, protect and promote the health of students and the school personnel (Baru 2009).

School Health Problems - refer to health problems of school children which vary from one place to another and may include malnutrition, stomach parasites, injuries and infectious disease including skin, eye, or ear diseases amongst others illnesses (Sonawane 2017).

Integrated School Health Policy (ISHP) - is a recognized advancement of the school health agenda and the recognition of school health services as a national priority programme, offered through the integrated involvement of the Departments of Basic Education (DBE) and Social Development (DSD) (Integrated School Health Policy 2012).

School Health Program - includes maintenance of the school environment, protection, and promotion of health, as well as health education (Currie & Vogl 2013).

Health Promoting School - is defined as a school that is constantly strengthening its own capacity as a healthy setting for living, learning and working (Struthers et al. 2013).

School Health Team - according to different authors and in the view of experience in South Africa, the important team members include a school nurse who coordinates the work of other members and the school principal with support for effective health programmes. The teachers, who can assist also in health education and detect health problems by taking note of early symptoms, as well as parents, the learners and the wider community, may also be regarded as part of the school health team (Searle et al. 1989).

ABBREVIATIONS

ADEA	Association for Development of Education in Africa
CAPS	Curriculum Assessment Policy Statement
CSTL	Care and Support for Teaching and Learning
DBE	Department of Basic Education
DoE	Department of Education
DOH	Department of Health
DSD	Department of Social Development
HPS	Health Promoting School
ISHP	Integrated School Health Programme
LO	Life Orientation
NSHP	National School Health Program
SA	South Africa
SADC	Southern Africa Development Community
SGB	School Governing Body
TB	Tuberculosis
WHO	World Health Organisation

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1. Orientation and Introduction of the Study

1.1. Introduction

The study focuses on the effective provision of School Health Services (SHS) related to the principles of Care and Support of Teaching and Learning (CSTL) and Integrated School Health Policy (ISHP) in the Western Cape formerly disadvantaged schools. CSTL & ISHP are briefly discussed in section 1.8.

This study was designed to explore the provision of school health services available and its practices in primary and secondary schools in the Western Cape. The World Education Forum held in Dakar in 2000 claimed that the provision of effective school health services is an important strategy for achieving Education for All (Department of Health & Department of Basic Education 2012). SHS refer to the services that are provided to the learners in schools to promote their health, as well as to prevent and control illnesses (Parrett & Budge 2012). This confirms that learners need to feel healthy, supported and safe in order for them to learn effectively in schools.

Bundy (2011) indicated that SHS, commissioned by the World Bank shows that, across countries of all income levels, the dual role of school health in contributing to both the health and education status of children has been recognized. This involves helping children to enter school at the right age by addressing health barriers to school entry; helping children to stay in school until completion; reducing absenteeism due to health reasons and contributing to educational performance by minimizing health barriers to learning (Bundy 2011). Consequently, considerable efforts are being made to develop and support school health services delivery globally (Shung-King, Orgill & Slemming 2014). It has been indicated that provision of school health services does not only respond to a need, but also increases the efficacy of other investments in child development, ensures better educational outcomes, achieves greater social equity and is a highly cost-effective strategy (DOH & DBE 2012).

Furthermore, according to the World Health Organization (2011), the impact assessments of effective school health services are vital in contexts characterized by substantial social inequalities. In South Africa, for example, Shung-King, Orgill & Slemming (2014) discovered

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that a health information system is likely to yield good quality in future, although school health service data has been uneven and of poor quality, which restricted monitoring of progress and impact. Shung-King, et al (2014:59) postulated that even in favourable political and policy reform environments, school health implementation will not progress satisfactorily due to a lack of significant support of the management and leadership, infrastructure, the resource base, and the staffing. Hence, the extent to which children should receive the required interventions is still not known, that is, one of the important outcome measures of the school health service delivery. In short, provision of school health services for the large numbers of South African children in formerly disadvantaged contexts might not be sufficient due to prevailing social inequalities and lack of effective support for services delivery within the country.

Inequalities in delivering health services in schools have been described as a contributing factor to health problems faced by the schoolchildren. According to Spaull (2013), South Africa is a middle-income country with high income and social inequalities that affect the delivery of services, including the provision of SHS. Department of Health (2017) indicated the evidence that the screening coverage for Grade 1 and Grade 8 learners achieved national targets. However, only one-third of Grade 1 and just under one-fifth of Grade 8 learners were screened, suggesting that further investment is still required if school health services are to benefit all learners as outlined in the National Health Insurance (NHI) White Paper (Department of Health, 2017). The school health problems among the learners and the related need for effective SHS are still concerning within some of the Western Cape formerly disadvantaged schools, as supported by the above statement in terms of services delivery.

Hence, the purpose of the study is to understand the effective provision of school health services in terms of Care and Support for Teaching and Learning (CSTL) and Integrated School Health Policy (ISHP) frameworks in the selected Western Cape formerly disadvantaged schools. This chapter, therefore, outlines the background and contextualization, research questions, motivation, and rationale for conducting the research regarding the effectiveness of school health services in the Western Cape formerly disadvantaged schools. Furthermore, the problem statement, aim and objectives of the study and the significance of the study are outlined. The chapter ends with the structure of the thesis.

1.2. Background of the study

It has been documented that ill health prevents many children from growing into productive, capable citizens, who can help their communities grow and prosper (DBE & DOH 2012). Furthermore, health deprivation can have a negative influence on learners' education as they cannot focus and thrive at school due to hunger, depression, illness, abuse and tiredness (Marx et al., 1998:38). Learners from low-income households have been found to be more likely to struggle with their engagement in school, due to varying experiences, including dilapidated/worse living conditions, continuous hunger and irregular access to health care (Jensen 2013). These situations can result in the impediment of cognitive growth and the learner's ability to learn (Hagell et al. 2013). Hence, learners from poor families are faced with challenges related to academic attainment. These challenges include the lack of food and clothing which surpasses educational goals when their health needs are not fully met (Bojuwoye et al. 2014). Compared to children from affluent backgrounds, children in low-income families are more likely to experience higher rates of acute and chronic medical conditions and learning and behavioural problems (Gracy et al. 2014). It has also been noted that children frequently face barriers to health care access that are associated with worse health outcomes (Larson & Halfon 2010). This suggests that these same health problems may become health barriers to learning and that schools with the largest proportion of low-income children may have an increased burden of student health problems (Gracy et al. 2014).

The majority of schools in the Western Cape are not excluded from the above-mentioned health problems and the related challenges that suggest the need for the provision of effective schools health services. It has been noted that the chance for success in school is possible when learners from poor backgrounds experience widespread school support in addressing unhealthy factors in their lives (Cornell & Mayer 2010). The World Health Organization supports the concept of health promoting schools in Africa as one way of building intersectoral collaboration, drawing on the Ottawa Charter for Health Promotion and the Jakarta Declaration for Promoting Health. According to WHO (2013), the Health Promoting School (HPS) concept fosters health learning with all the means at its disposal and provides a healthy environment, school health education, school health services, and school or community projects.

1.3. Problem Statement

There is a direct connection between learners' health, their performance at school and their prospects in the labour market in adult life. The health of schoolchildren is important not only for their individual well-being and their ability to benefit from education, but also because it may have long-term effects on the quality of society (Wagstaff & Mkhasibe 1988). In South Africa health problems still persist as a barrier to learning and as a threat that prevents many children from developing into productive citizens that can contribute back into their communities (DOH & DBE 2012). The school health service analysis in 2013 revealed that the ISHP operation had not fully enrolled in some schools in South Africa (Shung-King et al. 2014). Consequently, the immediate health problems of learners, the challenges regarding implementing health-promoting interventions, and the socio-economic factors including poverty, are the concerns of this research in the Western Cape formerly disadvantaged schools. The current sub-optimal provision of school health services in most parts of the country is attributed to a range of factors, including inequitable distribution of resources in both urban and rural settings (DOH & DBE 2012). This also raises the question of whether school health services in South Africa are or are not delivered effectively, because of inadequate facilities and the shortage of resources in the majority of schools. Since the introduction of ISHP, there has been limited research on the health outcomes and the learning difficulties that the ISHP was required to address in South Africa and inequalities in school health resource allocation gaps that still continue to affect schools (Du Plessis et al. 2014; WHO 2011). School health services are currently delivered by designated school health nurses who form part of the primary health care (PHC) staff component (DOH & DBE 2012:9). However, the review undertaken of implementation of the school health policy showed that nurses identified a number of challenges that impact on the provision of quality services. According to DOH & DBE (2012:9), these includes amongst others:

- Insufficient staff and infrequent visits to schools; this limits their ability to give children the time and attention that they need;
- Lack of or insufficient basic equipment and unavailability of transport and;
- Lack of conducive environments in classrooms for screening and examining children properly, including mental health assessment due to lack of privacy.

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Moreover, the role of parents of learners with regards to school health, particularly in disadvantaged areas, is not well documented in existing literature. Generally, it seems as if there is still a need to improve the implementation environment for the effective provision of school health services, particularly in the selected Western Cape formerly disadvantaged schools

1.4. Motivation and Rationale

The intention of the thesis is to determine the content of health information from a holistic view of health, with regards to the availability of effective school health services in the Western Cape formerly disadvantaged schools. The Care and Support of Teaching and Learning (CSTL) and Integrated School Health Policy (ISHP) 2012 frameworks were used as tools to fulfil this intent. The research is motivated by the step that was taken by the South African Government to "put children first" by committing to the aims to ensure that children's rights are upheld and that the provision benefits all children in order to reach their full potential. According to the Integrated School Health Policy (2012), this is parallel to the United Nations Convention on the Rights of the Child and children special recognition in the Bill of Rights of the South African Constitution. In essence, this is important in the formative school years, during which providing special attention to children's optimal health will improve not only their survival, growth and health, but also their learning outcomes and development (Integrated School Health Policy 2012).

The study is also motivated by gaps in CSTL and ISHP frameworks. According to the Department of Basic Education & Department of Health (2012), ISHP initially targeted the most disadvantaged schools with the sequenced plans for progressive implementation that aim to ensure that all schools benefit. However, it has been reviewed that some Western Cape formerly disadvantaged schools have no effective school health services for learners facing health problems at a particular point in time time as result of health service delivery which is not integrated in schools (Kwatubana, & Kheswa, 2014). Thus it is still an open question of how government departments concerned with school health links effectively with the school-based shared leadership, including School Governing Bodies (SGBs), in providing the effective school health services through CSTL and ISHP in order to benefit learners in schools. According to Donald, Lazarus, and Lolwana (2010), healthy development occurs when there is a concern for the environment in which teaching and learning take place.

As a teacher and community developer by profession, I have been working with principals, educators and parents of various schools within the Western Cape. In the process, I have realized that there are some parents, educators and principals who still have problems in dealing with ill health and other related challenges among learners. The research planned to explore ISHP aims in building and strengthening the existing school health services in the Western Cape formerly disadvantaged schools. Clarke (2007) perceived school as a happy place where learners feel welcome, secure and feel that there are adults who care about their individual wellbeing. This might be possible when learners' physically, emotionally and intellectually are supported through the existing effective school health services provided in CSTL and ISHP frameworks.

1.5. Research Questions

1.5.1. Main Question

How effective is the provision of school health services in the Western Cape's formerly disadvantaged schools?

1.5.2. Sub-Questions

1. What school health services are offered in the selected Western Cape formerly disadvantaged schools?
2. Is the ensuring of the provision of school health services in the selected Western Cape formerly disadvantaged schools important?
3. How does school health services provided in Western Cape formerly disadvantaged schools benefit learners?

1.6. Aim and Objectives of the Study

1.6.1. Aim

The aim of this study is to explore the provision of school health services documented within CSTL and ISHP in the Western Cape formerly disadvantaged schools.

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1.6.2. Objectives

The following objectives of the study were recognized:

- Firstly, to explore what school health services are being offered in the selected Western Cape formerly disadvantaged schools that might relate to the CSTL and ISHP.
- Secondly, to analyse what is working in terms of the school health services available and what the challenges thereof are in the selected Western Cape formerly disadvantaged schools.
- Thirdly, to recommend on how educators, principals and parents collaboration might stimulate the provision of school health services in the selected Western Cape formerly disadvantaged schools, while overcoming the challenges in implementing school health services related to the principles of CSTL and ISHP in their schools.

1.7. The Significance of the Study

The existing literature on the topic of the effectiveness of school health services delivery in schools as related to the CSTL and ISHP is deficient in some way. The researcher attempts to close the gap in that respect, by seeking to present the information that might contribute to the body of knowledge and building up on the existing literature. Therefore, the research may be of importance to schools that might need information to justify existing school health services offered or support services expansion. The study may also offer insight and provide the basis for further research, as it is a study which relates to the identifying of learners' health needs and the positive practices that provide effective school health services in terms of CSTL and ISHP in meeting the need. The study results may be useful in the reasoning for support and distribution of effective school health services to the selected Western Cape formerly disadvantaged schools.

1.8. Conceptualization of the Care and Support of Teaching and Learning (CSTL), Health Promoting Schools (HPS) and Integrated School Health Policy (ISHP) Frameworks

1.8.1. CSTL Framework

According to DBE & DOH (2012) the CSTL is a holistic framework, adopted by the DBE that looks at the full spectrum of interventions, across several different sectors that can enhance the well-being of school children. The strengthening of school health services represents one of

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the key components of the health sector's efforts to re-engineer and strengthen primary health care delivery and in the education sector provision of school health services is a key element of the CSTL with HPS (DBE & DOH 2012). Health Promoting Schools within CSTL is an initiative that focuses on the promotion of health, through partnerships between schools, the community and relevant sectoral partners such as health. CSTL began being implemented in schools in 2009, and is built on the principle of multi-sectoral collaboration including public and private, formal and non-formal education institutions at the community level (Department of Basic Education & MIET Africa 2010). The principles of CSTL involve guiding the care and support-related development based on education policies that place the child at the centre of individual, societal and political processes when considering the full provision of services, care and protection (ADEA 2009). Thus the child should be supported and protected by the family and household, but also by the schools and key institutions such as clinics, police and the community. This means that no single sector, structure or role-player can deliver the full services necessary for the child's educational wellbeing and development (ADEA 2009). The features of the CSTL are included within the essential packages of care and support for learners framework presented in the figure 1 below:

FIGURE 1: CSTL Essential Packages of Care and Support

Source: Van Der Elst 2011

DBE and MIET Africa (2010) outline the key elements of CSTL that focus on services including health services, counselling, attending to learners' illnesses and nutrition services to enhance learners' health and academic results. These are designed to promote the health of

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learners, identify and prevent health problems, injuries and ensure care for learners. The health promotion priority area of the CSTL provides the point of intersection for the school health and health-promoting school programmes that link with ISHP 2012, health education and with the school environment (Department of Basic Education 2012). Community participation included in CSTL framework is all about sharing and maximizing resources and expertise in advancing the healthy development of children, youth, and their families.

1.8.2. HPS Framework

The policy content and experience of the health promoting schools (HPS) in South Africa from 1994 to date, still focuses on benefiting learners and their communities, and to detect and prevent health risks through health services (WHO 2013). In South Africa the HPS framework had been developed around five key action areas denoted as SPECS. According to Struthers et al. (2013), S-P-E-C-S described as the following:

- Skills – to promote the health of all school community members;
- Policy – to develop healthy school policies;
- Environment – to create a safe and healthy school environment;
- Community – to strengthen interaction between the school and the surrounding community;
- Services – to access support services for the school.

The provision of school health services is a key component of the CSTL programme which aimed at realising the educational rights of all children and one of the pillars of health promoting schools is the provision of school health services, where the ISHP fits in (Integrated School Health Policy 2012). There is a noticeable reciprocal relationship between school health services delivery, health promoting schools and the CSTL and the ISHP frameworks. It is obviously when given the key factors of HPS through SPECS, CSTL's essential package of Care and Support and the principles of ISHP.

Even though HPS is a well-known international concept for the provision of school health services, both CSTL (which is confined to Southern Africa) and ISHP (which is limited to South Africa) stand for improved school health delivery. The policies, procedures, activities and structures within these frameworks were thus designed to protect and promote the health and well-being of learners, staff and wider community.

This was supported by the World Health Organization's programme "Global School Health Initiative" as it was designed to improve and benefit the health of students, school personnel,

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families and other members of the community (WHO 2011). WHO and other international agencies still continue to advocate for comprehensive, programmatic and varied interventions pertaining to the promotion of health, focusing on teachers and parents as well as learners (Mohammadi et al., 2010; Cushman 2008). Health professionals, health education and health promotion activities are fundamental requirements for the management of health conditions. However, mostly health education programmes are implemented but are rarely assessed to allow for future improvement (Sauls & Frantz 2014; Clift & Jensen 2005).

Health promotion as one of the key areas of CSTL's essential packages links directly with ISHP to create a healthy school environment by promoting the general health and wellbeing of school community members (DBE & MIET Africa 2010). The health-promoting school (HPS) approach within the ISHP incorporated elements of CSTL including the community aspects that address many factors affecting health in school context (Suraya Mohamed, Trish Struthers and David Sanders 2013). Consequently, ISHP recommends the use of community health workers (CHWs) for some health service delivery in schools. According to Suraya Mohammed et al (2013) CHWs play a bigger role in the ISHP by becoming a link between communities and schools, and advocating for the needs of the school community.

Both HPS and ISHP aim to provide common ground for an alliance between health and education and also between various professionals, disciplines, and sectors (WHO 2013). These two programmes are therefore inextricably linked and would be the 'health 'arm within the broader, education-driven, CSTL initiative. It is well documented that the HPS embrace the empowering of the communities to act together with health, education and other social services (WHO 2011). Similar, the implementation of the ISHP requires collaboration and linkages of different sectors, most importantly, the DOH and DBE, as well as the DSD (Integrated School Health Policy 2012).

The aims of health promotion in school context are realized through Health Promoting Schools included within Care and Support of Teaching and Learning and Integrated School Health Policy. According to WHO (1996), the HPS approach is one that constantly strengthens its capacity as a healthy setting for living, learning and working. Furthermore, HPS engages health and education officials, teachers, teachers' unions, learners, parents, health providers and community leaders in efforts to make the school a healthy place. Similar, the capacity building for the ISHP depends on re-orientation and training of PHC personnel to assist and support the delivery of the school health service within the ISHP (Integrated School Health Policy 2012).

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However, it is confirmed that low parental involvement in education and health of their children, particularly in the poor communities in South Africa, is a limitation for child development (Lemmer 2007). This means that a few parents being actively involved, if any, concerning learners' wellbeing in schools is not enough to benefit all learners.

1.8.3. ISHP Framework

According to DBE and DOH (2012) the Integrated School Health Policy is part of the comprehensive primary health package which operates within the DBE's CSTL Framework. One of the important principles of ISHP involves ensuring that appropriate assessment, treatment, care, and support services are available and accessible to all learners who are identified as requiring them (DBE & DOH 2012). The school health plan specifies objectives, including detecting and addressing health barriers to learning, providing accessible health care services to the learners and supporting schools in creating a safe school environment for effective learning (Integrated School Health Policy 2012). The ISHP focuses on addressing both the immediate health problems of learners including those that constitute barriers to learning, as well as implementing interventions that can promote their health during both childhood and adulthood (DBE & DOH 2012). This involves health screening, provision of on-site services and Health Education and Promotion framed as ISHP 2012 health services package for schooling phases Grade R- Grade 12 is presented in Table 1 below:

Table 1: ISHP School Health Services Package

Schooling Phases	Health Screening	onsite services	Health Education
Foundation phase (Gr R-3)	• Oral health • Vision • Hearing • Speech • Nutritional assessment • Physical assessment (Gross & fine motor) • Mental Health • Tuberculosis • Chronic illnesses • Psychosocial Support	• Parasite control: Deworming and bilharzia control (where appropriate) • Immunisation • Oral health (where available) • Minor ailments	• Hand washing • Personal & environmental hygiene • Nutrition • Tuberculosis • Road safety • Poisoning • Know your body • Abuse (sexual, physical and emotional abuse)
Intermediate phase (Gr 4-6)	• Oral health • Vision • Hearing • Speech • Nutritional assessment • Physical assessment • Mental Health • Tuberculosis • Chronic illnesses • Psychosocial Support	• Deworming • Minor ailments • Counselling regarding SRH (if indicated), and provision of and referral for services as needed	• Personal & environmental hygiene • Nutrition • Tuberculosis • Medical and Traditional Male circumcision • Abuse (sexual, physical and emotional abuse including bullying, violence) • Puberty (e.g. physical and emotional changes, menstruation & teenage pregnancy) • Drug & substance abuse
Senior phase (Gr 7-9)	• Oral health • Vision • Hearing • Speech • Nutritional assessment • Physical assessment incl. anaemia • Mental Health • Tuberculosis • Chronic illnesses • Psychosocial support	• Minor ailments • Individual counselling regarding SRH, and provision of or referral for services as needed	• Personal & environmental hygiene • Nutrition • Tuberculosis • Abuse (sexual, physical and emotional abuse including bullying, violence) • Sexual & reproductive health • Menstruation • Contraception • STIs incl. HIV • MMC & Traditional • Teenage pregnancy, CTOP, PMTCT • HCT & stigma mitigation • Drug, and substance abuse • Suicide
FET (Gr 10-12)	• Oral health • Vision • Hearing • Speech • Nutritional assessment • Physical assessment incl. anaemia • Mental Health • Tuberculosis • Chronic illnesses • Psychosocial support	• Minor ailments • Individual counselling regarding SRH needs, and provision of or referral for services as needed	• Personal & environmental hygiene • Nutrition • Tuberculosis • Abuse (sexual, physical and emotional abuse including bullying, violence) • Sexual & reproductive health • Menstruation • Contraception • STIs incl. HIV • MMC & Traditional • Teenage pregnancy, CTOP, PMTCT • HCT & stigma mitigation • Drug, and substance abuse • Suicide

• Note: An environmental assessment to be conducted in all schools:

First aid kit; Sick bay; Water & sanitation; Cooking area; Physical safety; Access for disabled learners; Ventilation.

Source: ISHP Resource Manual for School Health Nurses (SHN) April 2012

The ISHP 2012 health services package focuses on health education and promotion; learner assessment and screening; the provision of on-site services; follow-up and referral; coordination and partnership amongst all stakeholders; community participation; parents and learner participation. Similarly, the theoretical framework of this research highlights the family-school-community partnership which suggests that schools cannot be expected to address the learner's health and social problems in separation from community assistance. It is all about a collective practice that the School Health Support Team within ISHP should interact with School Based Support Team and direct all matters concerning the health of learners in schools (Shung-King et al. 2014; DBE & DOH 2012).

The health screening, on-site services, and health education components target all education phases, including foundation, intermediate, senior and further education and training phases. Additionally, an environmental assessment element is built in, intended to target all phases and all schools. It comprises aspects such as the accessibility of a first aid kit, proper water and sanitation, ventilation to counter airborne infections, and waste disposal. Significantly, the ISHP makes it clear that learners under the age of 18 need parental consent before they can receive any health services. Learners above the age of 14 may assent to receiving treatment, but should be advised to discuss the involvement with their parents or caregiver (DBE & DOH 2012). The expansion of services includes screening for developmental conditions such as hearing and vision, immunization, and health education with an emphasis on sexual and reproductive health, is envisaged once more finances become available (Pillay & Barron 2011).

1.9. Structure of the Thesis

This study is divided into five chapters. The first chapter introduces the study, as well as its orientation. The second chapter provides a literature review on health problems related to learners in schools and on the school health services. The third chapter describes the methodology of the research. The fourth chapter presents the findings of the study. The fifth and final chapter provides a conclusion and recommendations for the study.

CHAPTER TWO

2. Literature Review

2.1. Introduction

Chapter One provided a brief overview and orientation of the study where the background, motivation and rationale, and the significance of the study were presented. The research questions, problem statement aims, and objectives of the study were also stated. This chapter provides a literature review on school health problems, school health services available to address health issues and the challenges related to delivering school health services in the selected Western Cape township schools.

Sonawane (2017) claimed that school health services are rendered to learners in order to prevent illnesses and promote their health through the provision of a healthy environment, early diagnosis, treatment, and follow-ups. Searle et al., (1989:448) claimed that learners' health depends on today's decisions and actions; hence it is essential that their health is seen to be a social responsibility. These writers further indicated that the community owes it to the learners to create a safe school environment and to provide health services that will help to benefit learners' health. The intention of this literature review is to identify the gaps in the existing research, regarding the challenges related to the effective provision of the school's health services. It is important to review what has been documented before and to see how and why other scholars present similar research problems, in order to fill the gap when possible (Ntuli 2013). This literature review begins by looking briefly at the history of school health services in SA and other countries. Secondly, the review presents the general health problems of schoolchildren. Thirdly, the causes and effects of health problems of schoolchildren are discussed. Fourthly, school health services, effective provision of School Health Services that relate to CSTL and ISHP in South Africa, principles of ISHP and challenges related to delivering of School Health Services in schools are also provided.

Lastly, the theory framework consists of six types of involvement that operate within the three overlapping spheres of influence is provided. This chapter concludes with a summary of the review that points to the research direction.

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2.2. A Brief History of School Health Services Delivery

This section presents the evolution of the school health programmes across the world by looking at how the concept of the school health services was first developed in SA and other countries including Europe, India, and America. A historical review shows that the provision of a health service for school-aged children started quite early and has spread all over the world, thus most countries have initiated some form of school health service (Akani 2001).

According to Searle et al. (1989:448) school health nursing originated at the end of the 19th century in Europe and Britain. They further noted that the organized public health nursing was extended to schools in France in 1837, by the enactment of an ordinance which provided for health care for schoolchildren and for maintenance of sanitary conditions in schools. This was about identifying the school members with health problems, studying nutrition for learners and educated parents and teachers. A similar system was also introduced in the United States in the late 19th century and in 1902 the first school doctor was appointed (Searle & Brink 1985:473).

Sonawane (2017) described the beginning of school health services in India from 1909, when the first time medical examination of school children was carried out in Baroda city. The writer indicated that the Bhore committee in 1946 reported that school health services were practically non-existent in India, and where they existed, they were an under-developed practice. In 1953, according to Sonawane (2017), the secondary education committee emphasized the need for medical examination of pupils and school feeding programmes and in 1960, the government of India constituted a school health committee to assess the standards of health and nutrition of schoolchildren. The committee recommendations in 1961 led many state commands to provide school health services within five-year plans.

In spite of these efforts to improve school health in India, the provision of school health services is hardly more than a token service, because of a shortage of resources and insufficient facilities (Sonawane 2017).

According to Allensworth et al. (1997), the mid-1800s was characterized by the absence of school health programmes in the USA, until the late 1800s when Shattuck's report revealed that schools could play a role in controlling communicable diseases among learners. Writers founded that in the 1890s, schools in Boston and Philadelphia were early pioneers in forming supportive programmes with generous organizations to provide school lunches to combat

malnutrition. The period of health inspection in schools started at the end of the nineteenth century in response to problems of urbanization and immigration. In 1894, 50 "health visitors" were appointed in Boston to visit schools and examine learners who were thought to be unwell. By 1897, Chicago, Philadelphia, and New York had all started similar programmes and most of the contributing medical personnel provided their services without compensation (Allensworth et al. 1997). Following this, was Lillian Wald's postulation in 1902, that the school nurses could decrease absenteeism caused by communicable diseases to 50%, in a matter of weeks (Lynch 1977). According to Allensworth et al. (1997) school health became the focus of a variety of agencies and professional organizations between the 1930s and 1960s and many important documents emphasizing a range of health issues were published during this period. They further indicated that nationally and at state levels, maternal and child health agencies sponsored numerous conferences to improve school health services by linking them to other community health efforts.

South Africa realized in the early 20th century that schoolchildren had serious health problems when most of young men volunteers who were recruited for services in the First World War had physical, mental and emotional conditions that could have been treated and corrected in childhood (Searle et al. 1989:449). This raised a question of whether or not the schools could have played a role in preventing or correcting many of the observed conditions by providing health services to benefit the health of children. The great emphasis then was consequently placed on the health of schoolchildren. During the same period, the Transvaal Provincial Administration recognized the fact that schoolchildren need to be healthy and nourished if they are to perform well in school (Searle & Brink 1985:473). This led to the appointment of Dr. Louis Leipoldt as the first school doctor in South Africa. According to Searle et al. (1989:449), Ms. Frances Hassall became the first South African school nurse appointed in 1914, after Dr. Leipoldt established that no thought had been given to examining learners individually, or to the appointment of the school nurse. She was followed by other school nurses, appointed in Natal in 1916, Cape Province in 1918 and in Orange Free State in 1920 for the medical examination of learners. During the 1920s, the value of school-based nutrition schemes and the potential impact on children's health and educational performance resulted in the provision of school feeding schemes to poor white children (Duff Se 2013 in Shung-King, Orgill, & Slemming 2014:62). Obviously, it took a few decades before these interventions were extended to children of other "classified race groups". Throughout its history, the South African school

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health service took the form of a school-based outreach service led by the department of health (Shung-King, Orgill, & Slemming 2014:62).

According to Maillacheruvu and McDuff (2014), the social inequalities carried by apartheid in South Africa prevented holistic health care to black township communities from the 1940s-1990s when the country was liberated. Provision of school health services was based on the degree of differences in terms of race during the apartheid period (Mohlabi et al. 2010). This means that schools situated in privileged areas sustained a regular and good quality of school health services, while township-based black children received occasional services. Beyond the focus on nutrition, school health services eventually provided vaccinations and health screening assessments for hearing and vision problems (Shung-King et al. 2014:62).

According to Shung-King et al. (2014) adjusting the unequal provision of school health services established by the apartheid regime, South Africa launched its National School Health Policy (NSHP) in 2003. The NSHP was poorly understood, under-resourced and prioritized the district-level implementation of health services above school and learner coverage, which resulted in the absence of coverage to some schools. This disappointment in policy implementation provoked a reconceptualization of school health. In 2009, the Primary Health Care (PHC) Re-Engineering Strategy accepted school health as a possible vehicle for realizing broader policy objectives. In 2012, South Africa's Integrated School Health Policy (ISHP) was launched to substitute the NSHP and to support the comprehensive provision of school health services (Shung-King et al. 2014).

2.3. General Health problems of schoolchildren

Regardless of the efforts of countries, non-government organizations (NGOs) and communities, health problems still remain a problem among schoolchildren. The ISHP highlights health problems in schoolchildren such as hearing and vision impairment, poor oral health, HIV and AIDS, mental health issues such as psychiatric disorders, and risky behaviours including substance abuse and unsafe sexual practices (DOH & DBE 2012). The challenges facing schools that lead to learners' ill health including hearing, speech, vision, malnutrition, traffic injuries, non-communicable illnesses, tuberculosis, and other infectious diseases are the concerns of some schools in SA (Struthers et al. 2013). Hearing, speech and vision impairment are significant barriers to a child's learning and development (DOH & Furthermore, ISHP (2012) included that 81% of children with significant refractive mistakes had not been provided

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with spectacles. Learners from disadvantaged areas have more untreated ear infections and hearing loss issues, than middle-class children (Jensen 2013). Oral health problems and skin infections are the most commonly reported health problems in school-aged children in South Africa (Shung King 2012 in Shung King et al. 2014:61). Other preventable illnesses that occur in young children include fever, whooping cough, allergies, ringworm, headaches, diarrhoeal illnesses and higher incidences of asthma, that are mostly found in Third World countries (WHO 2011). Chronic illness as a measure of child health status is by definition an illness that lasts for a year or longer, whilst asthma is the most prevalent with an estimated prevalence in children of 13% (Shung-King et al. 2000:372). Estimates indicate that at least 1 in every 10 children has some form of chronic illness and other infections that have been part and parcel of poverty-stricken communities for decades, which are also not yet well controlled (Shung-King et al. 2000:372).

The socio-economic circumstances of the majority of schoolchildren are not optimal, almost 60% of schoolchildren live in poverty and almost 16% of children who enter school are stunted, some severely so, such that their ability to perform academically is already significantly compromised (Shung King et al. 2014:61). Many children, according to literature in South Africa, have to travel more than half an hour to school which exposes them to road accidents, violence and sexual abuse (Shung King et al. 2014:61). Considering health determinants, personal behaviour; lifestyle and community influences which can sustain or damage health, learning and living conditions, access to health services, socioeconomic, and environmental conditions provides insight into the burden of illnesses, which could help in establishing intervention programmes (Govender 2005).

2.4. Causes and effects of health problems of schoolchildren

2.4.1. Health-related factors

It has been illustrated that the acute respiratory infection (ARI), fever, and dehydration from diarrhoea are important contributing causes of childhood morbidity and mortality in developing countries (WHO 2003). These health problems include allergies, infectious and skin diseases that might contribute to the inability to learn (Landsberg & Kruger 2016). It has also been indicated that children with ear infections specifically have trouble with sound discrimination, making it tough to follow directions and understand the teacher and do highly demanding auditory processing (Jensen 2013). The reading ability might be discouraged as a result of

hearing loss or middle ear infection. Prompt medical attention when a child has the symptoms of these illnesses is therefore crucial in reducing child deaths. The review revealed that some health problems result in dietary deficiencies, including diarrhoeal diseases due to the inadequate food supplies and often caused by poor hygiene during the preparation of food (Williams et al. 2015). According to Landsberg & Kruger (2016), teachers in schools are uncertain of how to deal with an ill learner and might be overly sympathetic and forget to take into consideration the effect of the illness has on a child's school experience. Health problems develop at any phase of childhood and the way in which a family or school respond to the illness rests in the way they address the impact of the health problem. For instance, it has been indicated that illness may decrease peer interaction and make a child feel different. Ill learners may not progress with their peers to the next grade and this may increase their social isolation (Smith et al. 2014).

2.4.2. School Factors

The South African School Health Policy protects sick children against discrimination and supports teachers' focus on all learners in their classrooms including children suffering from common illnesses, or chronic diseases (Zuma et al. 2016). However, Khumalo and Mji (2014) established that the overcrowded classrooms are unsupportive learning environments, unhygienic and may even affect the learners' physical health, because if one learner has a contagious infection, then others can be easily infected. Education becomes ineffective due to the influences of overcrowded classes and other related challenges that result in poor concentration, poor eyesight and listening among learners (Khumalo & Mji 2014). Children are uniquely vulnerable to environmental and developmental factors, especially in the places where they live, learn and recreate (Mathee et al. 2018). The most important environmental hazards to children's health may be found in and around the settings in which they spend most of their time including their homes and schools (Chaudhuri & Fruchtengarten, 2005 in Mathee et al. 2018). The situation of learners avoiding going to the lavatory, due to the inadequate school facilities, still exists in the majority of the Western Cape schools that are surrounded by poor communities (Ngubeni & Gopa 2016). Unapproachable lavatories suggest that learners do not eat or drink all day to avoid requiring the toilet, which is the foremost to health problems among schoolchildren related to the poor focus in classes and ultimately dropping out of school completely. Physical inactivity among young people is a risk factor for heart diseases and

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cancer later in life (Micklesfield et al. 2014). The prevalence of physical inactivity is an estimated 43–49% among those 15 years and older in South Africa (Naidoo and Nyawose 2016). Although Blair & Raver (2012) emphasized that the social interaction with peers may be enabled by means of effective school and recreational activities, the opportunity for the majority of learners to be physically active during school hours is insufficient in the majority of schools in South Africa.

2.4.3. Socio-economic Factors

Health problems may place huge financial and emotional problems on families of ill learners. Families may suffer from tension due to the frequent loads of an ill child with health needs (Jaress & Winicki 2013). Furthermore, the two main contributing factors to school health problems in the South African majority of schools include poverty and malnutrition.

Poverty has been perceived as resulting in poor childhood health since the poverty-related illnesses in South Africa, such as childhood infectious diseases and malnutrition remain widespread (Currie and Vogl 2013). Schoolchildren experiencing poverty are more likely to struggle with engagement in school (Jensen 2013). Furthermore, according to Govender et al. (2016), financial limitations due to unemployment generate poverty that contributes to preventable illnesses, because of the inadequate basic necessities, including shelter, food, water and sanitation, health care and basic education. The experiences to the situations related with poverty facilitate Tuberculosis (TB) contraction – particularly in the presence of poor socio-economic status – overcrowding, and houses with poor ventilation in the developing nations (Khazaei et al. 2017). It has been perceived that malnutrition is a serious challenge in South Africa associated with inadequate child development and in provinces including Gauteng and Free State; many children are stunted because of persistent malnutrition (Statistics South Africa 2018). It has been documented that malnutrition remains common and the stunting affects one in five children in South Africa (Integrated School Health Policy 2012). Childhood stunting contributes considerably to the global disease problem (Black et al. 2008).

Stunting has been defined as an anthropometric measure of height-for-age by which a child is characterized as having stunted growth if her or his height is less than two standard deviations below the average height of a child at the same age (Devereux & Waidler 2017). The consumption of foods that lack adequate nutrients for an extended period of time has been

found as the leading cause of stunting (Labadarios 2007). Stunting is perceived as a serious health problem, as it can lead to reduced mental development, poor performance in school and to increase the risk for chronic lifestyle diseases later on (Reddy et al. 2010).

The high occurrence of stunting still poses a key health challenge in South Africa and it needs to be addressed in order to decrease the problem of disease and to save lives (Steenkamp et al. 2016). It has been pointed out by Coovadia et al. (2010) that delaying provision of required school health services to address the issue might result in children facing health and development barriers because of the growing burden of non-communicable diseases. Hendriks (2014) exposed the bigger rates of child stunting and the smaller rates of child nutrition in South Africa (See Figure 2 and Figure 3 below).

2.4.3.1. Stunting rates increase in South Africa

FIGURE 2. CHILDREN EXPERIENCING STUNTING IN SOUTH AFRICA, 1993-2012
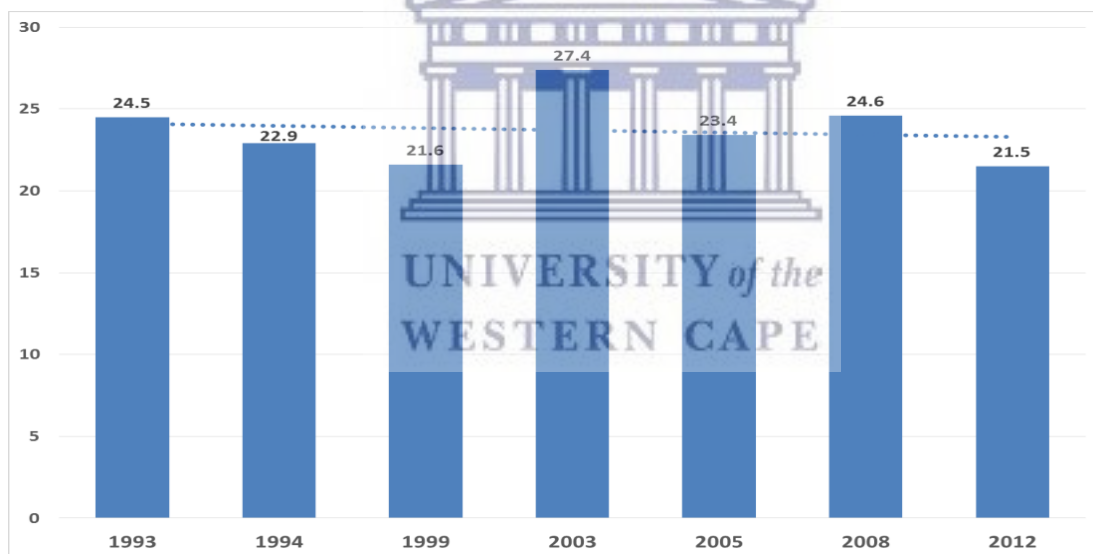
Source: 2012: data from South African National Health and Nutrition Examination Survey (SANHANES-1); n=2,044 children aged 0–6 years, data are for children aged 0-5 years (Shisana et al. 2013:21in Devereux & Waidler 2017)

Malnutrition contributes negatively on child development and the high prevalence of stunting in different age groups is also a cause for concern that is likely to have serious implications for future school performance (DBE & DOH 2010). Nutrition plays a crucial role for healthy children, although many children who grow up in poor families are exposed to food with a lower nutritional value which can adversely affect them in the womb (Antonow-Schlorke et al. 2011). The provision of school health services in ISHP 2012 also considers food insecurity and

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malnutrition, including under- and over-nutrition, with their consequences such as stunting and obesity. Conversely, Figure 3 below reflects the resistance of South African children experiencing the results of poverty.

2.4.3.2. Child nutrition rates decrease in South Africa

FIGURE 3. CHILDREN EXPERIENCING HUNGER IN SOUTH AFRICA, 1994-2012
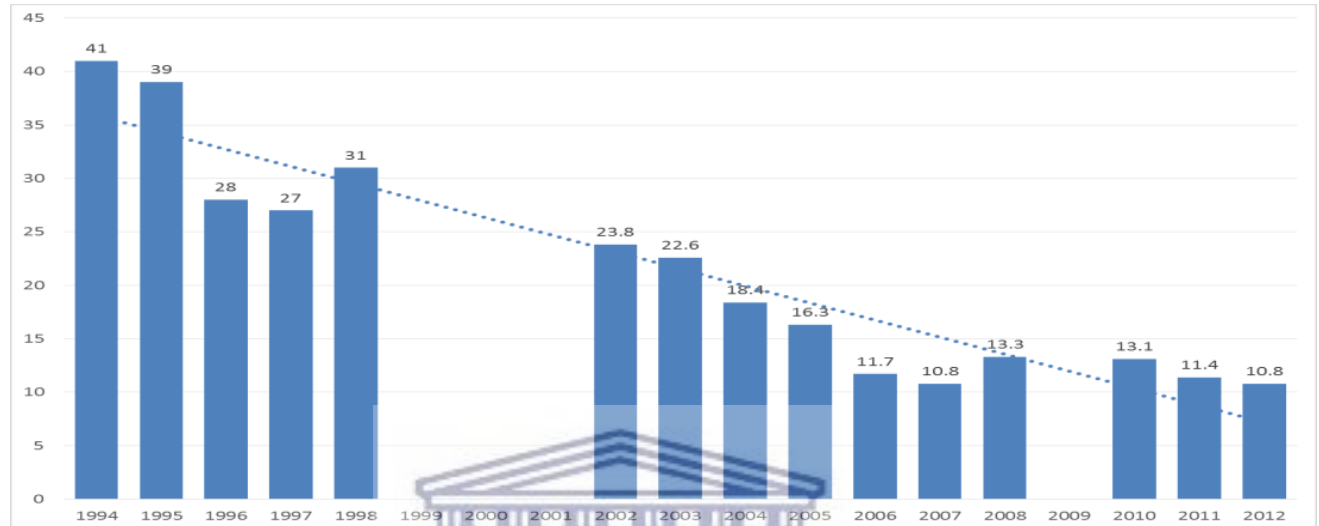
Source: Authors, derived from Aliber (2009, Figure 1); Hendriks (2014, Table 2)

Furthermore, poor nutrition for example at breakfast, affects children's brains and concentration (Taki et al. 2010). Skipping breakfast is highly prevalent among poor communities and it negatively affects learners' academic success by adversely affecting cognition and raising absenteeism (Basch 2011). Poor diets also affect behaviour and learners can often appear with low energy or hyperactive on a sugar "high" (Taki et al. 2010). When learners experience poor nutrition and diminished health practices, it is harder for them to listen, concentrate and learn (Jensen 2013:2). It has been showed that there is a need to provide school health services in order to overcome poverty-related odds, including hunger, stunting, and illnesses that may result in high rates of dropouts in poor community schools (Kamper 2008). Generally, a lack of access to health facilities and the inadequate hygiene standards that result in the poor school environment and in poor health control of children, has been founded as rife in some Western Cape formerly disadvantaged schools (Landsberg et al. 2016). Inadequate living conditions, lack of sanitation or clean water, home and school environment behaviours, poverty and limited access to health and education resources, all have a negative impact on the health of learners in schools which results in certain health problems that request for a need of provision of health services in schools.

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2.5. School Health Services

This study was intended to explore the provision of school health services available and its practices as related to the CSTL and ISHP in the Western Cape formerly disadvantaged schools in South Africa. School health services are a vital point of regular interaction between children and the broader health system (World Health Organisation 2016). School health is not merely hygiene, health promotion, health literacy or health education, but a combination of services delivery to ensure the physical, mental and social well-being of learners so as to maximize their learning capabilities (WHO 2016).

It is a fusion of nursing practices and public health services, a totality to maintain the health status of the school-going children and the health services provided to them to solve their health problems are called school health services (Sonawane 2017). School health services bring up the health care provision system that is operational within a school or college and aims at promoting and maintaining the health of school children, so as to give them a good start in life (Kuponiyi et al. 2016). Moreover, these services seek to enable children to benefit optimally from their school learning experience (Okafor 1991). Internationally the number of children reaching school age is estimated to be 1.2 billion children (18 % of the world's population) and rising (Ogbuji 2003). Consequently, the purpose of the school health services delivery is to help children at school to achieve the maximum health possible for them to obtain full benefit from their education. The goals of school health services differ at the individual school, district, and community and state level (Htun et al. 2012 and Ståhl 2012). Some of the contributing factors to these differences are the learners' needs, community means for health care and the availability of school funding. The general objective of school health services is to protect and maintain the learners' health, to prevent illnesses and rehabilitate learners who have been ill or have a health status below the standard (Struthers et al. 2013). This is achieved through the school health promotions, the introduction of health services in schools, controlling the school environment and providing necessary information (Bojuwoye et al. 2014).

The integrated school health policy (2012) noted that school health services are both preventive, curative services and useful information to parents and school personnel, regarding the health status of schoolchildren. School health services delivered for the benefit of learners in schools include pre-entry health screening, routine health screening, school health records,

a sickbay, and first aid and referral services (UNICEF 2007). Other services included are health observation (which involves physical inspection of the physiology and behaviours of children), health examinations (screening tests and medical diagnosis) and health records including health histories of children. The ISHP Resource Manual for School Health Nurse SHN (2012) indicated that learners, who are referred due to poor school performance, require full assessment, while learners referred for a specific problem including a skin condition, do not require full assessment. Moreover, the manual for SHN revealed that more services in future should be provided on-site, for example, within the current package for screening of visual problems most cases of learners that are identified as having visual problems are referred for further assessment. However, in an ideal situation, these services are provided on-site by an optometrist, and where possible this approach is encouraged (ISHP Resource Manual for SHN 2012).

2.5.1. Provision of School Health Services in Other Countries and in South Africa

The international literature revealed that once medical, mental health and psychosocial conditions are effectively prevented, identified, managed and treated, children have the greatest likelihood of fulfilling their potential in school and life (Gracy et al. 2014). This section provides a brief outlook of school health services delivery in other countries, including America, Australia, India, Nigeria, and Southern African countries.

2.5.1.1. United States of America

According to the American College Health Association (2001), health services refer to the services available for physical examinations, treatment for illness, health screening, health education, and promotion of healthy lifestyles. The association further noted that school health services are free or low cost, on-site, primary and protective health care available to schoolchildren. In the United States of America, Health Promoting Schools (HPS) concept means that all forms of safety and security while at school are met, including food, clean clothes, and medical attention when necessary (Cornell & Mayer 2010). In California, school-based health centers represent a model of care that responds to the physical and mental health issues of learners, by offering care in an accessible, youth-friendly environment (Soleimanpour et al. 2010).

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2.5.1.2. Australia

Lewin et al. (2014) claimed that school health services delivered in Western Australia utilize a population-based approach for health enrichment and early detection of health issues for learners. This involves a focus on working with learners, families and classroom educators for early detection of physical, psychosocial health and development issues which impede learners health and school achievements.

2.5.1.3. India

Baru (2009) highlighted school health services (SHS) in India as one that looks at school health in a holistic manner by locating the context of learner's socio-economic situations and by locating the health needs that arise from learners' backgrounds. In India, school health is regarded as a key aspect of leaners' health and an integral part of the education system and it involves practical work to look at the context and programmes that address learners' needs and then examines the engagement of health-related issues in the school curriculum. Baru (2009) also added that (SHS) in India brings together original exploration that addresses the learners' backgrounds and programmes, including nutritional programmes and school health services that are intended to address the nutritional needs and health concerns of learners.

2.5.1.4. Nigeria

In Nigeria, school health programmes entails health and educational programmes directed to meet health needs of learners and staff, as well as laying the foundation for their future through support from home, community, and government (Mbarie, Ofovwe & Ibadin 2010). However, the writers also confirmed that the school health idea in Nigeria remained largely at the policy level, with marginal implementation within the schools due to the lack of active participation by the stakeholders.

2.5.1.5. Southern African

Care and Support for Teaching Learning (CSTL) Programme is a Southern African Development Community (SADC) initiative that was adopted by Education Ministers in 2008 (Van Der Elst et al. 2011). It has been stated that the goal of the CSTL is to realize the educational rights of all children, including those who are most vulnerable, through schools becoming inclusive centers of learning, care, and support (DOH & DBE 2012). South Africa

is one of six countries (others include Swaziland, Zambia, Madagascar, Democratic Republic of Congo and Mozambique) implementing Phase 1 of the Programme 2008-2015. In order to realise CSTL goal, nine priority areas that address barriers to teaching and learning had been identified in chapter one. It is the evidence that CSTL intends to prevent and alleviate factors that have a negative impact on the enrolment, retention, performance, and progression of vulnerable learners in schools by addressing barriers to learning and teaching (Van Der Elst et al. 2011). The CSTL package of care and support described in the sub-section 1.8.1 (Figure 1), has as yet not been tested, because the defined essential elements have not yet been fully implemented (ADEA 2009). However, health promotion within CSTL relates to HPS which according to World Health Organisation (2016) is an approach rooted in the six key factors as indicated below:

1. Establishes and documents school policies that promote health and well-being;

2. Provides a safe, secure, clean, sustainable, conducive and healthy physical environment for learning;

3. Builds a secure school social environment that fosters positive relationships among and between students, staff, parents and the wider community;

4. Strengthens community links through connections and partnerships among families, the community, schools, organizations and other stakeholders;

5. Includes action competencies for healthy living in the formal and informal curricula for development of students' knowledge and life skills; and

6. Facilitates access to health–care and health promotion services.

HPS as underpinned by the Ottawa Charter is about the action areas including reorientation of services, community participation, development of personal skills, creation of supportive environments and development of policies for good health (WHO 2009a). This suggests that a good health supports lifelong learning, living, and wellbeing (O'Dea & Maloney2000).

For the learners to obtain a good health within schools, the HPS encourages school health services delivery and provides a supportive environment for health through health education and events, and active teamwork among school community members (Struthers et al. 2013).

2.5.1.6. South Africa

In South Africa school health services are health promotion and preventive school-based services delivered to children who attend formal schools (Shung-King 2013). In an attempt to the strengthening of school health services in the country in support of children's health

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throughout their school years, the South African government introduced the Integrated School Health Policy (ISHP) of 2012 to address school health problems. The ISHP is a joint developed programme by the Departments of Basic Education (DBE), Health (DOH) and Social Development (DSD) for the provision of school health services (DBE & DOH 2012).

South African school health services provided within the ISHP 2012 comprise health education, health screening, and some on-site health services health services and referrals (Integrated School Health Policy 2012). The aim of the ISHP is to improve children's health, reduce health barriers to learning, and assist learners to stay in school and perform to the best of their abilities. The Integrated School Health Programme also aims to promote attitudes and behaviours that will positively impact the current and future health status of learners. Despite the fact that the ISHP acknowledges the importance of intersectoral intervention, it has been reviewed that the package of proposed services will not fully address the social determinants of health (Mohamed, Struthers & Sanders 2013).

2.6. Effective Provision of School Health Services that relate to CSTL and ISHP in South Africa

It is clear from the problems described earlier, that prevention and health promotion could be the backbone of the health service response for the kinds of health problems that emerge with schoolchildren. It is also clear that many of the health problems that affect schoolchildren have their origin in social factors of health and would not be resolved through health-specific interventions alone. The launch of ISHP under the theme: 'Taking responsibility for our learners' health and wellbeing effectively', meant that the barriers to successful learning will be a thing of the past. The theme was a response to many children facing the barriers to optimal health and development as a result of the HIV and AIDS epidemic, violence, injuries and non-communicable diseases (ISHP 2012:34). Furthermore, a commitment was made to reinstating school health programmes in order to address the imbalances that contribute to unequal health outcomes for school children. This section looks at the South African school health services in response to these health requests of school-aged children, in the light of how school health services have been provided in terms of CSTL and ISHP principles. Challenges concerning the provision of school health services are also presented here.

2.6.1. Implementation of the ISHP

The ISHP being implemented in public schools as the Integrated School Health Programme supports South Africa's commitment to "Put Children First", as a signatory to the Convention on the Rights of the Child (Mohamed, Struthers and Sanders 2013). The ISHP emphasizes new developments for its implementation, including both the health and education sectors that require intersectoral and interdisciplinary actions. Departments of Health (DOH) and Basic Education (DBE) are signatories to the ISHP (Mohamed, Struthers and Sanders 2013). The Department of Social Development (DSD) provides assistance for learners to access services, particularly where financial barriers impede accessing services, including providing transport to health facilities where necessary (Integrated School Health Policy 2012:7). Primary Health Care (PHC) has four key components: curative, preventive, promotive and rehabilitative to ensure comprehensive health care and actions that can address the social determinants of health (Mohamed, Struthers and Sanders 2013). The ISHP identifies the DBE's Care and Support for Teaching and Learning (CSTL) framework as central to its implementation and the provision of school health services (DOH and DBE 2012). Implementing structure responsible for school health in South Africa is shown in Figure 4 below:
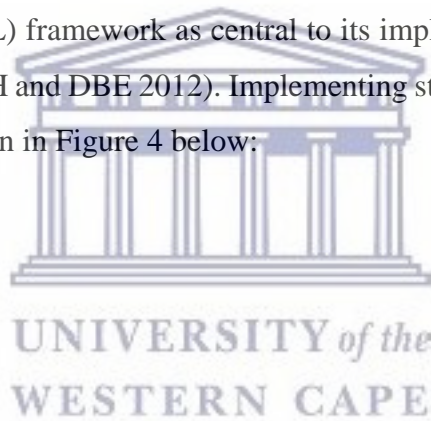
Figure 4: IMPLEMENTING STRUCTURE FOR SCHOOL HEALTH IN SOUTH AFRICA

National ISHP Task Team

⬇

9 Provincial ISHP Task Teams in various states of construction

⬇

At service provision level: DBE: a school-based support team. The functions of this team include overseeing schoolchildren's health concerns. This is a mandated structure as per the CSTL framework

⬍

Health: The school health team, managed by health facilities

⬍

A network of referral facilities, in various forms and functioning to varying extents includes (primary-level clinics, optometrists, dental services, audiology services, mental health services, social workers). For some of these services, such as optometry, contracting of private sector providers through public-private partnerships is required due to inadequate public sector capacity.

Source: Shung-King, M., Orgill, M., & Slemming, W. (2014).

Important progress made at national, provincial, district, health facility, and school level to support the management, coordination, and implementation of the ISHP involved setting structures and putting them in place (Shung-King et al. 2014). At the service-provision level, in particular, the school health team liaises with a school-based support team, which co-ordinates all matters in schools, including health that concerns learners. Despite the presence of health and education officials in these structures, which indicates a growing link between these two crucial sectors for the provision of school health services to curb health concerns of learners, it is not yet fully functional (Shung-King et al. 2014).

2.6.2. The Principle of ISHP

The ISHP is a part of the comprehensive primary health package within the DBE's CSTL framework (Integrated School Health Policy 2012). It clearly outlines health screening, on-site services, and health education as the basic elements to be employed when dealing with the school health problems (See section 1.8.3.).

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It further includes the principles listed below:

- Focus on achievement of health and educational outcomes;

- Ensure full coverage of all learners starting in the most disadvantaged schools;

- Ensure that appropriate assessment, treatment, care, and support services are available and accessible to all learners who are identified as requiring them;

- Be informed of local priorities;

- Take into account quality and equitability in the distribution of resources;

- Be implemented as a partnership between the Departments of Health (DOH), Basic Education (DBE), Social Development (DSD) and all other relevant stakeholders and role players.

2.6.2. General Guidelines for the School Health Nurse (SHN) to conduct School Health Services: As According to ISHP Resource Manual for SHN April 2012.

Adequate planning and preparation are essential to ensure that visits to schools run smoothly and that high-quality services are provided to all targeted learners. Planning and preparation include provincial health and district health forums with members comprising of Provincial coordinators of DBE, DSD and DOH, District coordinators, health specialists, NGOs, CBOs and partners (e.g. Spec Savers), engaged in paving for the delivery of school health services. The main duty of provincial health and district health forums are presented in Table 2 below:

TABLE 2 Tasks of Provincial Health and District health Forums

Provincial health forum duties	District health forum duties
Is to:	Is to:
• Clarifying roles and responsibilities of the respective Departments and partners;	• Develop an annual plan which must be jointly developed by the DBE, DOH, and DSD, and approved by the relevant managers and structures, including the District Based Support Team (DBST).
• Clarifying objectives, Health Services Package and yearly targets; and conducting a needs	• The plans are required to communicate to all role-players including the school health teams and

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analysis regarding equipment, medication, and services; and • Addressing challenges regarding HR, shortage of equipment and medication, collaboration, etc.	the School Based Support Teams (SBSTs). • The DBE District Coordinator and school health coordinator are responsible for ensuring that the School Governing Body (SGB), as well as parents /guardians /caregivers, are informed about the school health programme.

The forum members decide which schools require screening and on which dates; schools are informed of the estimated number of days that school nurses will be working in a particular school and what will be required for example a working space, 2 tables or 4 chairs. It is indicated that any challenge encountered is to be reported to the Provincial Task team. According to the ISHP Resource Manual for SHN (2012) Grade Rs and/or Grade 1s are to be visited in the first quarter of the school year, so that individual learner assessments and on-site services of the School Health Services (SHS) Package can be provided to these new entrants and then assessments of learners in other targeted grades can be undertaken.

It is also indicated that the schools are required to select a person responsible for liaising with the school health nurse, either a Life Orientation teacher or SBST member as delegated by the School Management Team (ISHP Resource Manual for SHN 2012).

2.7. Challenges related to delivering of School Health Services in schools

2.7.1. Lack of clear understanding of Health Promoting School (HPS) Initiative

Analysis of the ISHP recognizes many aspects that affect the health and overall development of school-age children (Mohamed, Struthers & Sanders 2013). However, despite a comprehensive PHC approach and the CSTL framework, there is a strong focus on service delivery to address pre-determined issues, with little acknowledgment of the other needs of the school community. Mohamed, Struthers, and Sanders (2013) established that the ISHP has very little emphasis on health promotion beyond health education. Health education, included in the Curriculum Assessment Policy Statement (CAPS) as Life Orientation (LO), is not a school health promotion manual (Peu et al. 2015). This means that it does not provide sufficient

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knowledge for teachers to facilitate school health promotion in preventing health problems among learners in schools. LO is an intervention that prepares children to make informed decisions about healthy lifestyles by focusing on individual behaviour change, which is a method that does not address the wider social determinants of health (Jacob & Frantz 2014; Peu et al. 2015). Lack of clear understanding of HPS and its interrelatedness to school health services led to implementation problems and has a negative implication on the quality standards and the provision of school health services in most areas in South Africa (Mohlabi et al. 2010).

2.7.2. Lack of support and policy guidelines for school health services

It has been indicated that despite several programmes directed at schools to improve learners' health in South Africa, inadequate implementation resulted in improper coordination that contributes to the lack of school health service delivery (Mohlabi et al. 2010). This suggests that numerous health and social challenges facing many learners in South African schools are still unattended, due to unclear policy guidelines for implementation and provision of school health services effectively. Moreover, Maluleke (2014) noted that some of these concerns include lack of parental involvement in some schools, as they are uncertain about how to play a more active role in their children's health and education. Educators also lack a working knowledge of identifying and integrating the ill learner into the classroom or to facilitate good peer relations with healthy children (Landsberg & Kruger 2016).

The ISHP implementation requires major financial and human resources support because of an inadequate number of school nurses at present (Mohamed, Struthers & Sanders 2013). Furthermore, the absence of school health nurses and mobile clinics to deliver onsite services when required, suggests unnoticed health problems in some schools due to a lack of health information and support a school nurse would have carried along during school visit (Pitsoe & Ramulumo 2013; Matlala 2014).

2.8. Theoretical Framework

The idea of school health services is the consideration of the values of community health services, school and its environment in working together to ensure learners achieve optimal health status and learning opportunities (Searle et al. 1989). School-family-community partnerships can help maximize resources or encourage sharing expertise that influences the healthy development of learners, their families, and their community (Lawson & Alameda-

Lawson 2011). In South Africa, school-family-community partnerships have been given official recognition through legislation and educational policies, including South African School Act (RSA 1996). Moreover, a fundamental principle of the ISHP 2012 is the collaboration between the Department of Health, Basic Education Department and Department of Social Development. Community-based implementation and School-Based-Health (SBH) teams working together in ISHP are the key strengths of ISHP that encourage interaction among school-family-community (Shung-King 2013).

This study was informed by the theory of overlapping spheres of influence. Joyce Epstein developed this theoretical perspective in the 1980s, based on the fact that the most effective schools and families have overlapping shared goals and missions concerning their children (Epstein 2001). The model recognizes family, school, and community as the three major contexts in which children learn and grow (Christenson & Reschly 2012). This theory fully supports Health School Promoting School concept as it fits in processes that enable people to make decisions about improving their own health and the communities and the engagements between parents, teachers, learners, community, health, and education personnel (Struthers et al. 2013). The model of overlapping spheres accepts that the mutual interests of families, schools, and community can be successfully promoted by the actions, policies and the programmes of associations (Epstein et al. 1997).

The three major contexts can be drawn together or pushed apart (Christenson & Reschly 2012). For instance, when educators adhere to the view of separate duties, they highlight the specialized skills essential of educators for school training and of parents for home-based training. The division of duties pulls the spheres of school and family influences apart through specialization (Epstein et al. 1997). Conversely, when instructors and guardians feature their common obligations, they bolster the speculation of aptitudes fundamental of teachers and guardians to make fruitful students. Their joint endeavors drive the spheres of family and school influences together, increasing the interactions between the parties and generating family-like schools and school-like families (Epstein et al. 2001). The theory's framework consists of six types of involvement that operate within the three overlapping spheres of influence including parenting, communicating, volunteering, learning at home, decision making, and collaborating with the community. For instance, Epstein's theory postulates the provision of information and workshops for families on health topics that relate to lessons taught in health education classes or physical education. The theory also considers effective

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forms of two-way communication designed from school-to-home and from home-to-school about school programmes and children's progress (Michael, Dittus & Epstein 2007).

This model embraces interesting prospects for SA specific contexts. According to Coetzee and Venter (2016), the SA Constitution supports a child-centered approach which demands a modified examination of the accurate real-life conditions for a specific child. The theory's framework is a child-dedicated model that guides educators and parents to collaborate in improving opportunities for learners in many areas including academic, social and health considerations (Christenson & Reschly 2012).

2.9. Conclusion

The literature review revealed factors contributing to school health problems and how the school health services delivery within CSTL and ISHP could respond to those concerns. Furthermore, Epstein's theory of overlapping spheres of influence as a guiding theory for the study was discussed. The following chapter discusses the research methodology of this study.

CHAPTER THREE

3. RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction

In the previous chapter the literature review on the effectiveness of school health services delivery related to the CSTL and ISHP in the Western Cape formerly disadvantaged schools was discussed. This chapter clarifies the tactics and methodology that were utilized in the discovery of answers pertaining to the research questions of this study.

The qualitative research method was selected for this study. Holloway and Wheeler, (2013) provide a reason for the choice of qualitative study that it explored and described the nature of the human condition, while serving to obtain responses from the participants regarding their experiences on the provision of school health services in their schools. This study also conformed to the following reasons for undertaking a qualitative approach (De Vos et al. 2005):

- The nature of the study problem relating to the 'how' and 'what' questions;

- The 'story' could be voiced from the participants' viewpoints;

- The study involved a study of individuals in their natural site.

According to Denzin and Lincoln (2011), qualitative research is difficult to define clearly, as it has no theory or paradigm that is distinctively its own nor a distinct set of methods or practices that are entirely its own. This means that qualitative research is a very broad school of thought and includes a wide range of approaches and methods found within different research disciplines. However, according to Ritchie, Lewis, Nicholls and Ormston (2013), a number of writers have attempted to capture the essence or defining characteristics of qualitative research, despite the diversity and the conflicting nature of underlying assumptions about its inherent qualities. At a general level, according to Flick (2009) qualitative research is often described as a naturalistic, interpretative approach, concerned with exploring phenomena 'from the interior' and taking the perspectives and accounts of research participants as a starting point. Denzin and Lincoln (2011) propose that in spite of the inherent diversity within qualitative research, it can be described as a set of interpretive, material practices that make the world visible. These practices transform and turn the world into a series of representations –

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including field notes, interviews and recordings, etc. Qualitative researchers study things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them (Denzin & Lincoln 2011). Other authors have focused on key features of research design that may identify a study as 'qualitative', including a concern with 'what' 'why' and 'how' questions rather than 'how many', a focus on processes, and the flexible nature of qualitative research design (Ritchie, Lewis, Nicholls & Ormston 2013).

This chapter provides a description of the research design and methodology used in this study. This comprises the selection of participants, data collection and analysis procedures, trustworthiness and ethical considerations observed of the study. In a nutshell, the literature review for the qualitative inquiry will be broadly discussed in this chapter.

3.2. Research Design

According to Yin (2003), a research design refers to an action plan that guides the study from the questions to the conclusions. It includes steps for collecting, analysing and interpreting evidence and findings. The choice of the study design for this investigation was motivated by the research questions and the aims of the study achievable through the objectives that were set (See section 1.3. and section 1.6.). A qualitative exploratory and descriptive mixed research design was employed.

Qualitative research approaches were used to explore and describe the perceptions and experiences of parents, educators and principals regarding the effectiveness of school health services delivery related to the CSTL and ISHP in the Western Cape formerly disadvantaged schools as supported by (Burns & Grove 2009). Furthermore, according to Marshall and Rossman, (1999) explorative and descriptive characteristics of the qualitative study provides the most suitable research design to explore and describe the attributes, including those of the provision of school health services within the participants' natural world.

3.2.1. Exploratory research design

According to Mohlabi et al. (2010), Health-Promoting-Schools notion is a fairly new concept in the context of South African schools as a result; little is known about what the mechanisms of a proper health-promoting school notion should be used. Van Wyk (2012) indicated that exploratory research design is the most appropriate for those studies that are addressing a subject about which there are high levels of uncertainty and ignorance about the subject, and

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when the problem is not very well understood or very little existing research on the subject matter. The exploratory research design was selected as the suitable design through which to understand the provision of school health services in terms of CSTL and ISHP frameworks in the selected schools and the situations in which schools functioned. Thus for that reason, the researcher entered the study field of the participants which includes the schools and conducted individual, in-depth interviews with participants. This allowed the researcher to explore questions of "what", "how" and "why" about the school health services offered in schools, beliefs, attitudes, and processes by which actions were created from the participants' worldview. Involvement in the area of study refers to the degree of dedication that the researcher was devoted to in reading, intuiting, analysing, synthesizing and drawing up the conclusions about the data collected during the study (Streubert & Carpenter 2011).

3.2.2. Descriptive research design

Polit and Beck (2008) defined descriptive research as research that "has its main objective the accurate portrayal of the features of people, situations, groups, and the frequency by which certain phenomena occur". In this study, the researcher explored and described the perceptions and experiences of the three population groups concerning the provision of school health services as related to the CSTL and ISHP in the selected schools. The descriptive method was incorporated for collecting data of experiences of the parents, educators and the principals concerned with the health of learners and delivery of health services in schools. This study is descriptive, because the researcher used the words of the educators, parents and the principals while the analysis is inductive, because categories and themes were derived from the data. The data collected was in the form of words which were obtained by conversing with all the participants and by taking quotations from the transcriptions of the interviews. The findings were rich and detailed and were gained by in-depth questioning.

3.3. Research Setting

The study was conducted in the three selected public schools comprising one public secondary school and two public primary schools. Primary schools in South Africa make provision for children from their reception year Grade R to Grade 7, while secondary schools admit learners

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from grades 8 to12. Two schools including a public primary school and a public secondary school (K1 School and K2 School) were selected from Khayelitsha and one public primary school (L1 School) was selected from Bishop Lavis. Two schools K1 and K2 were selected from the Metro North district of the Western Cape and one school L1 was selected from the Metro East district of the Western Cape. These schools presented common features that made them information-rich schools from which more about the practices, processes, and beliefs, attitudes and conditions in which health promotion in schools is manifested and may possibly be learned. The schools in the Metro East and North districts share a similar history, economic and social characteristics, as considered in detail under the section on schools' description and criteria of inclusion. Eight education districts were established in 2006/07 by the Western Cape Education Department (WCED) as part of the redesign process, based local government boundaries, to facilitate an integrated approach to service delivery by all levels of government, in line with national policy (Naicker, Combrinck & Bayat 2010). The districts include four rural districts (West Coast, Cape Winelands, Eden and Karoo, and Overberg), and four urban districts (Metro North, Metro South, Metro East, and Metro Central). Metro East and Metro-North districts, from which the schools were drawn, were also established then. According to Naicker, Combrinck and Bayat (2010) rural district, boundaries are based on municipal boundaries, while urban district boundaries are based on those of city wards. They indicated that the boundaries also allow for an equitable distribution of schools and resources across education districts and circuits. The K1, K2 and L1 schools became part of the city in 2006/7 redesign process and this partly explains why these schools exhibit features similar in terms of history, economic and social background. Primary and secondary schools in South Africa are organized under three categories: public fee-free schools that are subsidized by the government, public-private schools, and private schools. The schools of interest for this study were public fee-free primary and secondary schools.

3.3.1. School Sampling and inclusion criteria

The characteristic of the schools that would provide the best cases to provide perception into the school-health conditions that schools experience were first determined. This is supported by Merriam's (2009) argument that to discover the best case to research, it is essential for the researcher to first establish the conditions that will direct the case selection and then select a case that meets those conditions. In this study all schools were eligible and subsidized by the

government. Moreover, the researcher also worked with the K1 School as a contract educator, K2 School as a student teacher for teaching practice and with L1 School also as a student teacher for teaching observations and therefore the researcher was able to gain access to the population and the study setting hence they were included. This also suggests a purposeful sampling for schools which was conducted in this study. Silverman (2000) argued that purposive sampling allows researchers to choose a case, because it illustrates some features or process in which they are interested in. Other schools including two schools that were randomly approached by the researcher to conduct research with, did not respond back to the request by the researcher and were therefore excluded due to the time and financial constraints of conducting research with many schools or waiting.

According to Patton (2002), the reason for purposive sampling depends on selecting information-rich cases that allow in-depth understanding of the phenomena, rather than offering empirical details from a sample to a population. In this study, three schools were selected on the assumption that from these schools, I would be able to gain a perceptive and broad understanding of the provision of school health services, in order to report on the services delivery progress in those schools. This section presents a description of the case-study schools.

Both school K1 and school K2 are situated in Harare location within Khayelitsha Township, a dominant IsiXhosa speaking area in the Western Cape Province. The schools are located in a poverty-stricken community where most families live below the poverty line in the informal settlement. City of Cape Town 2016 Socio-economic Profile revealed that approximately 63 percent of households in the Khayelitsha district fall within the low-income bracket, of which 16.5 percent have no income and 50 percent of the increasing population is less than 19 years of age. The unemployment rate is high with those living in shacks and many homes are considered moderately to severely food insecure. Poor living conditions and sanitation for most areas surrounding the schools is evidence that can lead to the easy spread of disease. School K1 has approximately 1124 learners fluctuating from Grade 1 to Grade 7, an average of 43-44 learners per classroom and 26 teachers. K2 has approximately 1245 learners ranging from Grade 8 to Grade 12, an average of 30-41 learners per classroom and 32 teachers. Observation showed that K1 and K2 still have infrastructural challenges, including a high learner/teacher ratio, unreliable electricity, and water sources, some classes with broken windows including inappropriate building materials such as asbestos. In both schools, there are parents assisting in the provision of nutrition, cleaning and safe guarding of the schools. The selected school's

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feeding programme serves breakfast and lunch to learners to improve school attendance, to manage food shortages and malnutrition among learners, as well as to improve their school attendance. Delivery of nutrition and also cleaning material by suppliers were observed in K2 schools.

A mixture of different schools was not about comparing schools, as this is not a comparative study, but about observing the provision of schools health services from varying views, and contexts to gauge the depth and breadth of the school's health services delivery, hence L1 was included. L1 is an urban school situated in Bishop Lavis. Bishop Lavis is a dominantly Afrikaans speaking, formerly disadvantaged Coloured area. L1 is also a no-fee school using normal standards to pay or is subsidized by the government and falls under quintile 3, with 700 Grade1-7 learners, an average of 30-38 learners per classroom. The South African Schools Act was amended in 2005 to establish a quintile system. Under this system, schools are categorized into 5 groups (quintiles) based on the relative wealth of their surrounding communities. Schools in the poorest communities are classified as Quintile 1 and schools serving the wealthiest communities are classified as Quintile 5. Quintile 1, 2 and 3 schools are not allowed to charge fees and are often referred to as 'no-fee' schools. As in both the quintile 3 schools K1 and K2, L1 also has a problematic situation of poor sanitation and water supply. The immediate school background is socioeconomically underprivileged, has high unemployment rates, and small business undertakings to earn a living and high levels of crime which characterizes the area. The school atmosphere is peaceful; the researcher observed that educators team up among themselves and valued each other. The school principal is welcoming and warm. Her office is at all times open to those who want to see her.

It was not sufficient for the researcher to select schools without selecting whom to interview, in order to observe and learn from their understanding and gain an insight of the state of school health services delivery in public primary and secondary schools. The following section describes the sampling of the participants and their selection criteria.

3.4. Population and Sampling

3.4.1. Population

The population includes all elements that meet certain criteria for inclusion in a study (Burns & Grove 2003). For the purpose of this study, the population consisted a total of 15 participants

from Western Cape's Metro-North (Khayelitsha) and East district (Bishop Lavis), which included three principals, six educators and six parents (two teachers per school and two parents of learners per school). Creswell (1998) recommends 5–25 participants. These recommendations can help researchers in estimating for how many participants they will need, but ultimately, the required number of participants should depend on when saturation is reached. Saturation occurs when adding more participants to the study does not result in additional perspectives or information (Creswell 1998). In this study, the participants were diverse in terms of race, religion, and ethnicity, cultural and social backgrounds (Schneider, Whitehead, Elliot, and Lobindo-Wood & Haber 2007). The assumptions for this study were qualitative in nature; that the participants had personal experiences of the effectiveness of school health services provision through CSTL or ISHP and therefore had the ability to talk about the topic (Wood & Ross-Kerr 2011:123). The researcher was the primary instrument and was interested in the meaning that participants attached to their world, their personal and their experiences. To select people who understand the purpose of the study, who could speak English and willing to participate in the study was therefore crucial. In the selected schools educators including the principal, Life Orientation and Life Skills educators, parents including non-staff parents working in the schools' kitchens, cleaner and caretaker and volunteers were selected as illustrated in Tables below:

TABLE 3: Sample for in-depth interviews

School Name	Sampling Population	GENDER	Reason for Interviewing
K1	Principal 1	Male	The school principal has the experience of educational management in school and understanding of vision, mission, and policies applicable in school.
K2	Principal 2	Female	Same reason
L1	Principal 3	Female	Same reason

TABLE 4: Sample for the focused group interview

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School Name	Sampling Population	GENDER	Reason for Interviewing
K1	Teacher 1	Female	Grade 1-3 Life Skills educator: teaching learners to achieve their full physical, intellectual, personal, emotional and social potential and therefore familiar with school health services delivery
	Teacher 2	Male	Grade 4-5 Life Skills educator: Same reason
	Parent 1	Male	Caretaker: play a vital role in keeping the school environment neat by being responsible for the maintenance and security of school buildings. Familiar with the aspect HPS including healthy school environment
	Parent 2	Female	Kitchen Staff: play the key role of receiving and preparing food stuff for learners: Familiar with school health services delivery
K2	Teacher 3	Male	8-9 Life Orientation educator: teaching skills, knowledge, and values about the self, the environment, responsible citizenship, a healthy and productive life, social engagement, recreation and physical activity, careers, and career choices. Familiar with school health services delivery.
	Teacher 4	Female	10-12 Life Orientation educators: Same reason.
	Parent 3	Female	Volunteer in the school's food garden: Familiar with school health services
	Parent 4	Male	Caretaker: same reason as above

L1	Teacher 5	Male	The staff member responsible for first aid Kit in school: familiar with school health services
	Teacher 6	Female	Grade 4-6 Life Skills educator: Same reason
	Parent 5	Female	Kitchen Staff: same reason
	Parent 6	Male	None staff school cleaner: familiar with school health services delivery

3.5. Data Collection

The methods used to collect data for this study involved in-depth individual interviews, focus group discussions, and observations in the form of field notes. Rule and John (2011) support the collection data from more than one source, using more than one method for the purposes of triangulation. As the researcher I collected data by using a semi-structured interview guide that consisted of 17 questions, including 9 questions for in-depth individual interviews and 8 questions for focus group interviews for (Appendix B). Interviews allow collection of data from participants unable or unlikely to complete questionnaires, such as those whose reading, writing and ability to express themselves is marginal (Burns & Grove 2003). The setting for data collection was determined by the type of population group and a conducive, quiet environment was arranged for the in-depth individual and focus group interviews. Dates and times that did not interfere with school operations were arranged. For example, the in-depth individual interviews with the principals were conducted in the principal's office after school and focus group interviews with parents, educators including a principal, utilizing staff rooms of selected schools, were used as an appropriate setting during off duty time on Saturdays. Permission to conduct the interviews was given by the principals of the schools and the participants were given consent forms and the interview questions before the interviews were conducted to ensure the ethical procedures.

Although English is the medium of instruction in the Western Cape schools, for the majority of the participants, English was not their mother tongue. However, it was not essential to use an interpreter, because all Afrikaans or IsiXhosa speaking participants selected in this study understood English. I started visiting the school in the third term of the school year 2017. The availability of the some principals proved to be a major obstacle in some schools. I also worked

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as a contract assistant at the university and this factor, amongst other limitations, added to the challenge of commencing data collection. It was quite difficult to consult everyone in the selected schools.

3.5.1. Preparation of the Field

The office the principals had, had a table to place a recording device and for taking notes; the researcher's and principal's chairs were put in place apt for discussion to commence. In the staff room, a table big enough to accommodate six chairs, to place the recording device and for writing purposes was set and permission was obtained from the principal to use the staffroom during off duty times. There were six comfortable chairs positioned in a manner that conveyed a relaxed atmosphere in which a personal discussion could take place, an extra table for snacks and the door could lock. The venue thus provided security and privacy. The participants were familiar with the staffroom and the location could be considered as accessible without threats (De Vos et al. 2005). The recording devices that were used comprised of a digital recorder and a cellular phone. The recording devices were fully charged in advance and tested prior to each interview in order to ensure that the equipment was not unreliable and to avoid disruption during the interviews.

3.5.2. Field Notes as a Data Collection Method

Field notes are described as a written explanation of the effects the researcher sees, hears, experiences and thinks about throughout the process of collecting or reflecting on the data (Field and Morse 1994 cited in De Vos et al. 2005). This helped to recap what I had heard or observed when participants used non-verbal body language during interviews and focus group discussions. For instance, during the discussion; educators used gestures of stress and inability, nodding of the head and using of shoulders, with hidden meanings that added significance to the analysis of participants' opinions. The information was also collected through observing the situation as it happened, during the interview sessions and during LO period as I was allowed by the principal to observe LO periods. Notes were obtained on how LO controls health problems in and beyond schools, and how non-academic staffs preserve hygiene in school kitchens when preparing food for learners, as I was offered a sample during lunch time. The school environment and facilities, the number of teachers and learners, and the learner-teacher ratio per classroom were recorded to support with data analysis centred on school health

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problems. Observations were prepared and recorded in the form of field notes in a reflective journal, kept during the interview or immediately after data collection in order to prevent the loss of sequential flow of data in the order of the interviews.

3.5.3. Individual Interviews as a Data Collection Method

Three semi-structured individual interviews were conducted with the principals of the selected schools, using the interview guide (Appendix B). For this study, one-to-one interview method was used in the collection of data from each individual principal in their own offices, on different occasions. Ritchie (2003) claimed that individual interviews are probably the most broadly used method in qualitative research. They provide an opportunity for a detailed study of people's individual perceptions and allow an in-depth understanding of the individual context within which the study phenomena is located and for very detailed subject analysis. The questions probed were open-ended and thus allowed the participants to share their experiences. Each interview was in-depth and conducted in English. I guided the interview, listening carefully and probing for breadth, depth, and clarifications about health conditions in schools. Some of the probing questions emerged from the interview, while others were from the interview guide. I eluded probing leading questions in order to absorb from the participants without imposing meaning onto their interpretation of the provision of school health services situations. I upheld good connection with participants, allowing for the interview to become a comfortable discussion. The interviews varied in length and took no longer than sixty minutes. The principals were constrained for time and could not stay further than an hour. The recording device was replayed at the end of each interview to confirm with participants whether their meaning had been accurately captured. Finally, I switched off the recording device and thanked the participants for their participation in the study and for providing the information.

3.5.4. Focus Group Discussions as a Data Collection Method

Focus group discussions were used to collect data with educators, parents and principals. The aim was to achieve different perspectives concerning the provision of school-health service situations, in order to produce an understanding of diverse views. The cooperative nature of the group offered different views and interpretations that lightened the understanding of the situations in the provision of schools health services in schools. According to Kreuger and Casey (2000), a focus group provides a more natural environment than that of the individual

interview, because participants are influenced by each other's views, just as they are in real life. Lewis (2003) established that group discussions are helpful if there are some shared aims among the people in their relationship. Hence, the principals were also accommodated within the focus group discussions with educators and parents, as they all share the common aim for school improvement through the provision of school health services. The discussion began with the general question: What health problem do you encounter at school? Then, the debate went on as the participants cooperated freely to provide details about their school health problems, illnesses, and practices, processes and decisions that underpinned the need for school health services delivery. I kept the participants in an undisturbed mood as I listened sensibly, observed and encouraged them to exchange, using silence to let participants think, in order to deliver full analysis of their understandings regarding their school's health situation. The debates were lightly structured to permit the participants to interact within and among the group, which endorsed a deeper understanding of the schools' health practices and their implications for schools' core activities and the health of the school community. At the end of the discussion, the tape recording was replayed for the participants to verify whether the recorded reports mirrored their intended meaning and explanation of the situation.

3.5.5. The role of the interviewer

According to Patton (2002), the researcher is the instrument of both data collection and data analysis, because a qualitative approach includes having personal contact with and drawing close to the individuals and the situation under study. The researcher, as the key instrument, had to be professional at all times, even in his dress code, being neither overdressed nor underdressed. It is indicated by Welman, Kruger, and Mitchell (2005 that participants respond to the way the researcher is dressed. Being too overdressed or smart could result in the participant to feel intimidated and similarly, being dressed too casually, the researcher might be taken as not serious about the study. The key role of the researcher was to obtain the information needed for the study and he completed this by having discussions with the participants in order to extract as much information as possible about their perceptions and experiences on the provision of school health services, related to the CSTL and ISHP in their schools. The researcher did his best to position the participants at comfort during the individual and focus group interviews, pay attention wisely and offered a non-judgmental approach, whilst participants shared their experiences (Kvale 1996). I asked for further explanations from the participants during interviews and focus group discussions in order to expose the hidden

facts and meaning to avoid confusion or replacing participants' meanings with my predetermined ideas or assumptions and life experiences. The foremost skills utilized by the researcher was listening and observing skills to disclosures and signal expressions of the participants. The fact that I understood the participants' language(s) and familiarity with the schools' contextual background, helped in providing understanding into what participants revealed and meant. Coming from the same background assisted me to overcome complications of body language, and contributed to the precise analysis of the meaning that participants revealed to the discussion about the provision of school health services in their schools. It is indicated that sharing some features of social background or understanding may be helpful in elevating researcher's understanding of participants' explanation, their language and their tones and suggestions (Arthur & Nazroo 2003).

3.6. Data Analysis

The process of data analysis involves making sense out of text data, preparing the data for analysis, conducting diverse analyses, moving deeper and deeper into understanding the data, representing the data, and arriving at an explanation of the larger meaning of the data, Creswell (2009). Qualitative data analysis is further defined as largely an inductive process of organizing data into categories and identifying patterns or relationships among the categories (McMillan & Schumacher 2006). In this qualitative study, data analysis was not a separate phase, but happened concurrently with data collection and only data which was collected and transcribed during or after the individual interviews, plus focus group interviews were analysed.

Qualitative data analysis in this study involved making logic of the data in terms of the participants' definitions of the situation, noting patterns, themes, categories and regularities (Cohen, Manion & Morrison 2008). The researcher transcribed data collected during interviews and observations from the recording device and field notes, to translate it into an arrangement that would facilitate analysis. The researcher specified who was talking in the written text by putting "I" for the interviewer and "R" for the respondents, in order to facilitate analysis during the transcription procedure (Polit & Beck 2008). The researcher also showed overlaps in speaking turns; time pass-by between words, such as moans and excitement and emphasis of opinions. To ensure flexibility and accuracy of the transcribed data, the researcher transcribed the data on his own, so as to get closer and more familiar with the data (Polit & Beck 2008). When transcribing of the data was done, the researcher read each transcript and re-read several

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times, sentence-by-sentence, one at a time, highlighting phrases, passages and words, and behaviour patterns relevant to the study. The reason for this inductive analysis was to examine the data for the connections that were between codes, categories and themes and the other views voiced by the participants. The transcripts were coded by making use of an expert in qualitative research who assisted the researcher in order to ensure the reliability of data coding (Gorden 1992).

The researcher altered the data into smaller and more manageable units that could be revised and retrieved. The data analysis process involved taking groups of data and reducing these groups into categories and themes and after the themes had been identified, they were reported in a meaningful way for the intended audience (Streubert & Carpenter 2011). The relevant data units or codes, subcategories, and themes that emerged were marked as follow:

Interviewer: Tell me about the health problems that you encounter within your school?

Respondent: Well, health in schools is affected by various *problems that schools have*. We have the *problem of overcrowding* of many children per classroom 45:1 and obviously most of learners do not pay attention when teaching occurs, some are not listening or they can't hear you as teacher you have to repeat yourself, some are scratching their eyes or cannot see what is written on the board. Also, our *toilets are not always clean*, its either they are *blocked or overflowing and leakages* that *create dumps* outside with unkind smell which can lead to *accidents and diseases*. Some learners are coming *from poor families* where their *parents are not working* and some they come to school with an *empty stomach* because they know they are going to get at least a meal.

Firstly, I selected a research question and ask "what is this about?" then identifying keywords such as 'problems' 'illnesses' 'unhygienic', 'poverty' 'unemployment' 'background' of schools; classrooms or home; overcrowded. Secondly, the responses were categorised according to the keywords, such as the health problems; school background; school facilities; learner background. Thirdly, categories were consolidated into subthemes such as inadequate school facilities or overcrowded classrooms. Lastly, subthemes were organized under main themes, such as the School Health Problems that Originate from School-Based Factors; School Health Problems that Originate from the Learners Background.

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Data analysis was conducted following eight steps of Tesch (1992) below:

1. The researcher got a sense of the whole by reading through transcriptions.

2. The researcher selected one interview, asking: "What is this about?" not thinking about the information, but rather the underlying meaning of the data. The research wrote all his thoughts in the margin of the page.

3. After completing this task for several interviews, the researcher gathered a list of all the topics. Similar topics were clustered together and formed into columns that were arranged into major topics, unique topics and leftovers.

4. The researcher took the list and returned to the data. The topics were abbreviated as codes and the codes were written next to the appropriate segments of the text. The researcher then looked at whether new categories and codes had emerged.

5. The researcher looked for the most descriptive wording for the topics and turned them into categories. The researcher reduced the total list of categories by grouping together similar topics.

6. A final decision was made on the abbreviations for each category and the codes were alphabetized.

7. The data belonging to each category was assembled in one place and a preliminary analysis was performed.

8. The researcher recoded existing data if necessary.

3.7. Measures to ensure trustworthiness

Trustworthiness is described as rigour in qualitative research without sacrificing relevance (Lincoln & Guba 1985). Measuring trustworthiness according to Polit and Beck (2008) is a method which includes five aspects namely: credibility, dependability, confirmability, transferability, and authenticity.

3.7.1. Credibility

Credibility refers to confidence in the truth of the data and how well the data processes, analysis, and interpretations address the intended focus of the study (Lincoln & Guba 1985). Credibility in this study was sustained by the use of self-reflection, integrity and reflexivity as

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suggested by (Streubert & Carpenter 2011). This aided the researcher to be focused on how his opinions and attitudes could influence the study, either the collection of data or the findings. The researcher ensured credibility by doing member-checks with the participants to ensure an honest interpretation of the participants' views, by giving the participants the opportunity to correct mistakes and challenge interpretations. The researcher returned to some of the participants to discuss the interpretation of the collected data and confirm the reported findings as a true illustration of their experiences (Streubert & Carpenter 2011). Member-checks also provided an opportunity to recap the collected data, considered as the first step to data analysis (Lincoln & Guba 1985).

3.7.2. Dependability

Dependability refers to the reliability of data over time, conditions and over occasions (Polit & Beck 2008). This is one of the measures for judging the rigor of qualitative research and is allied to the consistency of the findings (Lincoln & Guba 1985). In this study, dependability was ensured through a consistent, well-documented report (De Vos et al. 2011). An analytical audit was done by the writing center expert and the researcher's supervisor checking the researcher's data, interpretations and findings. The goal of the audit inquiry was to establish the trustworthiness of the findings by performing an inspection of the study by peer researchers (Brink et al 2006). In this study, the official inspection of the collected data was made by the researcher, peer researchers, the participants, and the researcher's supervisor.

3.7.3. Confirmability

When a study shows certain features including credibility, auditability and appropriateness, then that study is considered to have confirmability (Streubert & Carpenter 2011). Confirmability transpired with credibility and the researcher achieved confirmability through the criteria of reflexivity, persistent observation, peer and participant debriefing, prolonged engagement and member checks (Creswell & Miller 2000). In this study auditability was confirmed by the use of field notes, keeping a record regarding dates and times of interview schedules and related data about the interviews. This proves auditability as there is an audit trail for others to check for truthfulness and reliability.

3.7.4. Transferability

Transferability refers to the extent to which the findings can be transferred or have applicability to other settings and target populations (De Vos et al. 2011). In order to achieve transferability, the researcher has provided a dense description from the data about the nature of the study participants, their stated experiences, and the researcher's observation during the study (Stommel & Celia 2004:289). The researcher has identified and defined sufficient data and compiled the report such that it can be applicable to other similar settings/contexts (Polit & Beck 2008).

3.7.5. Authenticity

Authenticity is defined as an important component of establishing trustworthiness in qualitative research that may be of some benefit to society (Guba & Lincoln 2005). Authenticity emerged in this study when it conveyed the fairness (Given 2008).

The researchers needed to ensure that participants have equal access to the research inquiry to avoid bias, for example, by developing research relationships that go beyond stereotypical roles of question asking and answering from the outset of the research (Seale 1999). Adopting this approach means that participants become responsible for the social reproduction of the research inquiry, in which they have a part and so have a stronger investment in ensuring that the outcomes of the inquiry are authentic (Given 2008; Guba & Lincoln 2005). The researcher avoided marginalization of participants during the inquiry process and ensured that all their voices, views and their perspectives were represented throughout the research process and in any texts where their stories should be treated fairly (Given 2008).
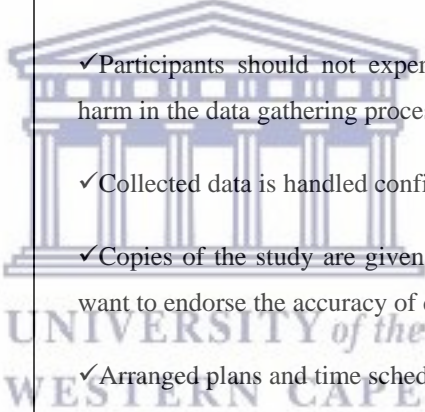
3.8. Ethical Consideration of the Study

The ethical considerations were adhered to, and this study was approved by the Ethical Committee of the University of the Western Cape. School principals of the selected schools and the WCED permissions to do research in schools were obtained. The participants were knowledgeable of the intention to develop the collected data for the research results. According to Ntuli (2012), ethics are groups of moral principles, guidelines, and codes that guide the actions of the researcher when conducting a study. Rule and John (2011) encourage researchers to conduct research in an ethical manner to enhance the quality of the research and its

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trustworthiness. The three principles that represented the ethics of this study concerning human subjects were autonomy, non- maleficence, and beneficence (See Table 6 below). Autonomy refers to the respect of participants' rights and confidentiality of information gathered from them for the study. Non- maleficence relates to the absence of risk in the collection of the research data. Beneficence relates to the benefits of the study.

TABLE 5: ETHICAL PRINCIPLES APPLICABLE IN THIS RESEARCH

Ethical principle	Application in this study
Autonomy: ✓Respect partakers' right to independence.	✓ Gain ethical approval from the Ethical Committee of the University of the Western Cape, Bellville. ✓ Acquire permission from DoE to do research in schools. ✓Complete anonymity is not possible due to focus group (face to face) interviews, however, no names are used. ✓Personal information of partakers is controlled in confidence. Non-compliance disclosure is left out. ✓ Participants can withdraw at any time. ✓Investigator respects the intellectual property of respondents.
Non- maleficence: ✓"Do no harm or No Risk."	✓Participants should not experience any emotional or physical harm in the data gathering process. ✓Collected data is handled confidentially. ✓Copies of the study are given to the DoE and participants who want to endorse the accuracy of data. ✓Arranged plans and time schedules are kept. ✓Interview setting is kept comfortable where focus groups are relaxed, offered seats and water.
Beneficence: ✓ To do good. ✓ To the benefit of participants and the community at large.	✓ Be sensitive to any physical or emotional discomfort. ✓ Provide for participants' special needs. ✓ Offer breaks according to specific uneasiness, e.g. break times (physical needs) or counseling (emotional incident). ✓ Provide feedback if requested. ✓ Advocate recommendations and action plans to the relevant authority based on study results.

3.9. Limitations of the Study and Recommendations for Further Research

The findings of this study are limited to the three Western Cape formerly disadvantaged schools in two districts in the Western Cape Education Department and could therefore not be generalized to all provinces in South Africa. The study concentrated on the views of the educators, principals, and parents concerned with the provision of school health services in the Western Cape formerly disadvantaged schools.

For future research, a larger number of participants, government departments, learners, school nurses and the wider community including schools in suburban areas could be included to gather more information on the topic.

3.10. Summary

This chapter provided a detailed discussion of the qualitative research method of data collection, including focus group interviews, in-depth interviews, and non-participant observation. Procedures for data analysis, rigours and ethical considerations were also described. The following chapter will present the findings of the research and interpret the qualitative data collected.

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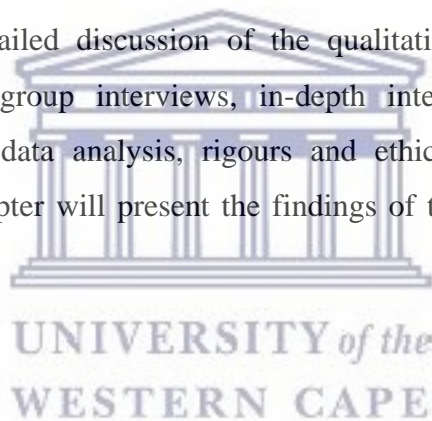
CHAPTER FOUR

4. FINDINGS AND DISCUSSION OF THE STUDY

4.1. Introduction

The preceding chapter provided a detailed discussion of the qualitative research design and methodology, as well as the way that the study was conducted to investigate the research questions. The main aim of the current chapter is to present the findings of this research.

4.2. Presentation of Findings

According to MacMillan and Schumacher (2010), qualitative research incorporates worldviews, theoretical frameworks, and the research problem into the meaning that the individuals or groups assign to a social problem. This section deals with school health problems and the aspects of school health services experienced by the participants. This study identified the following main emerged themes:

- School Health Problems that Originate from School-Based Factors;

- School Health Problems that Originate from Learners Backgrounds;

- Available School Health Services that Address School Health Problem in the Selected Schools.

4.2.1. School Health Problems that Originate from School-Based Factors

These school health problems were the main points for the request and ensuring of the ISHP implementation in the Western Cape formerly disadvantaged schools.

The participants exposed a need for better understanding of the ISHP and the provision of health services through necessary mechanisms, information, and personnel to address school health problems without loss of time for education activities in their schools. For the participants, the absence of facilities, mobile clinics or school-based-health-care for that matter to attend health problems at all times with schools, has a negative impact on schools' core activities and health of learners.

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4.2.1.1. The following sub-themes were recognized:

Inadequate School Facilities and the lack of school-based-health-clinic or health room that provides primary health care in the Western Cape formerly disadvantaged schools were considered by the participants as the contributing factors to school health problems in these schools. The participants were concerned by the learners who experience poor sanitation situations in their communities and again in schools. These unmet needs reflect larger issues of the selected schools concerning school infrastructure and community safety. Brink et al. (2012) also pointed out to the accidents occurred either at school, on their way to school or at home as part of the health risks to the school-age children that require the school health services to possible.

This is also supported by the observations recorded concerning the school environment and facilities that are inadequate. For example, some of the selected schools at the back yard, had open spaces in the fencing, used by learners as a short cut into or out of the school, when either the none-academic staff employed as caretaker or gardener is not watching and the dumps near water taps where there is no drainage.

To illustrate this situation in the selected schools, Teacher 1, Teacher 2 and Teacher 3 had the following to say regarding inadequate school facilities and unreliable infrastructure:

Teacher 1: The problem we are facing is that of the toilets which are too close
to the classrooms, few for the number of children using them and
when there's a blockage or overflow it become chaos and the
unkind smell is inhaled by the children. The sinks within the toilets
tend to leak and spill all over to nearby classrooms to create
slippery dangers. Community members with plumbing knowledge
are sometimes hired by the school for maintenance. When they are
found they are quick to fix a problem since the municipality is slow
and come when it suits them to fix the problem.

Teacher 2: We do not have heaters in our classrooms and some of the broken
windows in some classrooms mean that learners are freezing when

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it's cold. This is what contributes to learners' absenteeism or passiveness in our school or classroom due to the fever or flue acquired during getting cold in a school classroom. So as a teacher I wear warm clothing enough to stand in a classroom with broken windows when it's cold and I leave after the end of a period but the learners are strictly required to wear a uniform. Some do not have a full uniform and end up wearing a shirt even when it's cold... so that is when they are vulnerable to cold, flu and fever in school special when the broken windows are not fixed immediately.

Teacher 3: Our toilets are blocked and they need to be cleaned, sinks from the toilets are mostly leaking. Most of the time the toilet is flowing, it's always flooded with dirty water. When we are in the classrooms, we must close the windows and door for the smell. Half the numbers of the lavatories do flush and the remaining half does not flush.

Landsberg and Kruger (2016) claimed that the unmet hygiene standards by the formerly disadvantaged schools and the poor control of the school environment generally result in the school health problems including allergies, common illnesses, and unnecessary accidents. During the focus group interview Teacher 4 confirmed that the hygiene problems lead to the illnesses:

We do have a problem with learners that have allergies and most of the time we do not have soaps or detergents except the stock that was provided by a certain firm that is finished, so we end up saying they must rinse their hands before they eat. So I think it could be better if a school can buy or provide one soap or detergent per classroom each month, so that even if the kids are from the toilet they are able to wash their hands...generally, a hygiene problem is an issue in our school...I took my kid from nearby pre-school to the suburban one where there are enough resources...here there are not enough mattresses and my kid can easily get infected with illness when they all sharing few

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mattresses with dirty blankets… so even in preschool lack of funds to buy cleaning materials is also a concern.

The lack of adequate hygiene products and disposal services is another form of the health risk for female learners which forces them to be absent from school throughout their menstruation cycle (Ngubeni & Gopa 2016). These health issues have a negative influence on the learners' health, their ability to learn and on their academic achievement. Principal 3, during the individual interview, had the following to say concerning the challenges presented by a lack in addressing school-related health problems in the selected schools:

Principal 3: We do not have school-based health clinic, or a health room that provides primary health care in our school; it is unbelievable that for many of our learners who undergo poor sanitation conditions in their communities, the school setting does not offer more dignified amenities.

Parent 1 and 2 voiced their concerns about the lack of feminine hygiene products in School K1 when they were asked about any modifications they would suggest regarding the school environment during the focus group interview:

Parent 1: More dustbins, pad bins, and regular mobile clinic visit are all necessary for our school.

Parent 2: Blockage in school toilets are also due to the lack of these sanitary bins or dustbins…learners are incorrectly disposing of their used stuff because of lack of these bins…and it is unhealthy for the whole school.

The above statements strongly link to the fact that only staff toilets have the pad bin and hand soap by observations. Participants voiced their concerns of *Overcrowded Classes* and the related problems that characterize the Western Cape formerly disadvantaged schools. Adding to the issue of high learner-teacher ratio situations is the spreading of infectious diseases where detecting health problems among learners remain problematic in the selected schools. During the focus group interview Teacher, 5 expressed the following:

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Fever and headache are the health problems mostly experienced by learners in schools and it is sometimes awkward to ensure that all learners have been immunized prior to enrolment in an overcrowded class situation.

The issues of overcrowded classrooms and lack of school health infrastructure in the Western Cape formerly disadvantaged schools was thus central in these results and by observations particularly K1 and K2 schools have big numbers of learners per classroom. The participants maintained that the illnesses negatively affect their social interactions, particularly in overcrowded classrooms. During the individual interview Principal 2, said the following:

There is no school health infrastructure and the protection of learners from the spread of tuberculosis and respiratory diseases that are still problematic in school due to overcrowded classes. There is the Desmond Tutu HIV Community Centre on Norms and Standards for School Infrastructure which emphasizes school infrastructure and protection of learners from the spread of tuberculosis and respiratory diseases. But the problem, we still have to consult in order to have those facilities.

Large and overcrowded classrooms result in negative impacts including the issue of spreading infectious diseases (Khumalo & Mji 2014). During the focus group interview Teacher 6 aptly described the impact of overcrowded classrooms in response to a question of how to ensure a safe and healthy school environment for teaching and learning, as follows:

Unhealthy children might be a danger to other children… chicken pox is a problem we are facing with every now and then because children always interact with each other in an overcrowded situation as our classes are …which is easy to pass chickenpox to one another because an infected child may spread it by coughs or sneezes… that is why we encourage them to put a tissue, handkerchief or even hand when coughing.

Lack of Information and Support for School Health was viewed by the participants as the result of a narrow understanding regarding school health policy and ISHP implementation in their schools. At L1 school during the focus group interview Teacher 5 and Teacher 6 said the following:

Teacher 5: I am not aware of the Integrated School Health Policy as it was never presented in our school, the only people promoting health is Metropolitan and you know…and all these medicals people like Discovery…government need to have a workshop to teach educators, community and parents about the importance of making sure that learners are healthy and are not at risk.

Teacher 6: We do not have any health supporting materials on our own so instead we have to call the parent in case of emergency or accompany the child and take the child home …if school nurse can come every quarterly year to listen on the health issues we are facing and to assist in improving health status in our children then it could be better… because the government does not provide everything… educators have workload… First aid is good, but teachers also need to have workshops to alert them on school health promotion…because some universities do not provide first aid courses to their student teachers… Yes, I think I am aware of School Health Policy… we do have such policy in our classrooms…and it was also presented… but I don't think I fully follow it or understand well.

The following concerns were the expressions of the participants:

The school nurses do not come regularly to provide awareness on the school health issues and assist in improving the learner's health status by providing necessary support mechanisms with the schools. At K1 school during the focus group interview Teacher 1 stated as follows:

Government does not provide everything in our schools and educators have a workload, for instance in cases of emergency, parents are contacted or a teacher leaves the class to escort the child home. School nurse visit is required every term of the year to present school health policy with the schools because we don't fully understand of the policy and we do not have any health support mechanism in our school.

The inadequate school health services information of the schools and medical information of the learners provided by the parents has been viewed as related to health problems faced by the

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schools. The relationship between families, communities and schools and how they share responsibilities in supporting the health of children is central in the theory of overlapping spheres of influence relevant in this study (Landsberg & Kruger 2016). A passive working relationship between the school and parents regarding the medical history of learners contributes to the lack of addressing school health problems effectively. According to the results, participants in both individual and focus group interviews were concerned about the spread of infectious diseases, due to the lack of information. Teacher 2, Principal 1 and Principal 2 maintained that it is vital for the school to have the medical information of learners provided by the parents when asked about what health services information they have:

Teacher 2: The other thing to add is that we need information from the parents regarding the health status of their children, the parent must not keep quiet about the health problems of their children because other learners and even teachers can be infected by illness say TB which was not reported prior by the parents of the children…because there are also those learners who are sick, other children have TB and there is no awareness that they are sick with illnesses... for instance, just before health worker came by I wrote a letter and put in every child's bag to inform the parents to send medical history cards of children but not every child came back with cards the following day.

Principal 1: Immunization records and information forms from a parent are kept on file in our school, our, school asks parents to complete medical information forms each school year…medical dosage is included in the information form …so the school does ask parents to complete and sign medical information form for students.

Principal 2: Health history is vital to ensure all learners have been immunized prior to enrolment; the problem is… we do not have screening or referral records in our files for all learners.

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These comments clearly point to the need for better knowledge and the support for school health services initiative and its provision within the Western Cape formerly disadvantaged schools.

4.3. School Health Problems that Originate from Learners Backgrounds

The socio-economic barriers, including the unemployment, a lack of access to basic services and poverty are the negative impacts faced by the learners in the majority of schools surrounded by poor areas in the Western Cape Province. Currie and Vogl (2013) indicated that poverty results in poor learner health, as poverty-related illnesses in SA remain widespread. Epstein's theory requires families to engage with schools and the wider community in various ways to support learning and social results for learners.

The educator participants described their experiences with the health problems that originate from learners' background as factors that contribute to the poor health and academic outcomes of learners. To confirm these findings, educators in the selected schools had the following concerns that emerged:

- The scenario of poor background actions concerning children's health and their potential to learn. One educator participant during the focus group interview states as follows:

  Teacher 4: One learner was reported by others that he was urinating blood so I immediately called his mother and asked her about her good looks and appearance while the child is not well… that's when she told me that her child was not well after they swam in a stream of dirty water and I was still waiting for some money from his dad to take him to the doctor.

- Lack of initiatives to address poverty in schools and in the surrounding communities was one of the crucial concerns of the participants in this respect. In this research, poverty amongst the learners was revealed as one of the fundamental causes of illnesses among learners that may result in absenteeism and drop outs. Educators in the selected schools claimed that poverty was the reason for poor concentration and poor eyesight or listening among learners. The researcher's record for observations also noted a large number of learners in the selected schools during lunchtime lined up for school kitchen meals. To

confirm these findings, Teacher 1 during the focus group interview in the selected K1 school, had the following to say when asked how to address these related issues:

Teacher 1: Here at school we have nothing to help poverty except for feeding scheme…….towards the end of the term we tend to run out of food stock for feeding scheme so we also tend to ask those with lunch boxes to share if they have enough with those learners with nothing.

- Unemployment and the lack of access to basic services in surrounding areas of the Western Cape formerly disadvantaged schools for some parents with children in the selected schools, have been pointed as a contributing factor to learners' health and education by the participants. Teacher 6 and Teacher 3 during focus group interviews on different occasions, stated as follows:

Teacher 6: Most of our learners come from poor background communities with unemployed parents…some come to school because they are hungry… they slept without food and woke up with water… so they know they are going to get at least a meal at the school…the problem we have… is that they lack concentration in the classroom…scratching of body, head, eyes, nose…. copying wrong words on the board…you have to repeat yourself when you talk to them because they are not hearing…or to intervene in disturbance concerning what you can see is because of desperation in the classroom.

Teacher 3: I do not know what is happening with some parents… some parents do get child grant to make a child appear neat among other children when coming to school or take a child to health care center when sick, but still, there are learners who come to school untidy that you can see that s/he is either abused back at home or there is no proper care after school; you can see a child is developing ringworms over the head and there was nothing applied because his mother is unemployed, she can't buy any application for his ringworms or for his thrush or allergies.

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What was clear from the point of observations is that most learners do not come to school wearing a full uniform in the selected schools and hence neatness among other learners is not hard to see. It has also been indicated in the literature review that health problems place enormous financial and emotional burdens on families of ill learners and this has been supported by the above statement. Families suffer from stress due to the continual demands of an ill child who requires much physical care (Jaress & Winicki 2013).

- Poor living conditions, unhygienic dumps or dumping that can easily spread diseases characterized the most areas surrounding of the selected schools. One of the objectives of school health services is to offer school communities, including learners, teachers, and parents, with advice and facts on health and related problems (Oseji & Okolo 2011). This is also obvious by observations of coming across unhygienic water flow from the streets pavement and informal settlement when you take a walk around the nearby areas of the selected schools, specifically in Khayelitsha.

One educator, during a focus group interview at school K1, had this to say regarding learners backgrounds and about the health problem among learners in schools:

Teacher 2: I noticed one child was not as active as we were doing the physical activities so she was complaining about a headache and her temperature was high…. I told the principal who said I must accompany the child back home to explain to the parents… the parents responded by saying no she does not want to go to school she wanted to play with that kid who does not go to school… I said no this child is active but today she is definitely not well and that's when they responded by saying she is affected by this 'hokie' (shack) because it is leaking, there is draft entering in during the night when she is sleeping. So I explained to them that she does not have to go to school when she is not feeling well, she must be taken to health facilities because it is easy to pass flu to other children in school.

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4.3.1. Lack of Parental Involvement in Learners' Health and Education

The lack of commitment between the schools and the parents regarding the health and the education of the children were perceived by the participants as a serious contributing factor to the school health problems. These include the lack of effective communication that led to a lack of direction in order to address the health problems at the school level. The educators in this study revealed some issues regarding parental involvement, including lack of interest in working effectively with the schools regarding health issues among learners. According to a principal and educator participant during the focus group interview at school K2:

> Principal 2: Some parents show no interests in assisting learners or in what the
> school has to offer.
> Teacher 2: It feels like instilling health consciousness among learners rest on us
> as teachers.

Epstein's theory postulates the provision of information and workshops with families on health topics should relate to lessons taught in health education classes or physical education (Michael et al. 2007).

According to the study findings, some educator participants indicated that they require workshops for better awareness of school health promotion, as they have less knowledge regarding ISHP. This suggests one of the reasons for the lack of parental involvements in the handling of health issues among learners with the selected schools. In an effort to gain a better understanding of the challenges linked with getting parental involvement in school health services, the perceptions of the participants were noted as follows: Parent 4, revealed a lack of knowledge in working with the school to curb learners' ill health. Parent 5 showed the interests in working with the school in solving health problems faced by the learners, when asked whether they would like to work with the school to effectively manage their child's health condition during a focus group interview on different occasions:

> Parent 4:   I am not sure of how else to do except taking my child to local
> community clinic…. Because I do not know how to work with the
> school to most effectively manage my child's health condition.

Parent 5: I informed the educators of my child's health conditions and checked up on my child during school hours from time to time…and work with the school to manage my child's health condition.

The lack of awareness for the school-health-promotion initiative and its association with the school health services delivery, are the reasons for the unclear role of the parents in the existing literature on the school health services (Mohlabi et al. 2010). This has been indicated and suggested by the above statements made by the parents.

It is the duty of the principal, management, governing body, learners' representative council, and other structures to encourage collective decisions on matters that affect health in their schools (Clarke, 2007). Teachers and parents in the selected schools responded by pointing out the roles that should be played by school management and the principal in delivering school health services:

Teacher 1: Yes… management is the principal, HODs or SGBs must make sure that the health needs of children are met … because it's part of their duties to ensure that they have service contact numbers, especially most of them do not have more classes to teach so with the free periods on their hands they should spend on ensuring that they meet these needs.
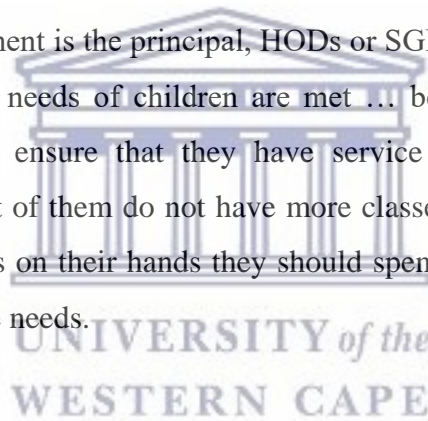
Teacher 5: May the principal ensure at all times …and must not give lip talk….you must actually see to it that a class gets services provided at the doorstep so that they can use it …when teaching and learning takes place they sometimes forget to deliver what is needed….especially five years and above experienced teacher realize it late what is happening in their territory or environment…the things that we need is not a lip talk…service delivery must be delivered at the doorstep of the classroom very sufficient and effectively…..the principal must not always prioritize what is important to him or circuit office but what could make job of teacher easier….and to ensure learners environment is

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conducive regarding health so that they could feel it within their minds and within their physical appearance.

Parent 6: We have a new principal that started on 2015 he is driving the school slowly but forward so when we find direction and vision we leading to the proper way…. the principal is the one that promotes what needs to be there.

The community, school and family partnership is about raising community participation and local input to support schools in the provision of care and support to vulnerable learners (Epstein et al. 2007). The ISHP 2012 provides important coordination to guide all the applicable school health services providers at all levels that include national, provincial, district and school (DBE & DOH 2012). How, then, the selected schools take advantage of the community partnerships to maximize resources or share the expertise that will influence the healthy development of learners, is debatable in this study. Principal 3, during a focus group interview at school L1, disputed poor parent engagement, while Parent 3 and Parent 5 thought it vital to be informed in order to maintain the connection with the school regarding their learner's health:

Parent 5: As a parent, I would like to have information on causes, symptoms and how to prevent illnesses including TB or HIV and to assist when a school-related problem arises.

Parent 3: Love Life Centre people must be invited in the school to come and talk about these illnesses out including family planning so as to be able to equip our children with what we learn as parents.

Principal 3: We have the overwhelming support of learners' parents who support and encourage learners to be health conscious …..What happens sometimes is that when we have meetings with parents, they do have a say regarding health issues in school, the inspector from the department also guide us regarding school health issues… in addition, some parents who reside close to school also provide suggestions when they see something in our school… Yes, parents are also informed first when their children are not tidy or unhealthy to find a solution because some parents get grants from the government.

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4.4. Available School Health Services that Address School Health Problem in the Selected Schools

This study provides an analysis which explores the features of both CSTL and ISHP frameworks that ensure the availability of effective school health services in the selected Western Cape formerly disadvantaged schools. The CSTL outlines curriculum support to the promotion of social and physical wellbeing of learners through life skills, sport and physical education (Hill et al. 2015). In the selected schools, CAPS included Life Skills and Life Orientation (LO), as health education themes to cultivate learners with an awareness of the healthy living standards. This is supported by Epstein's theory in terms of learning at home when schools involve families and learners in health education homework activities regarding healthy behaviours. Educator participants, during a focus group interview underlined the uncertainty and importance of LO in school health promotion, on the question of whether LO closes the gap between health problems and school health services:

Teacher 4: Learners only learn about social problems during life skills lessons, because there are no school health services available to address social problems. The Life Orientation as a subject does make a little difference, for example, learners or teachers and school leadership are given guidance regarding hygiene…it is in the CAPS curriculum ….it is in the life orientation learning area….where they speak about germs and all these things that contribute to sickness and how they should prevent diseases.

The ISHP relates to the availability of mobile clinics which are equipped particularly for school health services, comprising of on-site services, health screening and health education provided by the school nurses with learners in schools (Shung-King 2013). The participants highlighted a lack of the availability of the ISHP mobile clinics and health staff in the selected schools. This is also true in terms of observation records that noted no indication of health-care system assets of any form in the selected schools, at any given point in time of researcher's visits in those schools. Parent 6, during a focus group interview at school L1, said the following:

It is rare to see mobile clinic here at school I think they need to come to check-up our children.

Teacher 1 and Teacher 3, during focus group interviews, which occurred on different occasions in different settings, also commented as the following:

Teacher 1: Also because we don't have a nurse on the premises and no medication available, we take the child to sickbay while calling or waiting for parents of a sick learner to come and fetch the child …we do not have school health service.

Teacher 3: The nurses are scarce while there is a lot of work that I am facing as a teacher that causes a lot of stress…. for instance, the nurses only come once to prevent infectious illnesses and it ends up there and they do not return the whole year.

A lack of school nurses to carry on-site services implies the ineffective provision of school health services in the selected schools, as highlighted by the participants. Moreover, social and welfare services represent the role of the schools in the implementation of child care and protection legislation in promoting access to social welfare and health services. According to Donald, Lazarus, and Lolwana (2010), health promotion in schools is about the collaboration of all school community members, including teachers, learners, parents, caregivers, and wider community members, to prevent barriers to learning. This links strongly with Epstein's theory applied in this study which puts emphasis on the active involvement between school-family-community. The participants noted their awareness of health promotion, the educational right of the learners and the programmes that support the welfare and health services crucial for healthy children to learn successfully.

Teacher 1, Teacher 6 and Principal 1, during individual and focus group interviews, on different settings and times said the following:

Teacher 1: We do have such health promoting school policy concept in our classrooms… we also have this feeding scheme to address poverty-related problems.

Principal 1: Yes in our school we implemented programmes including feeding scheme.

Teacher 6: We do have first aid kit……should our learner get to hurt himself, we have antiseptic to wash all the dirt and germs before we apply

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any ointment and the bandages just to cover the blood to stop the bleeding …we have got cloves and anything in that first aid kit box…except few things but I went to the principal to inform of the things we need, otherwise we are covered, should anything happen, I will be addressing any other school health issue whereby I assist and provide first aid kit but I think learners or parents have not yet been trained to use it.

To substantiate the above-mentioned claims, specific objectives of the ISHP are meant to facilitate access to health and other services required to support the school community in creating a safe, healthy and secure environment for teaching and learning (Integrated School Health Policy 2012). The School Health Policy objectives are achieved by means of the key strategies including, amongst the others: health promotion and health education, provision of an essential package of health services in schools and community participation (ISHP 2012). It has been mentioned in the above findings that CAPS provides learners with health education, which equips them with necessary lifestyle skills applicable in school and home. Moreover, ISHP school health services package makes a note of environmental assessment for all schools which involves first aid kit, sick bay; and cooking area to provide a feeding scheme as mentioned by the findings above.
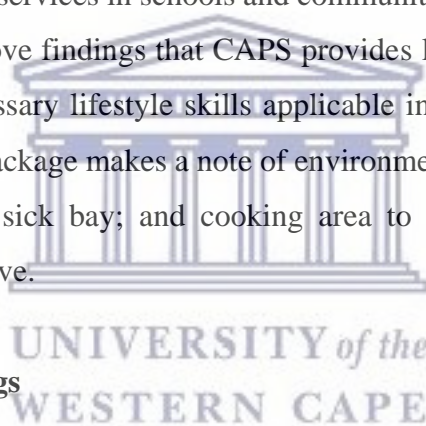
4.5. Discussion of the Findings

The findings of this research sought to answer the main question of this study posed in Chapter 1, Section 1.5.

Under this main theme, **school health problems that originate from school-based factors,** it has been found that learners in schools have common health challenges that require focused attention on the provision of the school health services. Protecting, promoting and maintaining learners' health while preventing illness is the actual aim of school health services delivery.

However, the health problems described as the factors that arise from the school included the following ***sub-themes: inadequate school facilities, overcrowded classes, and lack of information and support for school health.*** Shung-King's (2013) research suggested that performing of the positive health-promoting activities through ISHP cuts the occurrence of health problems in schools. Yet, some educators and parents had been left feeling incapacitated and helpless in addressing health problems, due to the effects of the sub-themes stated above in their schools. One of the challenges that characterize the selected Western Cape schools included a lack of basic infrastructure in the education system such as school-based health clinics, or a health rooms to provide primary health care within the schools. This was supported by Waggie's (2013) review which identified a general lack of resources and infrastructure in schools as well as a need for safe rooms in all the schools in the Western Cape. According to one of the principal participants, ***overcrowded classes and the absence of school health infrastructure*** and the lack of protection for learners were the reasons for problematic spread of tuberculosis and the respiratory diseases in the schools.

In addition, inadequate knowledge with regards to school health policy or ISHP had been viewed as resulting from the ***lack of information and support for school health*** in the selected schools. The unclear understanding of the policy guidelines suggests the lack of ISHP implementation by the health and the education departments concerned with school health services delivery (Mohlabi et al. 2010). The information presented in this study directly supports this finding, because for some educator participants the ISHP initiative in charge to instil and maintain the health-care for learners in the schools is unfamiliar. In the case of emergency, educator participants with less knowledge of the ISHP are unable to offer the health services required to the ill learner(s); for example, they chose to take the ill learner back home or to the sickbay but with no immediate health care response. There are several reasons for these actions. One is that they felt as if the instilling of health consciousness among the learners depends on them, only due to the absence of health facilities and health professionals in their schools. In addition, educator participants were not trained to offer the health services to the learners in terms of the ISHP's health screening, prevention and treatment. Hence, some educator participants stated a desire for the government to provide them with workshops with respect to the ISHP as they were in the dark regarding the health promoting school initiative.

The five action areas of the HPS were used as a guide to categorise and summarise the discussions on challenges raised by the participants in their schools, see Table 6 below:

TABLE 6 Summary of the Challenges identified at the participating schools

|	Components of HPS	Challenges at schools
1.	Develop healthy school policies that will assist the school community in constantly addressing its health needs.	Generally the schools do not have policies for health promotion; these are therefore required.
2	Development of the school as a supportive environment for the development of health attitudes and practices.	Lack of sustainable health promotion programmes. Lack of commitment of stakeholders.
3	Community action that involves the school and broader community in taking ownership of and seeking ways to address their collective health needs by accessing resources for health.	The study had revealed the ignorance within families regarding health issues. Parental and community involvement is needed. Parents require motivation and skills to identify initiate and lead projects in the schools and community. Poverty alleviation projects to be initiated by the school community, as poverty is experienced by the majority of learners.
4	Development of personal skills of members of the school community, thus enabling them to improve their own health and influence the health of others.	Too few visits from school nurses and other health professionals. An understanding of the 'health promoting school' related to CSTL and ISHP concepts is needed by the school community.
5	Access to appropriate services to address the health needs of the school community.	No access to appropriate service providers. No proper referral systems for vulnerable or sick learners. Safe rooms are needed at all the schools.

Source: Waggie (2013)

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One of the principal participants in this study stressed the need for health infrastructure in the selected schools. Participants were concerned about the safety of the learners, as the poor sanitation conditions could lead to accidents and illness, including fever or allergies, which are problematic in the selected schools. Some educator participants understood that, regardless of the conditions they were faced with, it was imperative for them to ensure that they transmit the hygiene knowledge to learners. This included common possible practices such as opening of windows in the morning, washing hands before taking meals, after visiting the toilet and putting a hand on the mouth when coughing in overcrowded classes.

In this regard as a main theme, **school health problems that originate from learners' backgrounds,** schools mentioned the lack of involvement of parents in the life of the school as a major problem. Parents were seen to be disinterested in school activities, even though they are usually deeply involved in and affected by their children's health and education. Moreover, the lack of family and community support, to the success of co-coordinated school health services and the unclear understanding of the ISHP by the schools, had been found to result in non-provision of effective school health services in the selected schools. In order to uphold the rights of children and adolescents and make provision for them to attain their full potential in all facets of their lives, the Health, Education, and Social Development sectors were entrusted with a vital role in developing the ISHP Implementation Guidelines.The theory of the overlapping sphere of the influence employed in this study clearly gave emphasis to active school-family-community partnership, as similar to the ISHP's foundation of the alliance within the state departments concerned with the school health. This suggests that the process for engaging parents or community at large is needed in schools to ensure school health matters.

Available school health services that address school health problem in the selected schools as a theme of the current study supported the need for health services delivery to protect and promote the learners' health while reducing school health problems in schools. According to Integrated School Health Policy (2012) the ISHP is a unique opportunity to bring health services closer to school schoolchildren. Conversely, the study results exposed the unavailable school health services delivery, including distant ISHP mobile clinics and the lack of school nurses visits in the schools. This has given rise to scarce resources and inadequate options in addressing health concerns among the learners in the selected schools.

The ISHP framework in Chapter 1 (section 1.8.3.) promotes health and provides preventive care among learners, curative and rehabilitative services. Enclosed by the health screening services on offer, immunisation to all learners and assessments of height and weight, oral health, skin health, vision, hearing, and speech remained provided within ISHP (Integrated School Health Policy 2012).

Although, mostly the educator participants interviewed indicated the absence of effective school health services delivery in their schools as a source of the school health problems, some of the parent participants vocally stated that they want to see the mobile clinics in their schools. There is an understanding and expectation of the ISHP that its coverage would prioritize the formerly disadvantaged schools with limited health facilities and then spread to all schools, for all learners (Integrated School Health Policy 2012). According to the policy, it was required for all schools to integrate health factors affecting the development of schoolchildren including issues relating to sexuality, violence, substance abuse, and mental health issues etc. However, throughout the interview processes, the educator participants were concerned about the unavailability of the school health services delivery and a lack of addressing the health problems among the learners in their schools. They felt that the parents, communities and the government are not doing enough to support them with the school health matters while parents, on the other hand, are not certain of their role to play regarding the provision of school health services.
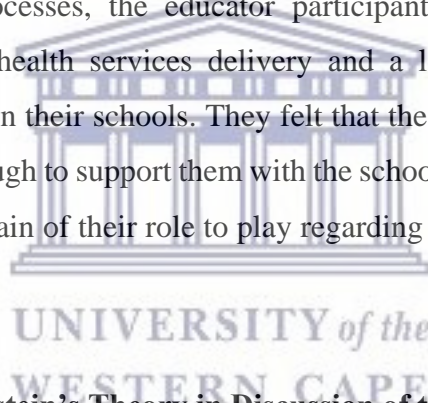
4.5.1. The Importance of Epstein's Theory in Discussion of the Findings

This research intended to highlight the importance of the above-mentioned theory in its application to the analysis of the effectiveness of school health services provision and the alleviation of school health problems in terms of the school-family-community partnership. According to Michael et al. (2007), the states, districts, and schools collaborate with community groups or agencies to promote school health programs (See Figure 4).

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FIGURE 4 Epstein's Framework of School-Family-Community Involvement

Source: Michael et al. (2007).

4.5.1.1. Type 1: Parenting

Parental support comprises direct effects on learning before and during formal education, as well as monitoring and facilitating factors that are indirectly linked, such as a stable home environment, nutrition, behaviours, health, and hygiene (UNESCO 2018). Epstein's theory postulates the provision of information and workshops for families on health topics that relate to lessons taught through health education classes or physical education. Moreover, Michael et al. (2007), assert that improved parenting skills help build a healthy home and school environments that support positive health attitudes among learners. The findings of this research revealed some issues regarding parental involvement, including lack of interest in working effectively with the schools regarding learners' health issues emanating from home or from school. According to the findings, the reason why some parents in the selected schools are not actively involved in the health and education of their learners, is because of lacking information on how to be involved on school health matters due to the fewer knowledge educators have regarding ISHP. However the ISHP manual for School Health Nurse (2012) emphasized that parents should be kept informed by the DBE District Coordinator and school health coordinator regarding the school health programme.

4.5.1.2. Type 2: Communicating

The theory considers effective forms of two-way communication designed from school-to-home and from home-to-school, about school programmes and children's progress. For

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example, this is possible when educators communicate with parents through phone calls, notices, newsletters and other means of communications. By using two-way communication, families receive educational materials about different health topics, recognize how they can be involved in school health programmes and keep in touch with teachers (Michael et al. 2007). The findings of this study also revealed the views of teachers in that, only a few parents attend school meetings, communicate with educators or visit schools for the effective handling of learners' health conditions. ISHP manual for SHN (2012) suggested that the organized parent meeting to discuss the health services package and the importance of participation in the programme is important to ensure that informed consent is obtained. For example, parents of new school entrants should be informed at registration that the school health programme will be visiting the school in order to assess new learners (ISHP manual for SHN 2012).

4.5.1.3. Type 3: Volunteering

The theory redefines a volunteer as a person who supports children's learning, development and school goals in any way, not only at the school building or during the school day, but any time or place (Epstein et al. 1997). According to these writers it involves recruiting and organizing parents' support, to take advantage of their experiences as families and community members in elevating health and physical education classes. This study found that some parents put this theory into practice, for example, one principal participant in this study commended some parents who also stay nearby the school for keeping an eye on the school or provide suggestions when they see something. However, challenges including establishing volunteer work with schools, educators' or learners' needs and recognizing their efforts to ensure their productivity persist as a critical factor for the theory. Hence, it is required to adjust to principle the ISHP of prioritizing local schools and empowering them with information and resources for the effective provision of school health services.

4.5.1.4. Type 4: Learning at Home

Epstein's theory is about providing families with strategies or information to support learning at home. In practice, the school might involve families and learners' abilities in terms of health education homework activities, for example, in setting personal goals regarding healthy behaviours (Epstein 2001). However, the absence of parental involvement in interactive homework activities that allow learners to discuss health subjects with families for awareness

of school content is assumed to be a critique of this theory in practice. Results of this study show that parents are not interested in helping learners with their school work and that instilling health consciousness among learners still remains a teacher's task.

However, the study also illustrated that some schools do make an effort to increase parental involvement in their child's health and education by the way of communication invitations to meetings to ensure the accountability of parents. Moreover, one of the key strategies of the ISHP is the capacity building to give training at all levels of DBE including SGBs, parents, as well as DOH for those involved in the provision of school health services (Mohamed, Struthers and Sanders 2013).

4.5.1.5. Type 5: Decision Making

According to the theory, a choice concerning learners should be made with parents. This requires the active participation of SGBs and advisory councils committees (e.g., curriculum, health, and safety personnel) in decisions when developing school health procedures (Epstein 2018). In terms of the findings, educators claim that parents and district officers participate in school decisions regarding school health, while parents highlighted a need for shared information regarding school health activities. The main issue in practice is the insubstantial inclusion of parents in schools' shared decisions. Mohlabi et al. (2010), highlighted the exclusion of SGBs in the action plans by health specialists concerning school health services. These statements are supported by the findings of this study that revealed a lack of mechanisms, services, information, training, and support among participants to make decisions towards offering effective health services in the selected schools.

4.5.1.6. Type 6: Collaborating with Community

Understanding how parents can become involved in school communities or to ensure parent participation and support for the health of learners, is the main theme of Epstein's theory (Michael et al. 2007). Collaborating with the community for this theory involves recognizing and incorporating services or resources from the community to reinforce school programmes and influence learning and development through family participation. Community involvement is an important component of a school health program integrated with the other components including health or physical education and activity, health and social services, nutrition

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services, healthy and safe school environment (Michael et al. 2007:569). This study found that some of the parents were willing to provide their skills, or to avail themselves in assisting the teachers, while others still found it difficult to engage with the school regarding learners' health status. Research findings also revealed the efforts of teachers in addressing the lack of parental involvement and behaviour through letters to parents when health information of a learner was required and by visiting the home to give advice. However, matching school goals with community contributions and integrating family and child services with education is still an area to investigate further. Moreover, the poor relationships amongst stakeholders and the ineffective school health initiatives constitute a critique for the theory-practice in the selected schools due to the absences of health professionals in schools (Shung-King et al. 2014).

4.6. Summary

Chapter 4 provided a discussion of the research findings, which addressed the research questions of this project and also linked the results to the theory applied in this study. Chapter 5 will focus on the conclusions arising from the findings and the recommendations of this study will be presented.

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CHAPTER 5

5. Conclusion and Recommendations

5.1. Introduction

The preceding chapters provided and discussed the findings of the research. This chapter intends to reach general conclusions; provide worthwhile recommendations on the effectiveness of providing school health services related to the CSTL and ISHP in the Western Cape formerly disadvantaged schools.

5.2. General Conclusions

This study was intended to probe for the effectiveness of providing school health services related to the CSTL and ISHP in primary and secondary schools within the Western Cape Province.

Moreover, this research generally aimed to explore the effective provision of school health services and to explore on how health problems in schools can be eliminated through the aspect of CSTL and ISHP in order to enhance health and academic results of learners.

This study was therefore conducted via literature review, interviews and observations of educators, parents, and principals in an attempt to answer the research questions. The effective school health service delivery and school health problems review was the main focus of the researcher, in order to answer the research questions. This study sought to provide recommendations hopefully to inspire school communities and other stakeholders for better implementation and provision of effective health services in all schools regardless of the school background.

5.2.1. Importance of School Health Services and Elimination of School Health Problems

Having reviewed, analyzed and discussed both the effectiveness of school health services delivery based on CSTL, ISHP and school health problems that are based either on school or learners' background, an attempt to answer the research questions was made. In terms of this study, the effectiveness of school health services was measured by the provision of available health services related to the CSTL and ISHP for learners to value, safeguard, and promote

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their health. It has been reviewed that school health services aim at improving the health of learners and to enhance their learning potential through the effective elimination of health-related barriers to learning. This automatically expects and suggests the effective delivery of school health services in Western Cape formerly disadvantaged schools. This study also revealed a lack of school health service coverage as a huge challenge in many areas generally in South Africa. Common illnesses that prevail in school and the community suggest a great demand for health, social welfare, and child protection services (Kruger & Swart 2016). Thus, the provision of emergency care for illnesses or injuries and promoting health, while providing optimal sanitary conditions for a safe school facility or environment, are considered to be the key factors in the selected schools.

In this research, it has become obvious that health problems negatively impact teaching and learning activities, including learners' academic results. It is for this reason that considering the effectiveness of school health services delivery related to CSTL and ISHP in the Western Cape formerly disadvantaged schools, is vital for school improvement to school effectiveness. Furthermore, health promotion in schools is crucial in order to have effective teaching and learning tasks.

According to Kruger and Swart (2016), health services can be conveyed to schools through mobile clinics and regular visits of school nurses, health workers and professionals who provide health screening, immunization, and dental check-ups, etc. Therefore, such services help in identifying, and preventing learners' health conditions on time before they become barriers to learning.

5.2.2. Respondents' Perceptions of the Effectiveness of School Health Services delivery related to ISHP

Educators displayed a lack of understanding of the ISHP and a lack of providing effective health services in their schools. Results showed that the effective provision of school health services depends largely on the health professionals, the school infrastructure and the active parent-community-school participations, that instill health awareness among the learners. According to the findings, the health promotion initiatives were not properly presented in the selected schools. It is crucial for the government departments concerned with school health to encourage information regarding the provision of school health services through workshops.

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According to the respondents, the absence of mechanisms to address health problems in the selected schools led to the delays and the loss of time for the teaching or learning activities in cases of emergency. This suggests that the absence of mobile clinics to attend to health problems in the selected schools at all times has a negative impact on teaching and learning activities, for both teachers and learners.

5.2.3. Positive Practices for Providing Effective Health Services in Schools: ISHP

This research has achieved its main purpose of understanding the effective school health services delivery related to CSTL and ISHP in addressing the school health problems, promoting and in improving the health of the school community members and the environment. However, the lack of health professionals and the school health infrastructure within the selected schools was an issue concerning the effective provision of the school health services. In Chapter 4 section 4.4., the methods of offering the health in relation to both the CSTL and the ISHP in the selected schools were identified by the participants. These methods included the mobile clinic, nurses, health inspectors, on-site health services, screening, and health information. Although these procedures were mentioned, some are regarded as being ineffectively provided, or out of the reach for schools.

5.3. Recommendations on Effectiveness of School Health Services delivery related to CSTL & ISHP

If possible for policy to be altered, all schools should have the school-based health facilities and constant availability of school nurses and the health inspectors, to efficiently and effectively address any health problems that might arise in school. However, this suggestion could have an economic implication on the government. Although not impossible, it would require additional funds to have the ISHP school-based clinics, staff, and the medications for the treatment of the school community members, particularly the learners. Maintaining a safe environment and appropriate security as a precondition for promoting healthy schools is vital for both primary and secondary public schools to ensure that school health problems, due to accidents or an unhygienic environment, are eliminated. This is related to health education and classroom management, where in the case of overcrowded classrooms; it is easy for example

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to contract tuberculosis (TB) from an infected learner who is not on medication in a physical environment where windows are closed.

For policy implementation principals, teachers, and parents should be thoroughly trained on how to deal with learners' health problems, which may arise at home or school. The government must ensure teacher development regularly through workshops on ISHP aspects, to furnish all educators and other school community members that might face health problems in schools. This will allow educators to have a working knowledge of how to develop health policies in their schools and provide effective school health services that alleviate health problems and promote and prevent health for learners.

Government departments concerned with the school health should also encourage schools through rewards or awards for producing good health standards, possible at a particular point in time and provide a necessary resource for schools in order to proceed with this challenge.

Improving both learners' health and educational outcomes should be regarded as the culture of all schools in the Western Cape Province. School principals, as school leaders, should reflect on features related to the role in improving the health and academic performance of learners at their school. Principals are advised to consider organizing meetings with parents, community clinics, learners and educators during the school day as part of the curriculum, or school-based workshops whereby a manual of health promotion can be discussed by all as a starting point.

Working relationships between the school, parents, and community concerning school health programmes are ensured by Epstein's theory and are suggested for each and every school to put it into practice. The six types of involvement – parenting, communication, volunteering learning at home, shared decision making, and community collaboration – are the key types of care. The school-family-community partnership should develop collaborative relations to promote healthy and inclusive communities that provide evidence about the vital roles that parents play in supporting their children's health and learning development.

Learners are encouraged to be health-conscious and active, both in school and at home. This is possible if learners take into consideration the Life Skills and Life Orientation they acquire

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from school and put it into action in order to minimize related health problems that may arise in schools or at home.

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INFORMED CONSENT

THE EFFECTIVENESS OF SCHOOL HEALTH SERVICES DELIVERY RELATED TO THE CSTL AND ISHP IN THE FORMERLY DISADVANTAGED SCHOOLS IN THE WESTERN CAPE'S PROVINCE CENTRAL AND NORTH EAST DISTRICTS.

I MENZIWA MZWANDILE (0836826679) a Masters student under the supervision of Prof S. Devereux at University of the Western Cape (UWC), is engaged in a research study on school health services in primary and high schools. The purpose of this study is to explore on how the available school health services that address school health issues in the Western Cape township schools in order to promote health and learning potential of schoolchildren can be obtained through school-family-community partnership.

For the purpose of this research, all principals of the three purposefully selected schools and six educators from each school will participate in the research.

I confirm that I have explained the subsequent elements of informed consent to the participant:
- The participant knows that their participation is voluntary and that they do not need to answer all questions.
- The purpose of the research, as well as the risks and benefits, have been explained.
- The procedures, as well as the time commitment, have been outlined.
- The participant understands issues of confidentiality.
- The participant understands that there is no compensation involved.

I, the participant in this study, have been informed of the following crucial matters:
- I shall be given a copy of this informed consent form to keep.
- Participation in this research study is voluntary.
- I am free to decline to participate in this research study, or I may withdraw my participation at any point without penalty.

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- I may choose not to answer specific questions.
- The information gathered from this study will be kept as confidential as possible.
- My real name will not be used in the report and all files, transcripts, and data will be stored in a locked cabinet in the researcher's home, and no one except the researcher will have access to them.
- My name will not be used and any identifying personal information will be avoided.
- My signature below means that I voluntarily agree to participate in this research study.

Participant's signature: _ Date: _ _ _ _ _ _ _ _ _ _

Researcher's signature: _ Date: _ _ _ _ _ _ _ _ _

UNIVERSITY *of the*
WESTERN CAPE

Semi-Structured Interview Questions for Educators/Principals

(a) What are the health problems that the school experience with the learners?

(b) How does the school deal with such problems?

(c) What information do you have regarding the School Health Service delivery? Do you have a full-time registered nurse or counselor in the school building at all times to help children with emergencies or with chronic medical conditions?

(d) Is there a school-based health center open for school community members?

(e) What are the quick ways that are available to handle the school health problem?

(f) What are the school health services available in the school to address social problems such as HIV/AIDS, teenage pregnancy, chronic illness?

(g) What is the school health services available in the school to address health problems related to hygiene?

(h) How do you deal with violent incidents taking place in school premises to ensure a healthy and safe school environment?

(i) How do you address the issues related to poverty in school?

(j) Do you think the school management needs to ensure that learners health needs are met? Why?

(k) Do you have any policy related to drug abuse, safety, first aid, use of facilities and extramural activities? How does it work?

(l) What do understand about school health promotion? Are the school community member including, district officials, school principal, teachers, none academic staff, parents, students, and community leaders all have an understanding of or involved in school health promotion?

(m) Would you say that installation health consciousness among schoolchildren rests only on the shoulders of educators to ensure the school effectiveness? Why?

(n) Does the school mission reflect the importance of parent engagement and establish a foundation for parent engagement in school health activities? How does a school increase parent involvement in school health?

(o) What do you understand about the Integrated School Health Policy implemented by the government? What would you consider a success or failure in your school as a result of the Integrated School Health policy implementation by the government?

(p) What training, support or resources do you need to instill health consciousness among school community members?

Semi-structured Questions for parents

(a) What health topics are important to your family and your child?

(b) What information would you like to receive related to school health?

(c) What school health-related activities, services, and programs would you like to know more about?

(d) What simple changes or modifications would make the school's physical environment more pleasant, accessible, and safe for parents and community members?

(e) For parents with a child with an identified health risk, such as asthma, diabetes, or food allergies: how would you like to work with the school to most effectively manage your child's health condition?

(f) What skills and talents do you have that might match with the health-related needs of the school?

APPENDIX C

Ethical Clearance

OFFICE OF THE DIRECTOR: RESEARCH

RESEARCH AND INNOVATION DIVISION

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South Africa

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29 June 2017

Mr. M Menziwa

Institute for Social Development

Faculty of Economic and Management Sciences

Ethics Reference Number: HS17/5/33

Project Title: School health services effectiveness in the formerly disadvantaged schools in the Western Cape's Central and North East Districts

Approval Period: 29 June 2017 – 29 June 2018

I hereby certify that the Humanities and Social Science Research Ethics Committee of the University of the Western Cape approved the methodology and ethics of the above-mentioned research project. Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval. Please remember to submit a progress report in good time for annual renewal.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms. Patricia Josias

Research Ethics Committee Officer

University of the Western Cape

PROVISIONAL REC NUMBER - 130416-049

PERMIT TO DO RESEARCH IN SCHOOLS

REFERENCE: 20170706 –2725

INQUIRIES: Dr. A T Wyngaard

Mr. Mzwandile Menziwa

R309 Hector Peterson Residence
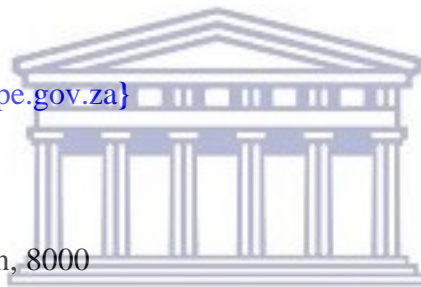
UWC

Bellville

7535

Dear Mr. Mzwandile Menziwa

Audrey.wyngaard@westerncape.gov.za}

Tel: +27 021 467 9272

Fax: 0865902282

Private Bag x9114, Cape Town, 8000

RESEARCH PROPOSAL: **SCHOOL HEALTH SERVICES EFFECTIVENESS IN THE FORMERLY DISADVANTAGED SCHOOLS, WITHIN THE WESTERN CAPE'S METRO EAST DISTRICT, RSA**

Your application to conduct the above-mentioned research in schools in the Western Cape has been approved subject to the following

conditions:

1. Principals, educators, and learners are under no obligation to assist you in your investigation.

2. Principals, educators, learners, and schools should not be identifiable in any way from the results of the investigation.

3. You make all the arrangements concerning your investigation.

4. Educators' programmes are not to be interrupted.

5. The Study is to be conducted from **24 July 2017 till 29 September 2017**

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6. No research can be conducted during the fourth term as schools are preparing and finalizing syllabi for examinations (October to

December).

7. Should you wish to extend the period of your survey, please contact Dr. A.T Wyngaard at the contact numbers above quoting the

reference number?

8. A photocopy of this letter is submitted to the principal where the intended research is to be conducted.

9. Your research will be limited to the list of schools as forwarded to the Western Cape Education Department.

10. A brief summary of the content, findings, and recommendations is provided to the Director: Research Services.

wced.wcape.gov.za

11. The Department receives a copy of the completed report/dissertation/thesis addressed to:

The Director: Research Services

Western Cape Education Department

Private Bag X9114

CAPE TOWN

8000

We wish you success in your research.

Kind regards.

Signed: Dr. Audrey T Wyngaard

Directorate: Research

DATE: 10 July 2017