

Comprehensive school-health services in selected secondary schools in the North West province

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Dissertation submitted in partial fulfilment of the requirements
for the degree Magister Curationis, Community Nursing at the
Potchefstroom Campus of the North-West University

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DECLARATION

Herewith I, _____, Student Number 10533222, declare that the dissertation entitled **Comprehensive school-health services in selected secondary schools in the North West province** which I herewith submit to the North-West University, Potchefstroom Campus, in compliance with the requirements set for the degree, Magister Curationis, Community Nursing:

- 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 (Annexure I for Turnitin report).
- This study has been approved by the Ethics Committee of the Institutional Office of the North-West University, Potchefstroom Campus.
- This study complies with the research ethical standards of North West University, Potchefstroom Campus.

EPJ De Klerk

Date:

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ABSTRACT

[Title: Comprehensive school-health services in selected secondary schools in the North West province]

Adolescents who are subjected to adverse health risks which limit school attendance and academic performance, is a national as well as an international recognised problem considering healthy youth to be productive members of society. The South African Department of Health has introduced a re-engineering program for primary health care of which school-health is one of three main areas of the primary health care services focusing on, but not limited to immunization, teenage pregnancy, education about HIV/Aids, and screening for health problems such as poor eyesight and hearing impairment. During October 2012 the new school-health program was piloted in very poor schools in KwaZulu Natal, Gauteng and Limpopo and will over the next four years be implemented in poor Secondary Schools.

The aim of this research was to explore and describe comprehensive school-health services in two selected secondary schools in the North West province in order to propose recommendations to enhance adolescents' quality of life. The researcher used an explorative, descriptive, holistic multiple case study to gather rich data from two separate institutions (secondary schools) to reach the following objectives:

- To identify and describe the demographic profile from existing records/documents available at each selected secondary school.
- To explore and describe how comprehensive school-health services are experienced by key stakeholders, in two selected secondary schools in the North West province.
- To explore and describe the perceptions of key stakeholders on how comprehensive school-health services should be rendered in two selected secondary schools in the North West province to enhance the quality of life of the adolescent.

A description of the demographic profile was possible by means of a demographic data sheet completed by the principal to understand the background of each school included in the research. Rich information of key stakeholders' experiences and views about comprehensive school-health services was gained by four focus group interviews. Results of the data analysis showed a lack of comprehensive school-health services to adolescents in two secondary schools. The findings included adolescents' health problems as well as physical and emotional challenges educators are not equipped for and/or have not sufficient time to manage. Conclusions made from the research findings, contributed to recommendations for the nursing practice, nursing education and nursing research to enhance the quality of life of adolescents through comprehensive school-health services in selected secondary schools in the North West province.

Key words: comprehensive school-health services, health, health promotion, adolescent, experience, perceptions, secondary school

OPSOMMING

[Titel: Omvattende skoolgesondheidsdienste in geselekteerde sekondêre skole in die Noordwes provinsie]

Adolessente wat as gevolg van ongunstige gesondheidsrisiko's beperkte skoolbywoning en akademiese vordering toon, is 'n nasionale en internasionale probleem indien in ag geneem word dat produktiewe lede van die samelewing gesonde jongmense vereis. Die Suid-Afrikaanse Departement van Gesondheid het 'n ontwikkelingsprogram vir primêre gesondheidsorg bekend gestel waarvan skoolgesondheid een van die drie hoofareas is, wat, alhoewel nie uitsluitlik nie, op immunisering, tienerswangerskap en MIV/Vigs-opvoeding fokus en aandag aan gesondheidsprobleme soos swak sig en gehoor skenk. Die nuwe skoolgesondheidsprogram is gedurende Oktober 2012 in baie arm skole in KwaZulu-Natal, Gauteng en Limpopo geloods en sal oor die volgende vier jaar in arm sekondêre skole geïmplementeer word.

Die doel met dié navorsing was om die omvattende skoolgesondheidsdienste aan twee geselekteerde sekondêre skole in die Noordwes provinsie te bestudeer en te beskryf om aanbevelings te maak ten einde die lewensgehalte van adolessente te verbeter. Die navorser het van 'n verkennende, beskrywende, holistiese veelvoudige gevallestudie vir die insameling van ryk data by twee afsonderlike instellings (sekondêre skole) gebruik gemaak om die volgende doelwitte te bereik:

- Om 'n demografiese profiel vanuit bestaande rekords/dokumente by elke geselekteerde sekondêre skool te identifiseer en te beskryf.
- Om te verken en te beskryf hoe omvattende skoolgesondheidsdienste deur sleutelpersone aan twee geselekteerde sekondêre skole in die Noordwes provinsie ervaar word.
- Om die menings van sleutelpersone oor hoe omvattende skoolgesondheidsdienste aan twee geselekteerde sekondêre skole in die Noordwes provinsie voorsien behoort te word, te verken en te beskryf ten einde die gesondheid aan adolessente te verhoog.

Die beskrywing van 'n demografiese profiel was moontlik met die hulp van 'n demografiese vraelys voltooi deur die skoolhoof vir volledige agtergrondkennis van elke skool ingesluit in die navorsing. Ryk inligting van sleutelpersone se ervarings en menings van omvattende skoolgesondheidsdienste is deur middel van vier fokusgroep onderhoude ingesamel. Resultate van die data-ontleding het 'n gebrek aan omvattende skoolgesondheidsdienste aan adolessente in twee sekondêre skole uitgewys. Die bevindinge het gesondheidsprobleme van adolessente sowel as fisiese en emosionele uitdagings aangedui waarvoor opvoedkundiges nie toegerus en/of nie genoeg tyd het nie. Gevolgtrekkings gemaak uit die navorsingbevindinge het bygedra tot die aanbevelings gemaak vir die verpleegkunde praktyk, verpleegonderrig en verpleegnavoring vir die verhoging van die lewenskwaliteit van die adolessent deur middel van omvattende skoolgesondheidsdienste.

Sleutelwoorde: omvattende skoolgesondheidsdienste, gesondheid, gesondheidsbevordering, adolessent, ervaring, menings, sekondêre skool

ABBREVIATION LIST

Aids	Acquired immunodeficiency syndrome
CDC	Centre for Disease Control and Prevention
CIA	Central Intelligence Agency
CTOP	Choice on Termination of Pregnancy
DENOSA	Democratic Nursing Organisation of South Africa
DoBE	Department of Basic Education
DoE	Department of Education
DoH	Department of Health
DoSD	Department of Social Development
HCT	Health Care Training
HIV	Human immunodeficiency virus
NEI	Nursing Education Institution
ISHP	Integrated School Health Policy
NGO	Non-Governmental Organisation
NQF	National Qualifications Framework
PHC	Primary Health Care
PMTCT	Promotion of Mother To Child Transmission
SADC	Southern African Development Community
STI	Sexual Transmitted Illness
UNICEF	United Nations International Children's Emergency Fund
USDA	United States Department of Agriculture
WHO	World Health Organisation

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CHAPTER 1

INTRODUCTION AND OVERVIEW

1.1 INTRODUCTION

“The foundation of every state is the education of its youth” (Laertius, s.a.).

Investments in the youth maximise their ability to contribute to society as adults (Sines, Saunders & Forbes-Burford, 2009:172; United Nations International Children’s Emergency Fund [UNICEF], 2011:62). There is a strong connection between education and health; two important investment areas of the youth (World Health Organisation [WHO], 1995; Marx, Wooley & Northrop, 1998:39). Education, which is a central part of adolescents’ development, prepares them for adulthood and later life (Panday, Makiwane, Ranchod & Letsoalo, 2009:9). Health deprivation can have a negative influence on adolescents’ education as they cannot focus and thrive at school due to hunger, depression, illness, abuse and tiredness (Marx *et al.*, 1998:38; Donald, Lazarus & Lolwana, 2002:27; Jones & Bradley, 2007:433; Larsson, Sundler & Ekebergh, 2012:1). The link between health and education already existed in 1902 and was noticed by Lillian Wald, a public health nurse and founder of the Henry Street Visiting Nurses Service (Brody, 1996). She assigned nurses to schools for teaching on child health (American Decades, 2001) in New York City with remarkable results. Within one year the absenteeism and/or school exclusions decreased by 90% (Clark, 2006:536). Geierstanger, Amaral, Mansour and Walters (2004:347) confirmed that healthy children make better students.

Furthermore, absenteeism or school exclusions is confirmed by Anthony Lake, the Executive Director of United Nations International Children’s Emergency Fund (UNICEF), who states that nine out of ten adolescents living in developing countries, are adversely challenged with anything from getting an education to simply staying alive (Jones & Bradley, 2007:433; UNICEF, 2011:ii). It was identified in the 2011 UNICEF Report on the Status of the World’s Children (UNICEF, 2011:19) that the biggest risks for adolescents are accidents, HIV/Aids, early pregnancy, unsafe abortion, dangerous behaviour such as tobacco and drug use, mental health issues,

poverty and violence with possible negative effects on their education as confirmed by Chinyoka and Naidu (2013:195) and the Department of Education [DoE] (2007:102). In South Africa adolescents are growing contributors to the health burden profile and deaths caused by HIV/Aids, injuries, violence and substance abuse (Panday *et al.* 2009:21).

In 2010 UNICEF reinforced the importance of caring for children's health and education during their convention on the Rights of the Child (UNICEF, 2010:18). The South African Government was aware of this report and therefore implemented regulatory documents, namely the Bill of Rights with reference to Chapter 2 of the Constitution (1996) and the School Health Policy and Implementation Guidelines (Department of Health, 2003:vi) which is replaced by the new Integrated School Health Policy (Department of Health & Department of Basic Education, 2012:1).

The rights of children with regard to health in a school setting was further challenged and complicated by differences such as language, culture and socio-economic status (Donald *et al.*, 2002:218; Vang, 2006:20). Globally children growing up in unsupported households are subjected to mental, physical and emotional abuse, apart from often being deprived of food, shelter and a safe environment. Subsequently exploitation frequently leads to diseases, teenage pregnancy, substance abuse, emotional instability, low self esteem, depression and even death. These factors all have a direct impact on poor school achievement and an increasing drop-out rate (UNICEF, 2011:31; Sines *et al.*, 2009:172; Department of Education, 2007:91; Coulson, Goldstein & Ntili, 1998:61).

These negative factors all lead to absenteeism or school exclusions as confirmed by UNICEF (2011:29). According to this report 38% of adolescents in sub-Saharan Africa are not attending school. Household surveys done in South Africa between 2000 and 2007 proved that 0.67% of children (122 000 out of 18.2 million) live in child headed households (Meintjies, Hall, Marera & Boulle, 2009:1) and although the surveys indicate that 95% of these children do attend school, the drop-out rate was not indicated. Currently, in South African public schools the drop-out rate for Grade 9 and 10 learners are more than 10% and more than 20% for Grade 12 (Department of Education, 2009:56). Other reasons for dropping out of school, as

indicated by adolescents, are poverty, inability to pay school fees, the need to get a job to sustain a family and teenage pregnancies (Panday *et al.*, 2009:38)

The opinion of the researcher, that available and accessible comprehensive school-health services in secondary schools could contribute a great deal to optimal health and better education amongst adolescent learners, is despite poor school attendance and academic performance. This is confirmed by Allison, Crane, Beaty, Davidson, Melinkovich and Kempe (2007:887). Promoting school-health to prevent health risks and effective programmes “can be one of the most cost effective investments a nation can make to simultaneously improve education and health” (WHO in Olver, Boulle, Kruger and Morran, 2011:11). Primary Health Care (PHC) in South Africa is known for poor service, inconvenient times, long waiting periods and unfaithful personnel with regard to confidentiality (Panday *et al.*, 2009:38).

Various authors suggest that the school setting is the ideal environment for the implementation of comprehensive school-health services to promote adolescent health (Reagon, Irlam & Levin, 2003:16; Stanhope & Lancaster, 2010:584; Sines *et al.*, 2009:176; Clark, 2008:651; Borup & Holstein, 2006:1). For a better understanding on what comprehensive school-health services should entail, the researcher studied international as well as national literature about current school-health services. Internationally the Coordinated School Health Programme was introduced to schools to determine the health and safety level of its learners, employees, environment, parents and the community at large (Stanhope & Lancaster, 2010:583; Clark, 2008:633; Marx *et al.*, 1998:4; Gross, 2004:796; McCullum-Gomez, 2006:2039). The aim of the Coordinated School Health Programme is to promote learners’ total health and includes eight components (Fig. 1.1). The school nurse coordinates the comprehensive school-health program which includes nutritional-, health and counselling services, mental health services, health education, physical education, parent and community involvement, wellness promotion as well as a healthy and safe school environment (Stanhope & Lancaster, 2010:581; Clark, 2008:637).



Figure1.1: Components of a Coordinated School Health Program adapted from Stanhope and Lancaster (2010:581) and Clark (2008:637)

Comprehensive school-health services range from preventing illness by implementing immunisation programs, identifying and treating current problems or referring adolescents to relevant health team members, care and support to chronic ill and handicapped adolescents and the implementation of a school wellness program to engage the community and to bridge the gap between physical activity, available nutritional food and obesity (Avery, Johnson, Cousins & Hamilton, 2013:13; Stanhope & Lancaster, 2010:584; Sines *et al.*, 2009:176; Clark, 2008:651). Additionally, Barnes, Courtney, Pratt & Walsh (2004:316) highlight another ideal health service to Australian adolescents. The authors refer to comprehensive health care services, including interventions, such as confidential health consultations to the school community, supporting school-health related programs, planning and implementing health promotion strategies, liaising with the community and non-governmental organisations as well as informing, supporting and advising young people about health matters.

However, the Southern African Development Community (SADC) identified unique health needs and challenges, making it difficult to render any kind of health service to children. In some instances the school setting is not even available. The Southern region of Africa, including South Africa, has 17 million orphans, which indicates that two-thirds of the population live below the international poverty line, 16% of all children do not attend school and 40% of those who do attend school do not even complete primary school (SADC, 2012:1). They recommend minimum health services to the youth including immunisation, micro-nutrient supplementation, therapeutic feeding and oral re-hydration, prevention, treatment, care and support to Malaria, HIV/Aids, Tuberculosis, sexual and reproductive health care, youth counselling and support to children with psychosocial disorders (SADC, 2012:v).

Comprehensive school-health services to adolescents in South Africa impose its own challenges as adolescents often live far from school without transport, prohibiting access to health care. The Policy Guidelines for Youth and Adolescent Health (Department of Health, 2001:30-32) states that, although 83% of adolescents between the age of 15 and 19 attend school, 56% of them live more than 5km away from any health facility. The Department of Health (DoH) describes these facilities as only relatively accessible. Furthermore, adolescents and young people are not comfortable to make use of these health services (Panday *et al.*, 2009:18). In this regard according to the South African Policy Guidelines for Youth and Adolescent Health the school is an effective site to render comprehensive school-health services to adolescents, comprising components outlined by the Department of Health (2003:21-29):

- health assessment of Grade R and/or Grade 1 learners with regard to nutritional status, hearing and vision ability, physical growth and development, health promotion and health education by incorporating life skills, healthy living styles and self-care for chronically ill learners into the school curriculum;
- referral to Primary Health Care (PHC) facilities;
- monitoring the progress of health issues;

- ad hoc activities, such as parasite control, counselling and treatment of minor ailments, such as skin conditions, and
- to involve all stakeholders in school health.

According to Meintjies *et al.* (2009:3) nutrition is one of the biggest challenges influencing adolescent health and subsequently, their school attendance (Department of Health, 2001:57; Marx *et al.*, 1998:197; Robinson & Weighley, 1984:163). Maslow's hierarchy of needs described in O'Donnell (2012:2) confirms that a person's basic needs (in this study the adolescent's basic needs) should be fulfilled before progress on the next level is possible, as illustrated in figure 1.2. Maslow's hierarchy includes poor nutrition. This is the reason why the School Health Services Program in South Africa (Department of Education, 2003:21-29) currently promotes assessment of poor nutrition. Although the assessment is mainly aimed at Grade R/1 learners, the National School Nutrition Program's Annual Report of 2009/2010 states that the Department of Basic Education (DoBE) also implemented the program in 123 secondary schools where 55 407 learners receive nutritional support (Department of Basic Education, 2010:54) to meet some of their basic needs.

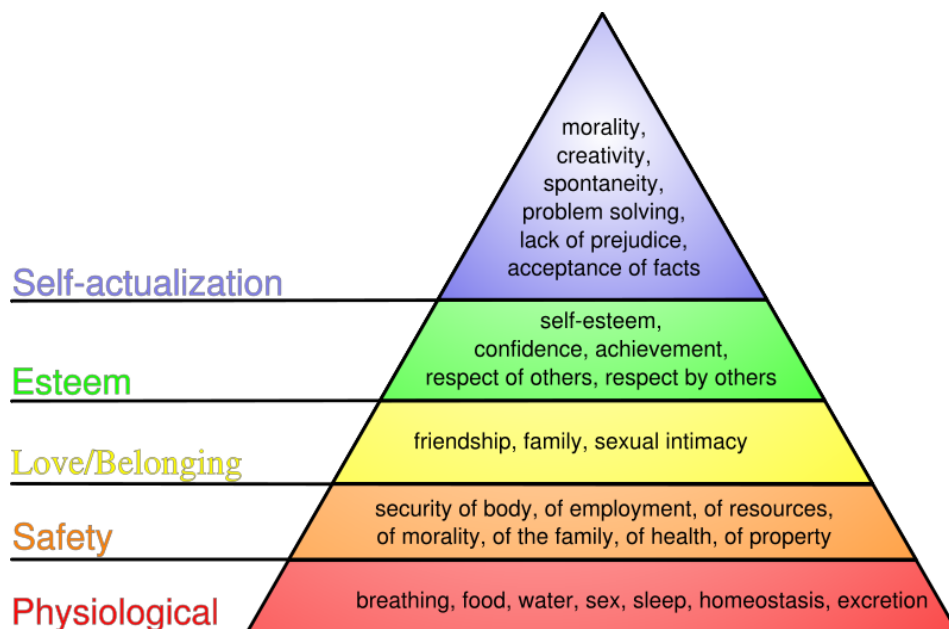


Figure 1.2: Maslow's Hierarchy of Needs as illustrated by O'Donnell (2012:2)

In addition to the mentioned nutritional support services in schools, PHC services are rendered to school settings where nurses implement the school-health programme to promote adolescents' health (Reagon, Irlam & Levin, 2003:15; Mukoma & Flisher, 2004:357-368). A survey done by Reagon *et al.* (2003:16) indicates shortfalls of school-health services during 2003. According to Table 1.1 only 60% of districts in the North West Province (NW) are regularly visited for school-health. It also indicates that only 56% of all sub-districts have formal school-health services.

Table 1.1: School Health Promotion Services provided as found in a PHC facility survey done in South Africa during 2003 (Reagon *et al.*, 2003:16)

Item (Survey done during 2003)	EC	FS	GP	KZN	LP	MP	NC	NW	WC	RSA
% Districts where schools are visited regularly by a nurse 2003	57	41	61	39	55	30	43	60	58	52
% School Health Nurses who were specifically trained in School Health 2003	56	40	88	100	32	49	50	69	82	67
% Sub-Districts who have a formal School Health Promotion Team 2003	46	17	38	50	40	73	15	56	52	45

In order to fully understand the importance of comprehensive school-health services in secondary schools, "health" in the context of school-health and "health promotion of the adolescent" should be examined separately in order to complement each other. Watson and Wissing (2004:24) stated from a pathogenic (illness) perspective that it is important to know what causes psychological problems, such as depression amongst adolescents within the school community and how the risks can be reduced. On the other hand, it is important to understand from a wellness perspective how it is possible for some adolescents to thrive even under miserable circumstances. Furthermore, the author states that both perspectives can uniquely contribute towards the understanding of the origin, dynamics and promotion of health.

The Ottawa Charter for Health Promotion (Hancock, 2011:405) defines health as "...created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by

being able to make decisions and have control over one's life circumstances, and by assuring that the society one lives in, creates conditions that allow the attainment of health by all its members". In the light of this description it is important to take cognisance of the various ways adolescents in secondary schools influence the *dimensions of human functioning*, linked to the WHO's definition of health as "...a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1948). The WHO expands its view of health promotion to an inter-sectorial activity by creating supportive environments and increasing community participation and involvement (Dennill & Rendall-Mkosi, 2012:20), which in this study applies to the health of adolescents in secondary schools supported by health and other services.

In order for adolescents, with basic health needs, to achieve optimal health – from a multi-dimensional viewpoint (Henderson, 2010:5), it can be achieved by focussing on the dimensions of health care including primary prevention; that is prevention of injury or illness and health promotion, secondary prevention; screening, diagnosis and treatment and tertiary prevention; prevention and treatment of consequences and prevention of recurrence (Clark, 2008:72).

It is important to remember that adolescents have various health needs to be fully functional human beings and at ease with themselves. Psychological health issues such as poor coping skills can influence their academic performance (Haraldson, Lindgren, Fridlund, Baigi, Lydell, & Marklund, 2007:31; Henry & Kelly, 2005; Pender, 1996). Literature also indicates that developing life skills equip adolescents to make better health decisions and to change risky behaviour (Biglan, Brennan, Foster, & Holder, 2005:133). To assist the South African DoH in attending to adolescents' health needs the Department of Education (DoE) appointed school counsellors and introduced Life Orientation as a school subject – a holistic approach which equips adolescents to become healthy and productive members of society (Department of Education, 2003:9). The holistic approach involves assessing, planning and implementing actions with a positive effect on adolescents' physical, psychological, social and spiritual well-being (Dossey, Keegan & Guzzetta, 2005:10).

According to the Ottawa Charter for health promotion in schools (Haraldson *et al.*, 2007:31; Marx *et al.*, 1998:4; 100; Donald *et al.*, 2002:142) available information about health issues and school counselling ascertain healthy adolescents as well as a positive and involved community and parent corps. Houghugi and Long (2002:9) and Topor, Keane, Shelto and Calkins (2010:1) confirm that children of involved and caring parents, within a safe home environment and operational ground rules, are more likely to stay in school and to become successful adults. Thus, it is imperative that stakeholders, teachers, peer group leaders, friends, members of the multi-disciplinary health team, non-governmental organisations, faith-based organisations and family members are part of adolescents' lives (Chun & Dickson, 2011:94).

According to the President of the Democratic Nursing Organisation of South Africa (DENOSA) the DoH intends to focus more on PHC and therefore also on school-health services to bridge the gap between health, wellness and academic achievement (Matebeni, 2011:19). The DoH and DoBE's new Integrated School-Health Programme (ISHP) was launched on 11 October 2012 by the honourable President of South Africa, President Jacob Zuma (The Presidency, 2012) to build and strengthen existing school-health services, which involves the following:

- close collaboration between all role-players, with joint responsibility by the DoH, DoBE and Department of Social Development (DoSD) to ensure that the ISHP reaches all learners in all schools;
- services to learners in all educational phases;
- more comprehensive services addressing not only learning barriers, but also other conditions contributing to morbidity and mortality amongst learners during childhood as well as adulthood;
- increasing emphasis on health services in schools to ensure that assessed learners in need of additional services receive it;
- a more systematic approach with regard to implementation than previous guidelines which mainly focused on district level implementation with inadequate coverage at sub-district, school and learner levels, aiming to ensure that all learners are reached and

- the ISHP should be implemented in the Care and Support for Teaching and Learning Framework currently used by the DoBE to cohere all care and support initiatives implemented in and through schools, including school-health services.

The complete proposed school-health package of services for primary and secondary schools are summarised in the Integrated School Health Policy (Table 1.2). It is interesting that Grades 10 to 12 are not indicated in the table below. The reason could be that the programme will first be implemented in the lower grades before the higher grades will be considered. Another important aspect is the proposal by the DoH to focus on a range of services to quintiles 1 and 2 schools which include screening for developmental conditions and assurance that all immunisations are up to date. Furthermore, the life skills program to all grades will be supplemented with sexual and reproductive health education. As recourses become available the services will be expanded to quintile 3, 4 and 5 schools (Pillay & Barren, 2012:3). According to a Report of the Ministerial Committee: Schools that Work (Christie, Butler & Potterton, 2007:3-4) schools are classified as quintile 1 or 2 when considered very poor and quintile 4 or 5 when considered to be privileged, including the majority of former white schools. The South African norm is quintile 3.

Table 1.2: Summary of the proposed school health package as outlined in the Integrated School Health Policy (DoH & DoBE, 2012:14)

Health Screening	On-site services	Health education
Foundation phase (Gr. R–3)		
<ul style="list-style-type: none"> • Oral health • Vision • Hearing • Speech • Nutritional assessment • Physical assessment • (gross & fine motor) • Mental Health • Tuberculosis • Chronic illnesses • Psychosocial Support 	<ul style="list-style-type: none"> • Parasite control • De-worming and bilharzias control (where appropriate) • Immunisation • Oral health (where appropriate) • Minor ailments 	<ul style="list-style-type: none"> • Hand washing • Personal & environmental hygiene • Nutrition • Tuberculosis • Road safety • Poisoning • Know your body • Abuse (sexual, physical and emotional abuse)

Health Screening	On-site services	Health education
Intermediate phase (Gr 4-6)		
<ul style="list-style-type: none"> • Oral health • Vision • Hearing • Speech • Nutritional assessment • Physical assessment • Mental Health • Tuberculosis • Chronic illnesses • Psychosocial Support 	<ul style="list-style-type: none"> • De-worming • Minor ailments • Counselling regarding SRH (if indicated), and provision of and referral to services as needed 	<ul style="list-style-type: none"> • 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)		
<ul style="list-style-type: none"> • Vision • Hearing • Speech • Nutritional assessment • Physical assessment incl. <ul style="list-style-type: none"> - Anaemia - Mental Health - Tuberculosis - Chronic illnesses - Psychosocial support 	<ul style="list-style-type: none"> • Minor ailments • Individual counselling regarding SRH, and provision of or referral to services as needed 	<ul style="list-style-type: none"> • 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

Health Screening	On-site services	Health education
FET (Grade 10-12)		
<ul style="list-style-type: none"> • Nutritional assessment • Vision • Oral health • Ear examination • (Hearing) • (Speech) • Chronic Illness • TB screen • Anemia screen • Psychological support • Mental Health • Physical assessment 	<ul style="list-style-type: none"> • Minor ailments • Individual counselling regarding SRH and provision of or referral to services as needed 	<ul style="list-style-type: none"> • Personal & environmental hygiene • Nutrition • Tuberculosis • Abuse (sexual, physical and emotional abuse including bullying, violence) • Sexual & reproductive health • Menstruation • Contraception • STIs incl. HIV • MMC and traditional • Teenage pregnancy, CTOP, PMTCT • HCT & stigma mitigation • Drug and substance abuse • Suicide
All Schools		
<ul style="list-style-type: none"> • First aid kit • Water and sanitation • Cooking area • Physical safety • Ventilation (airborne infections) • Waste disposal • Food gardens • Recycling 		

However, current school-health nurses identify concerns listed below which can have a negative influence on quality services, if not addressed (DoH & DoBE, 2012:10):

- insufficient staff for frequent visits to schools, resulting insufficient time and attention to children;

- a lack of or insufficient basic equipment, such as weighing scales;
- a lack of a conducive environment in classrooms for screening and examining children;
- improper health assessment due to a lack of privacy;
- referral systems not always available to respond to identified health needs;
- limited routine visits as nurses generally visit schools once a year due to a lack of transport, poor roads and infrastructure.

South Africa's commitment to address quality health care is based on the Brazilian PHC model, associated with a "Three Stream" PHC re-engineering model (Pillay & Barren, 2012:3) emphasising the following components:

- a ward-based PHC outreach team for home care in each electoral ward by focussing on health promotion and illness prevention in order to ensure a healthy community, family and environment;
- **strengthening school-health services;**
- district clinical specialist teams initially focussing on the improvement of maternal and child health.

The ISHP, integrated in the PHC re-engineering package, focuses on learner coverage, common learning barriers and learners' social well-being. Implementation of specific school-health programmes involve the appointment of a school-health team led by a dedicated professional nurse responsible for health assessment, screening and health promotion (Olver *et al.*, 2011:18).

1.2 PROBLEM STATEMENT

According to Dossey, Keegan and Guzzetta (2005:36) the focus should not only be on pre- and primary school health promotion, but also on health promotion which includes the adolescent. Thus, health care services should involve primary, secondary as well as tertiary levels (Clark, 2008:651-659). The WHO suggest that school-health programmes should be seen as a strategic means to prevent health risks amongst adolescents and to engage the education sector in efforts to change the educational, social, economic and political conditions affecting risk (Olver *et al.*,

2011:11). It is evident that there are many international and national identified challenges with regard to adolescent health. The researcher, a professional nurse and mother of adolescent children, is alert and concerned about the inadequate school-health services in secondary schools. The researcher's concern was triggered by informal discussions (Annexure H) with parents of adolescent children whose health needs were ante-natal care and aftercare after the removal of a brain tumour. One learner was confidentially and compassionately cared for with, a positive influence on her school attendance and performance versus the others who had to depend on their own devices. In addition, the main concern of a principal at a secondary school in an informal discussion was about teachers who are not well-equipped with skills to identify and/or do not have the time to tend to adolescents' health needs.

From the literature, and the concerns and needs voiced by parents and educators, the researcher ask the question; how can comprehensive school-health services be implemented in secondary schools in the North West province to enhance the quality of adolescents' health? Subsequently, the following questions should be answered by means of this study:

- What does the demographic profile of two selected secondary schools in the North West province entail?
- How do the key stakeholders in two selected secondary schools in the North West province experience comprehensive school-health services?
- How can comprehensive school-health services be rendered to the two selected secondary schools in the North West province to enhance the quality of adolescents' health as perceived by the key stakeholders?

1.3 AIM AND OBJECTIVES

The aim of this explorative and descriptive study about comprehensive school-health services to two selected secondary schools in the North West province was to propose recommendations to nursing practice, -education and -research for improvement in this particular field and ultimately enhance the quality of the adolescents' health. The following objectives are necessary to achieve the overall aim:

- To identify and describe the demographic profile from existing records/documents available at each selected secondary school.
- To explore and describe how comprehensive school-health services are experienced by key stakeholders, in two selected secondary schools in the North West province, and
- To explore and describe the perceptions of key stakeholders on how comprehensive school-health services should be rendered in two selected secondary schools in the North West province to enhance the quality of life of the adolescent.

1.4 PARADIGMATIC PERSPECTIVE

A paradigmatic perspective represents the researcher's views about life and its influence on the conduct of the study (Botma, Greeff, Mulaudzi & Wright, 2010:186), which comprises of meta-theoretical, theoretical and methodological assumptions.

1.4.1 Meta-theoretical assumptions

Meta-theoretical assumptions refer to the researcher's beliefs about human beings, the environment they live in, health and influencing interactions with regard to health and/or nursing. These assumptions cannot be tested. The assumptions for this research are based on the Biblical principle, in Genesis 2:7-8, that man has been created uniquely to be part of his environment (Bible, 1983). A Christian perspective is the underlying understanding of adolescents in secondary schools, key stakeholders' involvement in school-health programmes and the belief that comprehensive school-health services in secondary schools could enhance adolescents' quality of life as well as prevent risks.

The researcher views *adolescents' health* as a gift from God, implying that all human beings should be without disease, pain, hunger and emotional distress. Furthermore, adolescents' health include the satisfaction of all health needs to live in harmony and contentment in a particular environment.

Everybody is equal before God, although with a unique mind, body and spirit. Man's purpose on earth is to love and serve God as well as his fellowmen. *Human being* in this study implies the adolescent – a unique person between 13 and 19 years with

unique health needs which have to be addressed in order to reach his/her maximum potential and to experience and express love.

As man serves God in an *environment* created by Him, it should be safe and conducive to health, which includes school surroundings, homes and the community where adolescents participate in daily activities.

Nursing refers to goal directed actions and service-rendering interaction with the aim to help human beings. This study focuses on assistance to adolescents who need to accomplish equilibrium. Service-rendering should be of such a nature that adolescents' uniqueness and privacy is sustained. The nurse should draw her strength from God to integrate all nursing tasks with love and diligence in order for adolescents to be healthy and able to thrive at school.

Although the researcher's assumptions are from a Christian viewpoint, it was necessary to consider other authors and their views when defining applicable concepts in this study.

1.4.2 Theoretical assumptions

These assumptions represent theoretical knowledge including theories, models, concepts and definitions to support the research (Botma *et al.*, 2010:187). The Dimensions Model of Community Health Nursing as adapted from Clark (2008:69-74) and to a lesser extent the health promotion model of Pender, form the basis of this research and reason that adolescents are multi-dimensional in nature and interact within their environment where health and the level of well-being should increase.

Adolescents are seen as bio-psycho-social complex individuals who interact with their environment which could be the secondary school. Adolescents progressively transform the school environment, as they are being transformed over a period of time by the school environment. According to Pender (*in* Clark, 2006:197-200) stakeholders, such as the school nurse, teachers and family members, are part of adolescents' interpersonal environment. Pender also addresses resources, such as the availability of adolescents' families, peers and health care providers (school and health services) for personal use, which adolescents may lack in secondary schools whilst seeking better health by interaction with their environment. Adolescents'

characteristics and experience play a role in this interaction process. The Dimensions Model incorporates six specific dimensions of health; the biophysical-, the psychological-, the physical-, the social-, the behavioural-, and the health system dimension. Factors within each dimension affects the health of the adolescent individually, are in interaction with each other and form the basis for assessment of adolescents health and thus this research. In table 1.3 hereafter follows a short summary of the Dimensions Model applicable to the research.

Table 1.3: Dimensions of health of adolescents as adapted from Clark (2008:69-73)

Bio-physical Dimension	This dimension includes factors related to human biology that influences health, such as age (learners aged 13 to 19 years as adolescents), gender (including young men and women) and health problems, such as obesity which can cause diabetes, heart diseases and stroke, genetic inheritance such as ethnic character, immunity, the population and the prevalence of conditions, e.g. teenage pregnancy. Gatherings in the school hall or large groups living in hostels can spread colds, flu and TB. This dimension also relates to the availability of and actual resources received, e.g. access to health services and educational opportunities. Adolescents are in a developmental phase, which is known as active and susceptible to new experiences as well as experimenting themselves and which can lead to either a good or a bad outcome of their health.
Psychological Dimension	This dimension comprises of the internal psychological environment including factors such as the ability to cope with stress, depression and low self-esteem which can lead to health problems, such as suicide, substance use/abuse and violence, and the external psychological environment which includes factors such as emotional support or the lack thereof and stress.
Physical Environmental Dimension	Relates to terrain, buildings, unsafe conditions, sufficient light, exposure to pathogens, allergens, radiation, extreme heat or cold and noise. In this study the physical environment refers to school grounds and buildings, maintenance and safety thereof and whether it is sufficient for the amount of learners.
Socio-cultural Dimension	Some elements of this dimension influencing life and health are economics, politics, ethics, legal influences, societal norms and accepted modes of behaviour. Social attitudes towards substance abuse, mental illness, family violence, social networks, adolescent pregnancy, and the fear for stigma attached to HIV can contribute to the problem or hinder the solution. The two schools involved in the research are from two different socio-economical and cultural backgrounds. One school is predominantly English speaking learners and the other predominantly Afrikaans speaking learners.

Behaviour Dimension	Related behaviour promoting or impairing health include, but is not limited to dietary patterns which can lead to anorexia or bulimia, recreation and exercise can both enhance physical and emotional health. Some behaviour of adolescents in schools can be harmful, such as substance use and abuse, sexual activity which can lead to adolescent pregnancy and transmittance of diseases and the use of protective measures.
Health System Dimension	This dimension relates to the way in which health care services are organized and their availability (type and number of health services in a community), accessibility (adolescents' ability to use those services), affordability (ability to pay for services), appropriateness (health care system's ability to render needed services to adolescents), adequacy (quality and amount of rendered service in relation to existing needs), acceptability (the level of congruence between rendered services and adolescents' expectations, values and beliefs) and the extent to which adolescents actually make use of available health care services.

1.4.3 Central theoretical statement

By exploring and describing existing school-health services to adolescents as experienced by stakeholders and their perceptions on how comprehensive school-health services should be rendered in two selected secondary schools in the North West province, the researcher was able to make recommendations to the nursing practice, nursing education and nursing research on how comprehensive school-health services should be rendered in two selected secondary schools for adolescents to enhance their quality of life.

1.4.4 Concept clarification

In order to ensure consensus of different concepts in the research and clarity to the reader, all applicable concepts will be defined in the following paragraphs.

1.4.4.1 Health

The WHO defines health as "...a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (Dennill & Rendall-Mkosi, 2012:7; WHO, 1948). In addition, Lewin (2010:2) defines health as the condition of physical, bio-physical, social, psychological and spiritual equilibrium. Health and illness are part of the same continuum, and adolescents continuously move between the two striving towards wellness (Roy, 2010:3). Adolescents' health not only refers

to the state where basic needs, as indicated in Maslow's hierarchy of needs in O'Donnell (2012:2) have been met, but also to a higher order of needs. Thus, adolescents can function as holistic human beings in a harmonious environment with balanced dimensions of health, namely bio-physical, psychological, and physical environmental, socio-cultural, and behavioural and health systems (Clark, 2008:73).

1.4.4.2 Physical environment

Physical environment indicates the setting in which adolescents live, feel, learn and socialise. Adolescents interact with other learners and teachers on the school premises and with health care practitioners at health care centres which in turn has a positive or negative influence on adolescents' health or health behaviour (Neuman, 2010:4; Clark, 2008:73).

1.4.4.3 Nursing

The word "nursing" implies caring for individuals and communities in order to promote health in a holistic manner. Neuman (2010:9) states that nursing is a unique profession through which individuals (adolescents), families and groups are assisted to maintain maximum wellness and to help stabilizing the patient system (adolescents in a Secondary School) by nursing interaction. According to the National School Health Policy and Implementation Guidelines (Department of Health, 2001:4) nursing refers to the activities of a health worker who has been trained with necessary skills to render school-health services.

1.4.4.4 Comprehensive school-health services

School-health services should be structured appropriately and aimed at ensuring that rendered services are integrated with other Primary Health Care activities (Department of Health, 2001:6 & 12). In addition to this statement of the DoH, Clark (2008:74) indicates that the dimensions of health care refer to holistic care by primary prevention (prevention of injury or illness and health promotion), secondary prevention (screening, diagnosis and treatment) and tertiary prevention (prevention and treatment of consequences and prevention of recurrence).

Comprehensive healthcare services should be accessible and user friendly and rendered at existing healthcare centres or on the premises of secondary schools. School-health services should also encourage the school to develop and implement policies which promote and sustain health, improve the physical and social environment where children learn and develop, and improve children's capacity to become and stay healthy (Centre for Disease Control and Prevention [CDC], 2010:1). Therefore, an important challenge is posed upon health services in school settings to provide a promoting service as well as preventive activities for children and the youth (Department of Health, 2001:12). Comprehensive health services with regard to this research indicate coordination by using the skills and capacity of different key stakeholders including the community, learners, educators, parents and non-governmental organisations [NGOs].

1.4.4.5 Adolescents

According to the WHO (2011), adolescents are young people between the age of 10 and 19 years. Ahmead and Bower (2008:2) describe adolescence as “a transition period from childhood to adulthood that involves physiological changes, developments in cognition and emotion, changes in social roles with peers and the opposite sex, and considerations of school and career. It involves the development of identity, independence from family and adaptation to peer”. For the purpose of this research the adolescent is a young person between the age of 13 and 19 years, attending a Secondary School with basic health needs manifesting in different health dimensions: physical, bio-physical, psychological social cultural, behavioural and health systems.

1.4.4.6 Stakeholders

According to the Concise Oxford English Dictionary (2009:1404) a stakeholder is a person with an interest or concern in something. The WHO defines stakeholders as “persons, groups or institutions with interests in a project or policy or who may be directly or indirectly affected by the process or the outcome” (WHO, 2005). In this research, stakeholders are all educational leaders, teachers, peer group leaders, members of the multi-disciplinary health team, non-governmental organisations,

faith based organisations and family members who benefit from proposed action plans

1.4.4.7 Secondary schools

These relate to educational institutions for children from eleven to sixteen or eighteen years (Concise Oxford English Dictionary, 2009:1299). According to levels of education in South Africa, Grade 8 and 9 are classified under general education and Grades 10, 11 and 12 as further education and training. According to the National Qualifications Framework (NQF) Grades 8 and 9 are on level 1, Grade 10 is on level 2, Grade 11 on level 3 and Grade 12 on level 4 (National Qualifications Framework, 2008). In the context of this research, a secondary school is a facility with learners from age 13 to 19 (adolescents), in Grade 9 to 12 of which administration is private or Government subsidised.

1.4.4.8 Health promotion

Health promotion is a process which empowers an individual, in this study the adolescent, to take control of his/her own health. This empowerment is reached by health literacy, a safe and conducive environment for health promotion and support systems to sustain health growth (International encyclopaedia of public health, 2006:225–240). The WHO, as mentioned in Clark (2006:224), defines health promotion as “the process of enabling people to increase control over and to improve their own health.” In this study health promotion is described as a continuous process of not only providing relevant health information, but also services, facilities and support to adolescents in order to take control of their own health. Furthermore, health promotion activities can be presented at any secondary school setting.

1.4.4.9 Experience

Experience encompasses an individual’s contact with and observation of facts, events or activities which lead to knowledge and skills in a matter of time with a lasting impression (Concise Oxford English Dictionary, 2009:501). As seen by Weiner (2003:36), experience can be knowledge and/or skills gained by actions or

stimuli imposed on an individual. Experience in this study refers to an incident which demands one's attention, engages a person physically, psychologically, spiritually, emotionally and socially, and leaves a memory. Furthermore, the experience of stakeholders with regard to promotion of adolescent health and availability of comprehensive health services in selected secondary schools in the North West province are also explored.

1.4.5 Methodological assumptions

Methodological assumptions explain the researcher's beliefs of good science practice (Botes, 2006:6; Botma *et al.*, 2010:188). The research process is guided by the research model of Botes (2006:5-8). This model presents nursing activities on three levels, namely the nursing practice, methodology adapted for study and meta-theoretical assumptions.

The first level comprises of nursing practice, which entails health events in Secondary Schools. This research explores and describes experiences and views of stakeholders with regard to comprehensive school-health services to two selected Secondary Schools in the North West Province. Stakeholders and adolescents are the main focus groups in this research.

The second level represents adapted methodology, suitable to identify the research problem. The researcher and interviewer interacted with participants to gather data of their experiences and views on the availability of comprehensive school-health services to two selected secondary schools in the North West province. Consequently, recommendations and action plans are formulated for nursing practice, education and research. Research decisions direct the design, which include the sampling method, data collection, data analysis, ethical considerations and trustworthiness.

The meta-theoretical assumption becomes relevant on the third level (Botes: 2006:5-8), as described in paragraph 1.4.1 and of which the three orders interact with one another. Botes' research model (2006) has a functional perspective implying that actions within all three orders are diverted back to the nursing practice. In this study nursing practice implies the rendering of comprehensive school-health

services, as a component of the PHC re-engineering package, to adolescents in two selected secondary schools in the North West province in order to be healthy, to thrive academically and to become productive members of society.

1.5 RESEARCH METHODOLOGY

An overview of the research design and research method is given next. Chapter 2 contains a more detailed explanation.

1.5.1 Research design

The researcher approached the case-study qualitatively which was explorative and descriptive of nature (Rule & John, 2011:8) and generated rich data from an in-depth study of two separate institutions (Rule & John, 2011:17; Shuttleworth, 2008:1; Burns & Grove, 2009:244). These institutions refer to two secondary schools in the North West province, each as a contextual case.

As mentioned by Shuttleworth (2008:1), each case, even in more than one case-study, should be treated individually for the results to be cross referenced and to draw conclusions. The choice of a relevant case-study for this research, as supported by Rule and John (2011:13-17), generated information from two secondary schools, each with its own context for better understanding of the stakeholders' experience of the current status of comprehensive school-health services and specific views of what comprehensive health services in selected secondary schools in the North West province should entail. It is important to explain the contexts in order to comprehend the selected population for this research. The contexts of the two secondary schools differ and influence the findings in each case.

1.5.2 Research method

A brief description of the research method pays attention to data collection including population, sampling and data analysis.

1.5.2.1 Population

Population refers to an entire group of people from whom the researcher can obtain rich relevant data applicable to the aim of the research. All secondary schools in the North West province form part of the research population. There are 12 school districts, in which the Dr Kenneth Kaunda district falls, and is divided into 3 sub-districts: Potchefstroom, Matlosana and Maquassie Hills. The two secondary schools participating in this research are in the Matlosana sub-district. The Dr Kenneth Kaunda district has 321 schools of which 76 are Secondary Schools and 32 are in the Matlosana sub-district (Department of Education, 2011). Furthermore, the focus was on key stakeholders involved in these secondary schools as possible participants. Stakeholders as the population are educational leaders, teachers, peer group leaders, members of the multi-disciplinary health team, non-governmental organisations, faith based organisations and family members involved at the schools. The researcher decided to work in the Matlosana sub-district as it was accessible and convenient (Botma *et al.*, 2010:123-124).

1.5.2.2 Sampling

After consulting school-health nurses, the researcher decided to use a non-probability purposive sampling method for choosing the two secondary schools and stakeholders as informants. This method allowed the researcher to select key stakeholders as participants from the two secondary schools as the two cases to shed light on the phenomenon (Rule & John, 2011: 64), namely comprehensive school-health services in secondary schools in the North West province. The following inclusion criteria for the two cases (Botma *et al.*, 2010:126) applied in the research:

- the prospective schools should have at least 700 or more learners;
- Grade 8 to 12 learners should be represented in the school;
- schools should represent learners between 13 and 19 years; and
- schools should represent the socio-economic and cultural diversity of the district in the context of the research.

From the above inclusion criteria two secondary schools, one representing learners from a previous disadvantaged background and one model C-school representing learners from previously advantaged groups, had been selected to gather the most information. These schools are referred to as School [Case] A and School [Case] B.

The researcher liaised with each school's principal to act as mediator and to identify relevant key stakeholders willing to share their experiences and views on comprehensive school-health services to the two selected secondary schools in the North West province. All key stakeholders were sufficiently represented for the gathering of rich and true information (Rule & John, 2011:64). Key stakeholders had to be willing to participate; had to have an interest in the case and had to be physically and mentally able to participate to meet the inclusion criteria of the research.

The sample size indicates all stakeholders' contributions towards significant information of each case in order to supply the researcher with rich and in-depth data (Rule & John, 2011:64). The case-study focused on quality data rather than a big sample as long as saturation of data was reached (Burns & Grove, 2009:244; 361) to answer the research questions (Rule & John, 2011:72; Botma *et al.*, 2010:200).

1.5.2.3 Data collection

Data collection refers to pieces of information gathered by the researcher for a particular study (Polit & Beck, 2006:36). The purpose of this study was explained to the principals of the two selected secondary schools in order to cooperate as mediators. Data collection for this particular research is briefly discussed below.

- ***Method of data-collection***

Focus group interviews and case records like demographic information of the two cases were used to gather information (Burns & Grove, 2009:508). Discussions were led by an experienced facilitator who engaged 8 to 12 participants in each case (Rule & John, 2011:66) in order to obtain relevant rich data. The facilitator, a specialised psychiatric nurse, had the necessary skill with regard to appropriate

questions, listening and sensitive group dynamics. To initiate participatory discussions in the focus groups, the facilitator used a semi-structured interview schedule. The principal of each school completed a demographic data sheet beforehand to gain understanding on the background information and demographic profile of each school.

- **Setting**

The primary setting where the study had been conducted was the two selected secondary schools with its buildings and surrounding grounds. Focus group discussions were conducted in an available, ventilated, comfortable, private room of the primary setting, accessible to all participating key stakeholders. The natural setting excluded manipulation in any way (Burns & Grove, 2009:362). Electricity was another requirement in order for the researcher to use electronic apparatus, such as a voice recorder.

- **Role of the researcher**

The researcher observed and made field notes. Field notes (as suggested by Creswell in Botma *et al.*, 2010:191 & 219) consist of three segments being descriptive notes (notes on dialog, participant actions, immediate surroundings and events), reflective notes (the researcher's own thoughts, feelings and observations about what methods worked and what did not) and demographic information (notes about the time of day, the weather, the room and participants). The researcher used an electronic voice recorder to ensure that all data was captured for transcription.

1.5.2.4 Data analysis

All recorded focus group discussions had been transcribed for data analysis. Data analysis, as described by Creswell in Botma *et al.* (2010:223) implies data coding and identifying themes. A second, independent coder coded the data after which consensus discussions took place (Botma *et al.*, 2010:224). Demographic data was integrated with identified themes after which the findings of the two cases were integrated with discussions to formulate final conclusions for recommendations on comprehensive health services to selected secondary schools in the North West province.

1.5.2.5 Literature Integration

The researcher compared this particular study with other literature, either to confirm the findings as correct by similar studies or to confirm it as new information (Botma *et al.*, 2010:197).

1.6 MEASURES OF TRUSTWORTHINESS

The principles of trustworthiness are given in Table 1.4 as applicable to this study.

Table 1.4: Measures of trustworthiness as portrayed by Botma *et al.* (2010:232-235)

Epistemological standards	Strategies or Principles of trustworthiness	Researcher's application in the study
Truth value	Credibility <ul style="list-style-type: none"> ❖ Is the fullness and essence of the case captured? ❖ Does the study reflect what it set out to do? 	<ul style="list-style-type: none"> • Involve experienced interviewer for in-depth focus group interviews • Use interview schedule to pursue all information avenues • Adhere to ethical requirements • Give detailed description of the setting • Clarify understanding throughout focus group interviews to ensure accuracy and fullness of data • Make extensive field notes
Applicability	Transferability <ul style="list-style-type: none"> ❖ Can the outcome be applied to other cases? ❖ Can the results be contextualised? 	<ul style="list-style-type: none"> • Context clearly described and integrated with specific demographic information of each school • Sample must consist of knowledgeable representatives of the population • Conduct the interview until no new themes emerge • Thick / rich description of themes in relation to similar cases
Consistency	Dependability <ul style="list-style-type: none"> ❖ Focus on methodological rigour and coherence ❖ Can the community accept the results with confidence? ❖ Can the study be replicated and the same results concluded? 	<ul style="list-style-type: none"> • Clear identifiable research sources • Thick and dense description of methodology • Record and describe data accurately • Do a dependability audit (clear information on how and what data were collected) • Available data sets • Use a co-coder to verify emerging themes

Neutrality	Confirmability ❖ Concerns about the researcher's influence and bias on the study	<ul style="list-style-type: none"> • Full disclosure of the research process including limitation of the study and ethical considerations throughout the study • Let colleagues and more than one researcher as study leader check interpretation of findings • Do self-reflection to rule out bias
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1.7 ETHICAL CONSIDERATIONS

Ethics are part of a society's or specific community's moral principles adhered to. Rule and John (2011:111) concur and encourage researchers to conduct research in an ethically sound manner, thus enhancing the quality of the research and adding to its trustworthiness. According to Rule and John (2011:112) and Burns and Grove (2009:188-199) three principles denote ethical research involving human subjects, namely: (1) autonomy, (2) non-maleficence and (3) beneficence. The researcher indicates how these principles are adhered to in this research in Table 1.5.

Table 1.5: Ethical considerations as portrayed by Rule and John (2011:112); Burns and Grove (2009:188-199)

Ethical principle	Planned application in this study
Autonomy: ✓ Respect participants' right to self determination	<ul style="list-style-type: none"> ✓ Obtain ethical approval from the Ethical Committee of the NWU, Potchefstroom campus ✓ Obtain permission from DoE and informed consent from participants ✓ Total anonymity is not possible due to focus group (face to face) interviews, but no names are used. ✓ Personal information of participants is handled in confidence. Non-consented disclosure is excluded ✓ Participants can withdraw at any time ✓ Researcher respects intellectual property of participants

<p>Non-maleficence:</p> <ul style="list-style-type: none"> ✓ “Do no harm” 	<ul style="list-style-type: none"> ✓ Participants should not experience any physical or emotional harm during the data gathering process ✓ Gathered information is handled confidentially ✓ Give copies of the research to the DoE and participants who want to confirm accuracy of information ✓ Keep to agreed appointments and time schedules ✓ Keep the interview setting where focus groups gather, comfortable with available seats and water
<p>Beneficence:</p> <ul style="list-style-type: none"> ✓ “Do good” ✓ To the benefit of participants and the community at large 	<ul style="list-style-type: none"> ✓ Be sensitive to any emotional or physical discomfort ✓ Provide for participants’ special needs ✓ Offer relief according to specific discomfort, e.g. counselling (emotional incident) or break times (physical needs) ✓ Give feedback if requested ✓ Suggest recommendations and action plans to the relevant authority based on study results

1.8 PROPOSED OUTLINE OF CHAPTERS

Chapters of this study are formulated as follows:

Chapter 1: Introduction and overview

Chapter 2: Research methodology

Chapter 3: Discussion of research findings

Chapter 4: Evaluation, limitations and recommendations

CHAPTER 2

RESEARCH METHODOLOGY

2.1 INTRODUCTION

The introduction and background of the research as well as an overview of the research methodology were explained in Chapter 1. In this chapter the researcher explains in detail the research design, research method, ethical considerations and measures of trustworthiness during the research process.

2.2 RESEARCH DESIGN

The research design is a plan or strategy of logical sequence in which research is done, comprising of philosophical assumptions, selection of respondents, data gathering and data analysis (Creswell *et al.*, 2012:70; Yin, 2009:26). For the purpose of this research an explorative, descriptive and contextual case study design was chosen to generate rich data from an in-depth exploration of school-health programmes (Yin, 2009:4-5; Rule & John, 2011:17; Shuttleworth, 2008; Burns & Grove, 2009:244). The case study relevant to this research contributed to knowledge gained from questions about the “how” of a phenomena (Yin, 2009:4), namely comprehensive school-health services to two secondary schools in the North West province which are contemporary in a real-life context (Botma *et al.*, 2010:191).

The context of each Secondary School in the research differs which adds to the richness of the data. Therefore, a holistic multiple case design has been chosen (Yin 2009:108). A multiple case design was more advantageous than a single case design when conclusions of the two schools were analysed (Yin, 2009:53). According to Yin (2009:61) a “two case” rather than a single case study ensures successful research (see fig 2.1). With regard to the two involved secondary schools a two case study refers to the investigation or study of comprehensive school-health programmes in each school (Rule & John, 2011:5).

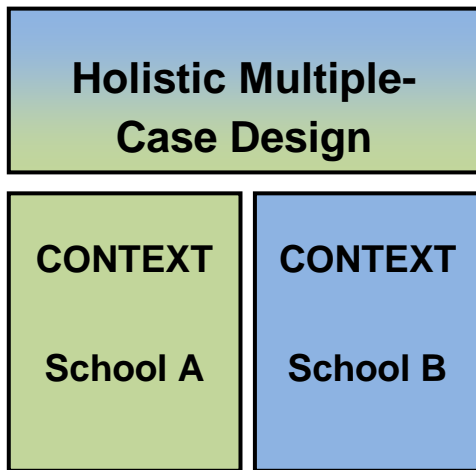


Figure 2.1: Multiple-case design adapted from Yin (2009:46)

The purpose of the research was to study experiences of key stakeholders on current school-health services of two secondary schools in the North West province. It is important to state that the two schools were chosen as cases to ensure good results due to adolescent learners' socio-historical differences, the present context of each school, the availability of each school and their willingness to voluntarily participate in the research. Throughout the research the researcher had been aware of Shuttleworth's (2008) notation that each case should be treated individually for results to be cross referenced in order to draw a conclusion. Rule and John (2011:40) explain context as "...the larger field of relevant factors, relationships and structures in which the case is located". The context of this research is the Matlosana sub-district in the North West province where two secondary schools (the cases) were selected as settings operating under the same national school governance. Thus the same School-Health Policy and Implementation Guidelines (DoH, 2003:21-29) as well as the new Integrated School-Health Policy (DoH& DoBE, 2012:14) apply to these two schools.

Next the researcher explains the research method consisting of the population, sampling, data collection and data analysis.

2.3 RESEARCH METHOD

2.3.1 Population

The population of this research included two secondary schools in an urban area of one of the three sub-districts, namely the Matlosana sub-district in the North West

province. The Matlosana sub-district falls within one of twelve districts consisting of 76 secondary schools. The focus was on 32 secondary schools in this sub-district and key stakeholders of each school as possible participants to share their experiences and views about comprehensive school-health services to adolescents in the North West Province (Botma *et al.*, 2010:199-200; Burns & Grove, 2009:343 & 344). The researcher decided to work in the urban area of the Matlosana sub-district as it is accessible and convenient (Botma *et al.*, 2010:123 & 124).

2.3.2 Sampling

After consulting the coordinator of school-health services at the Department of Health (DoH), school leaders and a representative of the Department of Education (DoE), the researcher used a purposive voluntary sampling method to select the two secondary schools as the two cases and the key stakeholders involved in the two schools as participants. Furthermore, the purposive nature of sampling allowed the researcher to select two Secondary Schools and participants for this research from an available, accessible population which complied with the selection criteria (Creswell *et al.*, 2012:79; Botma *et al.*, 2010:201). The chosen sampling method also ensured the most appropriate and adequate information about current comprehensive school-health services as well as how it should be rendered to adolescents in secondary schools (Rule & John, 2011:64). The following inclusion criteria applied to the selection of the two schools as cases and the key stakeholders as participants (Botma *et al.*, 2010:126, 199-201; Creswell *et al.*, 2012:79):

- prospective schools should have at least 700 or more learners;
- schools should represent learners from Grade 8 to 12;
- schools should represent the key stakeholders (headmaster, educators, peer group members, members of the multi-disciplinary health team, non-governmental organisations, faith-based organisations and parents) who were interested in the case, available and willing to participate;
- peer group members should be 18 and older;
- participants should be literate and able to speak English or Afrikaans, and

- schools should represent socio-economic and cultural diversity within the context of this study.

Both schools included in the case study were model C-schools, formerly known for admitting white learners only (Mncube, 2008:81). However, by transformation both schools currently represent the socio-economic, cultural and racial diversity in and around the urban area and therefore adhere to the inclusion criteria. The two cases referred to in the study are Case A and Case B.

The significance of the sample size is to gather rich in-depth data from each case (Rule & John, 2011:64), to focus on the quality of data rather than on a big sample as long as saturation is reached (Burns & Grove, 2009:244; 361) with answers to the research questions with no new themes (Rule & John, 2011:72; Botma *et al.*, 2010:200). The researcher ensured that the sample size of this research provided for sufficient key stakeholders to supply significant information about the two cases, namely experience of comprehensive school-health services and views on how it should be rendered to adolescents in the two selected secondary schools. Involved headmasters identified and invited key stakeholders available, willing to participate and involved with adolescents in school settings to attend focus group interviews. Table 2.1 consists of representing key stakeholders intended for each focus group.

Table 2.1: Suggested key stakeholder representation per focus group interview

Key stakeholder group	Amount
Educational leaders	1
Teacher	2
Counsellor/Psychologist/Psychiatrist	1
Multi-professional health team member	1
Parents/parent governing body	1
Religious leader	1
Adolescent learners older than 18 years	2
Non-governmental organisation representative	1
General auxiliary workers employed by the school	2
Administrative personnel	1
Total	(N=13)

2.3.3 Data collection

This section includes details about the plan and process of data collection involving the role of the researcher, method of data collection, research setting, field notes and data analysis.

2.3.3.1 Role of the researcher

Before starting with the data collection the researcher obtained permission from the Ethics Committee of the North West University, Potchefstroom Campus (Annexure A). A copy of the proposal was also submitted to and approved by the School of Nursing Science at the Potchefstroom Campus, after which permission was granted by the Department of Basic Education (DoBE) to conduct the research at the two mentioned secondary schools (Annexure B).

The researcher made individual appointments with the principals of the two selected schools to obtain permission for their participation as mediators (Annexure C), and assistance in more than one respect. Assistance involved completion of the demographic information sheets, identifying and inviting key stakeholders as participants and to explain the purpose of the study to them, pending the consent. The researcher clearly stated to the two principals that it should be explained to the key stakeholders that participation was voluntarily and no official and/or personal information would be used publically. A copy of the research proposal consisting of the background, problem statement, aim and objectives of the planned research was then submitted to them to clear any uncertainties.

After consent was granted by the authorities to conduct the research, the researcher visited the principals for the second time to supply them with the necessary informed consent forms for participants (Annexure E). During this meeting, dates, time and a convenient, comfortable and accessible venue for the focus group interviews were discussed and settled. Refreshments for participants were also arranged.

The setting for an interview should be a place where participants feel safe and comfortable. A natural setting (Burns & Grove, 2009:362-3) is not manipulated in any way to gather real, in-depth, rich information from participants. The two

selected secondary schools' buildings and surroundings were the primary setting where focus group interviews took place. The focus group of each school was interviewed in an available, accessible, comfortable and well-ventilated room.

2.3.3.2 Data-collection plan

Evidence or data in a case study may come from many sources (Yin, 2009:99). In this research evidence was collected by means of a demographic data sheet compiled by the principal of each school and during focus group interviews done by professional psychiatric nurse. Furthermore, the researcher ensured scientific true evidence by using three principles supporting data collection in a case study (Yin, 2009:101); the use of multiple sources of evidence, create a case study database and to maintain a chain of evidence.

➤ Use of multiple sources of evidence

A *demographic data sheet* (Annexure D) was compiled by the researcher to collect information about the background of the two secondary schools. Research assistants (administrative clerks) appointed by each mediator (principal) used documents and records from their administrative offices for this purpose. Demographic data of the two secondary schools supplied the researcher with the necessary information about the schools' characteristics for this particular research. It described the characteristics of a population as well as the structures and changes which can be measured numerically (Joubert & Ehrlich, 2009:24). The demographic data, part of the case records, informed the researcher about the total of learners per grade, health and safety issues and measures, absenteeism profiles, and discipline in the two schools.

Focus group interviews (two at each school with a total of four focus groups) contributed towards rich qualitative data. Yin (2009:106) describes it as one of the most important sources in a case study. Information gained during these interviews gave insight in stakeholders' experiences and views about school-health in secondary schools. With qualitative research the researcher has an opportunity to learn more about an individual's or group's experience of a phenomenon in specific contexts (Botma *et al.*, 2010:182). It produces verbal and not numeric data relating

to the phenomenon as words depict participants' feelings, behaviours, relationships, processes, experiences, thoughts, insights and actions. Therefore, qualitative research is rather explorative than descriptive of a phenomenon in a specific context. The emphasis is on gathering and describing rich, in-depth data by exploring participants' actual experiences (Creswell *et al.*, 2012:50, 51; Fouché & Schurink, 2012:308; Burns & Grove, 2009:51; Yin, 2009:133).

Two focus group interviews were planned at both schools to gather information from key stakeholders (Burns & Grove, 2009:508; Rule & John, 2011:66). Focus group interviews at both schools were conducted by an experienced facilitator – a psychiatric nurse practitioner – who is skilled to ask questions that promote participation, to listen and to be sensitive to group dynamics in order to obtain relevant and rich data (Rule & John, 2011:77) as well as to stimulate continuous dialog for this purpose (Greeff, 2012:345). Participants were interviewed in a language of their choice, assisted by a language expert who translated the conversation if necessary. The facilitator used a semi-structured interview schedule to encourage participation in focus groups.

The researcher arrived early at the setting on the day of the interview to ensure that all preparations had been done. The interviewer's own voice recorder was set up in the middle of the table and all interruptions, such as cell phones, were eliminated as far as possible. Arriving participants were greeted by the researcher who introduced them to the focus group facilitator. Refreshments were offered to participants to make them feel at home. After thanking participants for their participation in the study the researcher explained the purpose of the study as well as that participation was voluntarily, meaning that participants could withdraw any time. Participants were also reassured that no personal information would be used in the study and that recordings would be saved electronically by a password only known to the researcher. The researcher and facilitator cleared all uncertainties and answered questions during the information session. After signing the last page of the informed consent form, participants submitted their voluntary consent to the researcher. The facilitator also explained the course of the focus group interview to participants.

The researcher used another source during the focus group interviews, namely observational evidence to provide additional information (Yin, 2009:110) about comprehensive school-health in both cases of which field notes were taken (Annexure G) as suggested by Creswell in Botma *et al.* (2010:191 & 219). Field notes used in this research consisted of three different types:

Descriptive Field notes made of discussions, key stakeholders' actions, the setting where the focus group interview took place, immediate surroundings and events, e.g. disturbances.

Reflective Field notes on the researcher's own thoughts, feelings and observations about methods that worked or did not.

Demographic Field notes information about the time of day, the weather, the room and about participants' attitudes and body language.

➤ **Case study database**

Organising and documenting collected data for case studies is the second principle Yin (2009:118) mentions. Two sets of data applied to the research, namely the demographic data sheet (Annexure D) which was captured electronically in table format to present the reader with necessary information. Illustrations were used where possible, to present the demographic data. Qualitative data collected from focus group interviews were literally transcribed from a voice recorder. Adequate citations highlighted themes for discussion which was presented as a separate data set. The researcher compiled a report with findings of the research after which recommendations were made for comprehensive school-health services and how it should be rendered to the two selected secondary schools.

➤ **Maintain a chain of evidence**

The researcher applied the third principle indicated by Yin (2009:122-123) by using external observers, study leaders, authorised principals of the two cases, the co-coder of the qualitative data and the case study report. Evidence of collected information will be kept by the researcher for five years where it is available for any queries and/or inspection. An annexure is included in the research report for

readers' convenience should there be a need to check the completeness or to do any cross references.

2.3.4 Data analysis

Data analysis includes categorising, ordering, manipulating, summarising and describing information in meaningful terms (Brink, 2006:170). Information on the demographic data sheets were compiled into one table (Table 3.2), described and graphically displayed to note similarities or differences between the two cases. Demographic information supplied the researcher with well-organised data which served as background when describing and discussing the two cases, and eventually drawing conclusions.

According to Creswell (2003:190) qualitative data analysis involves sensible text and image data. The researcher used six generic steps in this regard:

- a) The data was organised and prepared for analysis as the researcher transcribed the focus group interviews and typed the field notes.
- b) It was possible to get an overall idea of the data as the researcher focused on key stakeholders' experiences and views about school-health services to secondary schools in the North West province, and checked the accuracy of the transcription by comparing parts of it with recorded data and by writing notes in the margins before it was printed to identify themes and/or categories.
- c) A detailed analysis included a coding process by reading each line of the transcriptions in order to describe meaningful words or phrases with other words or symbols. Repeated words and sentences significantly focused on the research topic which were underlined and written in the right hand column of the transcript as part of coding (Annexure F). This enabled the researcher to identify, retrieve and combine significant themes easily (Creswell *et al.*, 2012:105). The researcher and co-coder independently read the transcribed interviews and coded the data after which they discussed it to get consensus (Botma *et al.*, 2010:224).

- d) The most descriptive wording was found in each transcribed interview, coded separately after which Case A's two interviews were combined and reoccurring themes identified. The same procedure applied to Case B. All four transcribed focus group interviews had been interconnected in order to rewrite the themes into a story for a final conclusion.
- e) The researcher presented a summary of the themes in a table and discussed it with a direct citation to emphasise the findings.
- f) The researcher interpreted and gave meaning to the data with integrated conclusions on how comprehensive school-health services should be rendered to secondary schools in the North West province.

Findings from the data analysis were discussed and conclusions drawn from which recommendations and action plans for comprehensive school-health services to the two selected secondary schools in the North West province could finally be proposed.

2.3.5 Literature integration

The researcher integrated this particular study with similar literature in order to have a scientific basis for the research, which either confirmed the findings as correct or presented it as new information (Botma *et al.*, 2010:197).

2.4 MEASURES OF TRUSTWORTHINESS

The criteria for trustworthiness proposed by Lincoln and Guba (as discussed in Botma *et al.*, 2010:232-235; Schurwink, Fouché & De Vos, 2012:419-421) set four standards, namely truth value, applicability, consistency and neutrality. To achieve these standards specific strategies were used.

2.4.1 Truth value

The model of Lincoln and Guba, as outlined by Botma *et al.* (2010:233), was used in the research to ensure trustworthiness. Truth value realised through the researcher's prolonged engagement with a secondary school setting as a mother and nurse. Confidence has been established in the truth of findings of participating

key stakeholders who shared their actual experiences and views of school-health in their familiar secondary school context. To ensure credibility the researcher used various data sources, such as school documents and records to compile demographic data. A dense description of each case was possible with focus group discussions. The researcher checked the findings with two study leaders to ensure the credibility of the research. Literature integration re-enforced findings and field notes guided the researcher throughout the study towards a specific outcome.

2.4.2 Applicability

Research findings are transferable which means that, although the context of the two cases differ from other schools in the North West province it becomes possible to apply the same sampling and description method of demographic data to other cases. The researcher ensured data saturation during focus group interviews to give a dense description of key stakeholders' views about school-health in secondary schools in the North West province.

2.4.3 Consistency

A dense description ensured that information was not contradictory to selected data during focus group interviews. Therefore, a co-coder was assigned from whom data was available when needed to inspect and verify findings.

2.4.4 Neutrality

Neutrality refers to a bias-free study with scientific methods to gather and analyse results. Organising documented data in a clear and comprehensive way ensured that there was no bias (Botma *et al.*, 2010:233) and enabled the researcher to confirm findings by an audit which determined whether conclusions, interpretations and recommendations corresponded with data sources.

2.5 ETHICAL CONSIDERATIONS

Ethics are part of a society's or specific community's moral principles that should be adhered to. Rule and John (2011:111) concur and encourage researchers to conduct research in an ethically sound manner, which enhance the quality of research and add to its trustworthiness. Three main principles denote ethical

research involving human subjects, namely: (1) autonomy, (2) non-maleficence and (3) beneficence (Rule & John, 2011:112; Burns & Grove, 2009:188-199; Mouton, 2012:143-145). The following ethical considerations as portrayed by Rule & John (2011:112), Burns and Grove (2009:188-199), Mouton (2012:143-145) and Botma *et al.* (2010:277), were adhered to in this study.

2.5.1 Autonomy

Autonomy relates to participants' right to self-determination. The researcher had to respect the right of participants by informing them fully before they decided to participate or not in the research. Respect also pertains obtaining ethical permission from particular institutions to conduct the research on their premises by which the researcher considered the intellectual property of sources and participants with accurate referencing. The researcher obtained ethical approval from the Ethics Committee of the North West University, Potchefstroom Campus before commencing with the study. The DoE granted permission (Annexure B) for the utilization of two secondary schools in an urban area of the Matlosana sub-district in the North West province. Principals of both secondary schools were recruited as mediators (Annexure C) to assist in identifying key stakeholders for focus group interviews. The principals were fully informed about the study and had the research proposal for their as well as participants' perusal. The mediators as well as the researcher discussed the informed consent document with participants before the commencement of the focus group interview. The following information was provided to participants for their full voluntary, informed consent:

- Objectives of the study (see Chapter 1)
 - ✓ To identify and describe the demographic profile from existing records/documents available at each selected secondary school.
 - ✓ To explore and describe how comprehensive school-health services are experienced by key stakeholders, in two selected secondary schools in the North West province.
 - ✓ To explore and describe the perceptions of key stakeholders on how comprehensive school-health services should be rendered in two

selected secondary schools in the North West province to enhance the quality of life of the adolescent.

- Participants had the right to ask questions and to withdraw any time with no negative consequences.
- Data collection would take place within a focus group interview (8 to 12 people) regarding abovementioned objectives. Two interviews per case were planned, lasting more or less two hours. There was a possibility of a follow-up interview if data saturation was not reached.
- Selected venues arranged by the mediators should be familiar, non-threatening and comfortable;
- Interviews would have been recorded for accurate transcription and deleted afterwards to ensure confidentiality and anonymity. No names would be mentioned in the transcription or any other publication that might result from the study and transcriptions would be safeguarded electronically by a password only known by the researcher and transcribers.
- Anonymity was only partially possible due to the face-to-face focus group interviews. To ensure anonymity and confidentiality, only authorised persons would have had access to the records who would be the researcher, study leaders and members of the Ethics Committee of the North West University, Potchefstroom Campus. All transcribed data would have been locked away.

2.5.2 Non-maleficence

Non-maleficence is the researcher's obligation not to harm participants, an institution or the community during the research process. In order to prevent any physical or emotional discomfort, the following precautions were taken:

- Participants who initially experienced discomfort to participate in a focus group interview were appeased by the interviewer, also a psychiatric nurse practitioner.
- Should any emotional discomfort be experienced, the interviewer would do a debriefing session. Although one participant had been emotional once

during the interview, no participants indicated the need for emotional support afterwards.

- In order to alleviate any anxiety participants were reassured that all information would be handled confidential. Copies of the research were given to those participants who wanted to confirm its accuracy.
- Comfort was assured by being on time for scheduled meetings at arranged settings. Settings were well-ventilated and furnished with comfortable seats for all participants. Refreshments and water were also arranged by the two different schools

2.5.3 Beneficence

According to this concept the research should not only be harmless, but participants and/or the community should benefit from it. The “do good” principle was adhered to by offering comforting intervals during interviews. Furthermore, the interviewer conducted the interviews in such a way that participants did not experience any emotional discomfort. Although nobody gained financially from the research, it was stated clearly to participants that all secondary schools and adolescent learners could benefit from findings, recommendations and action plans.

2.6 CHAPTER SUMMARY

Chapter 2 discussed the research methodology in detail. Realisation of data collection, research results and literature integration are discussed in Chapter 3.

CHAPTER 3

DISCUSSION OF RESEARCH FINDINGS

3.1 INTRODUCTION

In Chapter 2 the researcher fully described the research design, research method, measurements for trustworthiness and ethical considerations during the research process. This chapter is concerned with data collection, analysis and research findings regarding comprehensive school-health services in selected secondary schools in the North West province as well as literature integration to confirm or compare research findings.

3.2 REALISATION OF DATA COLLECTION AND ANALYSIS

Data in this case study design served as evidence from more than one source (Yin, 2009:99) and was collected by means of a demographic data sheet (Annexure D) compiled by the researcher, focus group interviews (Annexure F) and field notes (Annexure G). The researcher adhered to principles of data collection by utilising more than one source, documentation data and maintaining a chain of evidence. Data analysis consists of examining, identifying, categorising, tabulating and combining evidence to draw empirically-based conclusions (Yin, 2009:101&126).

3.2.1 Data collection

Research was done in two secondary schools suggested by a representative of the Department of Education (DoE) to ensure replication of the two cases (Yin, 2009:54) and to give an in-depth description of the focus on each case, namely comprehensive school-health services. Thus, a platform for recommendations is provided to improve the quality of adolescents' health. These schools' rich contexts contributed towards the integration of its demographic data (Annexure D) provided by each principal who acted as mediators. A purposive, voluntary sampling method was conducted at both secondary schools – the cases – where the key stakeholders of each school ensured that the most typical characteristics, knowledge and experience of participants could deliberately be included in the study as part of the

focus group interviews (Botma *et al.*, 2010:126). Inclusion criteria applied to the key stakeholders as participants, identified by each mediator, who were engaged in four focus groups, two at each school (refer to Paragraph 2.3.2).

Permission to conduct the research was obtained from the Ethics Committee of the North West University, Potchefstroom Campus (Annexure A) as well as from the DoE (Annexure B). Both principals were furnished with a copy of the proposal and informed consent document (Annexure E) for their and potential participants' perusal. Each mediator completed the demographic data sheet on the researcher's explanation about the necessity of a well-informed background of each school. The researcher collected completed demographic data from each school after which information was clearly displayed in a table (Table 3.2).

The researcher explained the purpose of the research to each focus group and discussed the informed consent document for voluntary participation in detail to clarify uncertainties before participants signed it. The voluntary and confidential nature of the focus groups was also emphasised. Focus groups were conducted by a psychiatric nursing specialist skilled in group facilitation. Each focus group lasted for approximately 1½ hour during which repetition of information occurred. A summary of the key stakeholders who participated in the four focus groups is indicated below in Table 3.1.

Table 3.1: Summary of key-stakeholders participated in the focus group interviews

	Case A		Case B	
	Focus group 1	Focus group 2	Focus group 1	Focus group 2
Principal (n=2)	1	0	0	1
Deputy Principal (n=2)		1	1	
Educators (n=8)	1	2	3	2
General assistants (n=2)			1	1
Peer group members older than 18 years (n=8)	2	2	2	2
Administrative personnel (n=2)	1	1	0	0
Parents (n=4)	1	1	1	1
Total participants per focus group (N=28)	n=6	n=7	n=8	n=7

Willing participants were invited to the venue prepared by the mediator (the principal of each school) on the agreed date and time. As the researcher arrived

early at the setting, everything had already been prepared. A short report about the setting for Case A and Case B is given below.

Case A The allocated room for the focus group interview, which was on the first floor of the school, was well-known to all participants. It was a spacious room, well-ventilated with ample electric and natural light. Tables were arranged in such a way that the participants could look at each other and there were enough seats for all participants who were seated randomly. The school bell could be heard several times; the intercom to that section was disabled to minimize any disturbances. One participant joined the group after the interview had already started, but it did not interrupt the flow of the interview. To make everybody feel at home, the school prepared refreshments and water was available on the table during the interview.

Case B The school offered a spacious room on the ground floor with a large table and comfortable chairs for everybody. Although electric lighting was available in the room, sufficient natural light filled the room. Windows could open, but participants chose the air-conditioning instead. Refreshments were provided by the school to welcome all participants. There was no noise or disturbance due to the room that was situated away from classrooms. Although one participant was called away, he returned shortly, it did not seem to have any influence on the flow of the dialogue. After participants were settled, the interview started during which data about the main question was collected before a follow-up question. The main question asked by the focus group facilitator was: “How do you experience the current school-health services provided to adolescent learners in this school?” The next question was: “How would you describe the provision of comprehensive school-health services in this school?” Although key stakeholders participated enthusiastically, the interviewer used probing and communication skills, such as listening, paraphrasing, minimal verbal responses and reflective summary to encourage continuous dialogue and to obtain rich, relevant information (Greeff, 2012:345).

Focus group interviews were digitally voice recorded and verbatim transcribed for data analysis. The researcher compared the recorded discussions with the transcribed version to ensure a faithful reflection of the contents at all times. Field notes with regard to the interview process, demographic information about the venues and personal experience of the interviews (Annexure G) were taken during and immediately after each focus group discussion from which the researcher could come to an overall conclusion that participants initially did not know what to expect, but still participated actively due to the interviewer who explained the questions and recognized each participant's information and probed them for more information.

3.2.2 Data analysis

Demographic data of the two secondary schools, Case A and B, was examined, represented in columns and illustrated graphically to explain and comprehend the background of each case. Main and sub-themes emerging from the four focus groups (two from each school) were analysed and discussed in order to answer the main question of the research, namely how comprehensive school-health services can successfully be implemented in secondary schools in the North West province to ensure adolescents' optimal health. Data analysis was done according to the principles of content analysis by Tech in Creswell (2003:192-193) as described in Chapter 2. The researcher and co-coder analysed transcribed recordings for re-occurring information after which consensus about the main and sub themes was reached. The researcher identified the Dimensions Model of Community Health Nursing (Clark, 2008:69-74) presented in Chapter 1, Table 1.3 as a useful structure for organising demographic data as well using it as a framework to present and discuss the main and sub themes that emerged from the focus group interviews.

3.3 RESEARCH FINDINGS AND LITERATURE INTEGRATION

The following sections provide information about demographic data of the two cases and the results deriving from focus group interviews.

3.3.1 Demographic data

In order to interpret health information meaningfully, it is important to have knowledge about the size and characteristics of a population or community. The

composition of the population mainly suggests the type of health problems occurring and needed health services (Joubert & Ehrlich, 2009:24, 25). Demographic data presented in Table 3.3 assisted the researcher to describe the two secondary schools' context and backgrounds.

Table 3.2: Demographic data for Case A and Case B

Physical environment	Case A		Case B	
Location	Urban area		Urban area	
Number of class rooms	39		50	
Learners per class	30		33	
Is the building's maintenance plan up to date?	Yes		Yes	
Are the school grounds clean and maintained?	Yes		Yes	
How many teachers?	27 + 12 =39		50	
How many fire extinguishers?	35		58	
When had they last been checked?	2012		February 2013	
Is the evacuation plan in place?	Yes		Yes	
How many times per year does the school practice the evacuation plan?	0		4 times per year	
How many rugby/soccer fields?	2		2	
How many netball fields?	7		3	
How many tennis courts?	3		2	
How many athletic fields?	1		1	
How many hockey fields?	2		2	
Any hostels on premises?	0		2	
The Bio-physical Dimension	Case A		Case B	
Learners in each grade	Boys	Girls	Boys	Girls
Grade 8	83	94	111	124
Grade 9	80	101	122	126
Grade 10	75	99	106	116
Grade 11	65	72	83	102
Grade 12	45	76	73	70
Total learners per gender	348	442	495	538
Total learners per school	790		1033	

The Bio-physical Dimension (cont)		Case A		Case B	
Children with physical impairment		4		1	
School days lost due to sickness/illness January to November 2012	January	136		100	
	February	370		100	
	March	420		100	
	April	449		100	
	May	578		100	
	June	66		100	
	July	286		100	
	August	578		100	
	September	697		100	
	October	635		100	
November	40		100		
Total School days lost due to illness		4255 days		1100 days (estimated)	
What are the three main reasons for missing school?		Illness		Illness and medical tests	
		Parents take them out		Trauma	
		Training / sport		Parents	
The Psychological Dimension		Case A		Case B	
Children with mental impairment		± 10		Did not answer	
Name the type of mental impairments		Depressive mood disorder (± 40 learners) Bi Polar mood disorder (1-2 learners) Eating disorder (1-2 learners)		Did not answer	
Staff wellness program in place at the school		Yes		No	
Appointed counsellor at the school		Yes		No (3 educators do counselling)	
The Socio-cultural Dimension		Case A		Case B	
Active Parent Governing Body		Yes		Yes	
Ethnic representation at each school	Black	24		938	
	White	715		35	
	Coloured	51		35	
	Indian	0		25	
	Other	0		0	
Feeding scheme in each grade		Boys	Girls	Boys	Girls
Grade 8		1	4	0	1
Grade 9		1	5	1	0
Grade 10		5	2	0	1
Grade 11		1	6	1	1
Grade 12		0	3	1	2

Feeding scheme in each grade (cont)		Boys	Girls	Boys	Girls
Total learners per gender on feeding scheme		8	20	3	5
Total learners per school on feeding scheme		28		8	
Funding/Payment of school fees					
How many learners pay full school fees?		449		± 600	
How many learners pay partial school fees (internal arrangement)?		247		± 100	
How many learners are fully subsidised by Government?		98		± 300	
The Behaviour Dimension		Case A		Case B	
Disciplinary officer		No		Yes	
Disciplinary hearings from January to November 2012		20		6	
Three main reasons for disciplinary action		Smoking / drugs		Substance abuse	
		Fighting		Fighting	
		Bad Behaviour		No academic progress	
The Health System Dimension		Case A		Case B	
Qualified First Aid Practitioners	First Aid level 1	3		13	
	First Aid level 2	0		0	
	First Aid level 3	0		4	
First Aid bag		Yes		Yes	
Infirmary		Yes 2 bedroom		Yes 2 bedroom	
Who look after the learners in the infirmary?		Administrative personnel		The auxiliary worker and administrative personnel	
How far is each school from the nearest clinic?		± 2,5km		± 5km	
School's policy regarding medical emergency		<ul style="list-style-type: none"> • Child is brought to the administrative ladies • If necessary, parents are called • Otherwise, child is put in the infirmary. • On occasion, school paid for ambulance to transfer the learner 		<ul style="list-style-type: none"> • Apply immediate first aid • Call an ambulance and phone the parents • Learner to be accompanied by someone from the school until parent or family can take over 	

Both cases have an average of 31 learners per class. That is possible due to the fact that both Case A, with 39 class rooms and Case B, with 50 classrooms, have a full complement of educators. In this regard, all 50 education posts of Case B are subsidised by the DoE, whereas Case A only has 27 subsidised posts. Subsequently, 12 education posts are being paid for by the Parent Governing Body,

which might be a financial burden to the school's budget. Although both cases have the same average of learners per class (31), Case A has less learners (total of 790) than Case B which has 1 033 learners. To be clear on this matter diagrams and graphs below illustrate demographic data. The distribution of Grade 8 to Grade 12 is given in Figure 3.1.

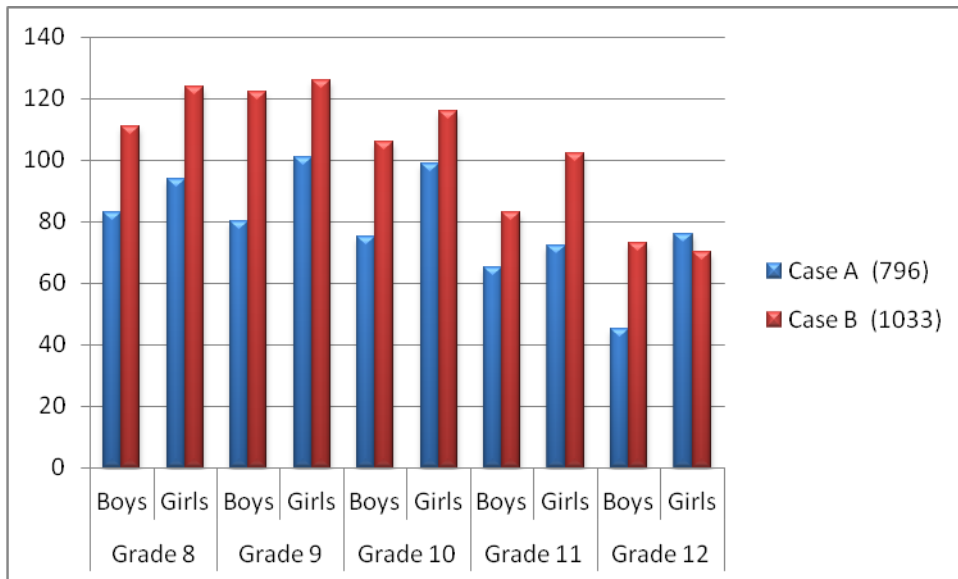


Fig. 3.1: Grade distributions of learners

It is evident that there are more learners in Grade 8 to 10 than in Grade 11 and 12. There are also more girls than boys per grade. The fact that Case B has 363 learners more than Case A could be due to the hostel on its premises.

The contexts of the two cases show a difference in ethnic representation due to different language teaching mediums. Since 1994 eleven official languages have been incorporated in South Africa. However, although English had been accepted for education (Serino, 2013:1), multilingualism promotes cultural diversity in a country such as South Africa (DoBE, 1997). Both Cases were former model C schools with predominantly white Afrikaans speaking learners.

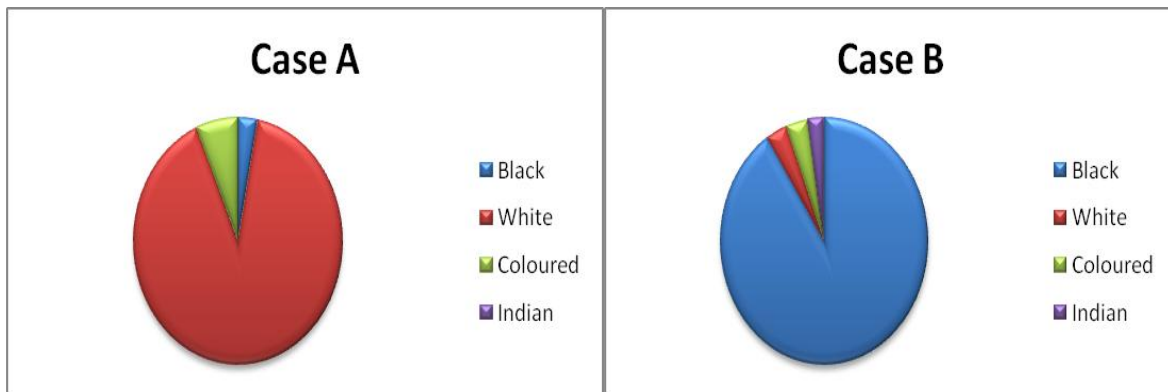


Fig. 3.2: Ethnic representation

Although both schools have been opened to everyone since 1994, Case B currently has predominantly black learners, possibly coming from previous disadvantaged groups (see Table 3.2). The reason might be that Case B's location in mid-town has more access to black townships. Case A on the other hand, has predominantly white learners, with a few black and coloured learners. The learners may choose where they want to attend school, but it could be that learners attend the school where they feel safe with the language that is predominantly used. Case A is still a predominantly Afrikaans teaching medium school whereas Case B is a predominantly English teaching medium school. Learners may choose their teaching language as well as the school they want to attend (DoBE, 1997).

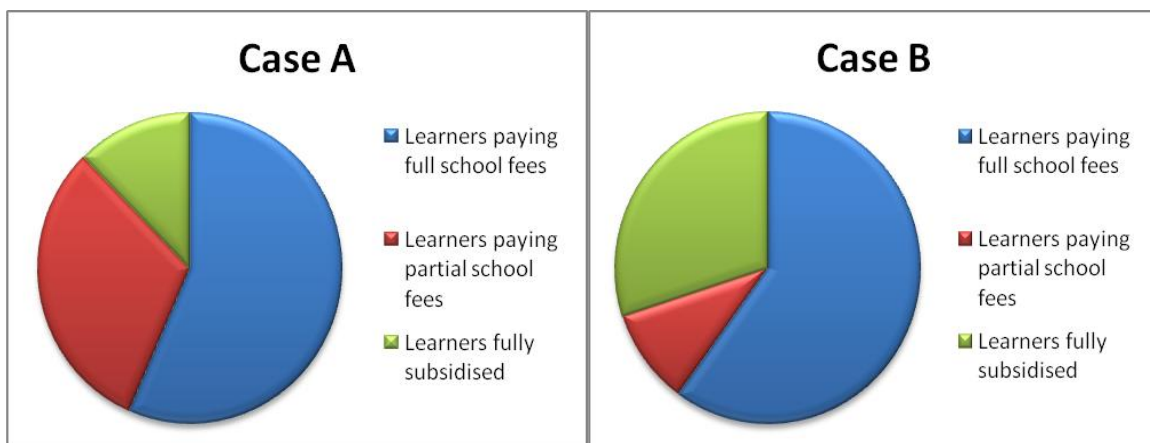


Fig. 3.3: Income by means of school fees

Many learners in both cases do not pay school fees or only pay a part of their school fees. According to law both schools adhere to the three basic principles (Education and Training Unit [ETU], s.a.), which are equity (the same basic

resources to all government schools), redress (more governmental resources to learners in historically disadvantaged communities) and access (to ensure that nobody is excluded from attending school on the basis of race, religion or poverty). However, these principles place constraints on the schools' financial position which may directly influence in-house services to learners and the staff. Otherwise, the maintenance to school buildings, sport fields and school grounds as well as safety regulations which should be adhered to is costly. Case A is equipped to accommodate a learner in a wheelchair, being a positive change as far as the inclusion of disabled learners is concerned.

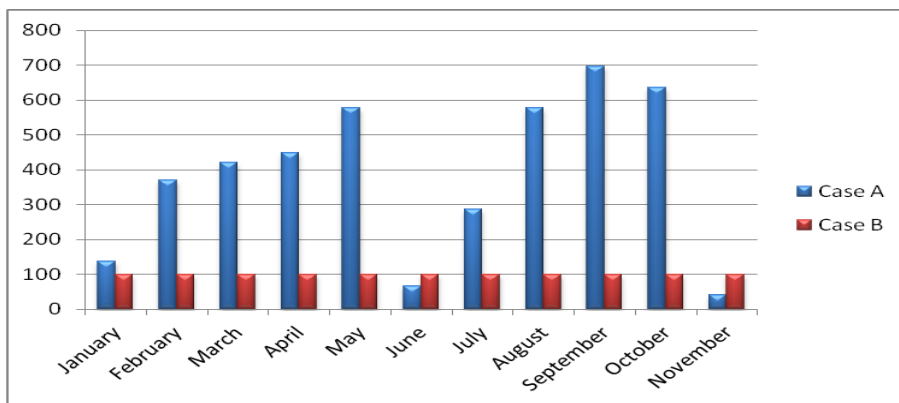


Fig. 3.4: Absence due to illness

According to the above graph there was significantly less absenteeism during June and November. This is probably the result of term examinations during those months. Instead, information about Case B does not reflect a true profile of their learners.

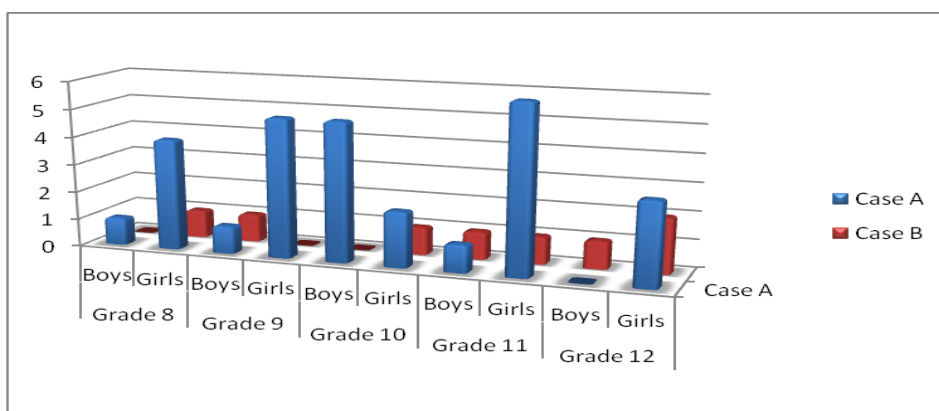


Fig. 3.5: Learners assisted by the feeding scheme

Figures on feeding schemes show the following results: Case A assisted an average of 28 learners with nutritional supplements and 8 learners were nutritionally assisted by Case B at the time of data collection. However, it is important to state that the amount of learners joining the feeding scheme differs from time to time, which is an indication of families' economic challenges. The 2011-2012 National School Nutrition Programme Annual Report states that the North West province had the second most days for feeding schemes (DoBE, 2013:9) opposed to the total of learners in the two cases of the research using a feeding scheme.

3.3.1.1 Conclusion statements on the demographic data of Case A and Case B

In conclusion, demographic data with regard to the *bio-physical and physical environment* shows that, although the total of learners differs in each case, classes are not overcrowded, but there are 31 learners per class. According to these figures, there are sufficient classrooms and teachers for the amount of learners. Furthermore, buildings and school grounds are well-maintained and health and safety regulations are adhered to in both cases.

As far as support for learners is concerned, Case A employs a part-time school counsellor whereas Case B only has a disciplinary officer who does counselling, assisted by some of the educators. This indicates that both A and B are in need of emotional and *psychological* support. However, the common occurrence of depression, bi-polar mood disorder and eating disorders should also be considered.

Socio-economic constraints on *multi-cultural* groups from historically disadvantaged backgrounds are a challenge to many adolescent learners in South African secondary schools. Challenges indicated by the demographic data refer to aspects such as cultural diversity, language barriers in cases where English is not learners' mother tongue and poverty in some homes – represented by the number of learners who are fully subsidised or only pay partial school fees. Although both cases have an active feeding scheme and Case A has more learners using it, there seems to be insufficient utilisation of the National School Nutrition Programme (NSNP).

Disciplinary hearings for mainly trespassing by smoking and/or using drugs, being physical aggressive and not progressing academically emphasised the *behavioural dimension* of adolescent learners in both cases.

Statistics on current *health care* reflect that both cases are well-equipped with first aid resources, including qualified first aid practitioners. However, it became clear that there are insufficient affordable and accessible comprehensive school-health services to adolescent learners.

3.3.2 FOCUS GROUPS

Findings of focus groups in each school (Case A and B) are discussed separately. A discussion of findings in each case mainly focuses on key stakeholders' experiences of and need for comprehensive health services in secondary schools. Research findings are enriched by direct quotations of participants and integrated with literature where possible.

3.3.2.1 Case A: Themes and sub-themes with regard to the key stakeholders' experiences on current comprehensive school health services and perceptions on how it should be provided in secondary schools in the North West province

Data analysis of Case A's two focus group interviews emerged in nine themes and well-supporting sub-themes in the Dimensions Model of Community Health Nursing (Clark, 2008:69-74) which is used as a framework and explained in paragraph 1.4.2. Themes and sub-themes are outlined in Table 3.3 and discussed accordingly.

Table 3.3: Case A: Themes and sub-themes with regard to the key stakeholders' experiences on current comprehensive school health services and perceptions on how it should be provided in secondary schools in the North West province.

Dimension of health	Theme	Sub-themes
Physical environment	❖ The school's physical structure enables a healthy environment.	
Bio-physical dimension	❖ Concern about the health status of adolescents.	<ul style="list-style-type: none"> • Educators are frustrated as they are aware of adolescents' health needs but don't have the time or knowledge to address them. • Lack of sleep and poor nutrition impacts negatively on adolescents' general health status. • There is a need for health services for the high prevalence of adolescents with chronic diseases.
Psychological dimension	❖ Conflicting roles	<ul style="list-style-type: none"> • Educators are aware of adolescents' psychological needs, but are limited by the educational boundaries. • Not all parents act on their primary responsibility to manage adolescents' health needs.
	❖ Manifestation of emotional distress by adolescents.	<ul style="list-style-type: none"> • Adolescents are prone to emotional distress. • Resilience and social context impacts on emotional distress.
Socio-economic dimension	❖ Debilitating factors specific to the socio-economic and cultural dimension.	<ul style="list-style-type: none"> • The impact of adolescents challenging socio-economic context compromise on the school's core business of education.
	❖ Responsibilities of parents.	<ul style="list-style-type: none"> • Parents have a misplaced responsibility. • There are parents who take their responsibility with regard to the management of the adolescent's health status seriously
Behaviour dimension	❖ Positive behaviours by adolescents and key stakeholders involved in the school.	<ul style="list-style-type: none"> • The adolescents' takes control of their own health. • The school acts on its responsibility to assist adolescents with their health management.
	❖ Negative behaviour of adolescents as a plea for help.	<ul style="list-style-type: none"> • Adolescents behave negatively to sexuality, peer pressure and cultural norms, which can be a plea for help
Health system dimension	❖ Health services to adolescents by the school.	<ul style="list-style-type: none"> • Basic emergency care can be rendered by the school. • Emergency care of the school is insufficient. • Health education is insufficient. • Administrative staff directly supports the ill adolescents at the "sick bay". • Need for professional health services at school. • School's aim is to enhance adolescents' active school participation. • Appointed part time counsellor. • School's need for the assistance by professional nurses for health services and the role of school health services.

❖ **The school's physical structure enables a healthy environment**

Participants indicated that the school's physical structure is well-maintained, which involved clean bathrooms: "Yes, they go through much trouble with the bathrooms...it is cleaned twice per day". Observational field notes confirmed the neatness of the school grounds and sports fields, also indicated in the demographic data (Table 3.2).

Subsequently it was reported that the school is equipped to accommodate physically impaired learners, as confirmed: "Yes...as for the stairs, as I think there are rails everywhere...our school is even equipped to accommodate learners in wheelchairs". In contrary to this finding of Case A, Pitt and Curtin (2004:1) concluded that physically impaired learners moved from mainstream to schools for the disabled not by choice, but because the mainstream schools are not accessible.

The summary of the proposed school-health package, as adopted from the Integrated School-Health Policy (DoH & DoBE, 2012:14), indicate that on-site services of all schools should comply with minimum requirements to ensure a healthy environment, referring to water and sanitation, a well-equipped cooking area, physical safety, ventilation (airborne infections) and waste disposal.

❖ **Concern about the health status of the adolescents**

Educators indicated ***that they are frustrated as they are aware of adolescents' health needs, but don't have time or knowledge to address those needs*** during school time, although problems such as poor eyesight or hearing, bad posture, poor general hygiene and mouth care are often noticed: "So, currently the responsibility to identify health needs is on the educator and the office personnel and if they do not have the time and ability to do that, the problems will go pass."

Some participants added to the concern that learners show disinterest and frustration during class as they find it difficult to keep the pace with the rest of the class. Consequently, they miss the work and fall behind in their academic performance: "He can sit at the back of the class and I won't know that he cannot hear me, and that will hamper his progress", one key stakeholder said.

According to educators learners are tired and lethargic during class, which they blamed on ***a lack of sleep and poor nutrition having a negative impact on learners' health status***, as stated by the following participant: "The child is not concentrating and sleepy...did he go to bed late last night...did he eat this morning?"

The link between learners' insomnia and fatigue with bad performance was confirmed by McNall, Lichty, Forney, Mavis and Bates (2007:7). Stakeholders voiced ***a need for health services to adolescents with chronic diseases***. Epilepsy, diabetes and asthma are the most frequent diseases educators, learners and their friends have to cope with at school: "...not only does she have sugar, she also has epilepsy now..." Although educators expressed their willingness to assist a learner with such a condition, their concern was about the learner leaving class unattended and not being trained in health care. Insufficient or even no knowledge about proper assistance to a learner suffering from one or other disease caused a lot of stress for the learner, educators, friends and parents. One participant even asked: "Must I take out the tongue? What must I do? I don't have that knowledge..." Finally, as a result of chronic diseases these learners are often absent from school to get relevant assistance and treatment. Chronic pain is another issue addressed by Logan and Curran (2005:281) insofar educators and school personnel feel inadequate to work with learners complaining of chronic pain and other ailments.

Gracey and Ward (2012:5) confirmed that a multi-professional team can improve the attendance rate of learners with chronic diseases. From an international context Taras, Wright, Brennan, Campana and Lofgren (2004:6) indicated that when a learner with a chronic disease, such as asthma was tended by a school nurse or case manager, the learner responded positively by taking control of his/her own health and remembering to bring medication to school. Yet, although treatment reduces the severity of asthma, it did not seem to have any effect on the learner's absence from school.

❖ **Conflicting roles**

Although ***educators are aware of adolescents' psychological needs, they are limited by educational boundaries***. An educator's primary task is teaching and not necessarily taking responsibility for learners' health care needs. Participating

educators in the research indicated that was expected of them to identify adolescents' health needs for which they have not been trained or equipped. They mentioned their inability and the lack of resources to handle a medical emergency such as an asthma attack, which was very traumatising. Although educators are trained to work with adolescents as total human beings, they have limited time to listen and to respond to learners' problems. It frustrated educators not being allowed to give medication for simple ailments, such as a headache or allergies: "We are not allowed to give anything to the learners, not even anti-histamine...and then unexpectedly, a bee stung a learner..." Educators also had difficulty to assist a learner with a problem whilst the rest of the class was left unattended: "...there is not even ten minutes during a school day to give additional attention to a learner, because your next class walks in and I mean you cannot leave the rest of the class..."

Educators cannot always perform the way they should as they themselves were sometimes emotionally and physically drained. It was mentioned that they often felt helpless and wanted health services back into schools: "...the school-health services that we had in the past...if that could come back..." With regard to emotional and physical exhaustion, Jackson, Rothman and van der Vijver (2006:264), explain that, when job demands become too much, educators tend to cope by maintaining a mental distance. When this coping mechanism becomes a habit it manifests in poor task performance, causing exhaustion and making the person dysfunctional.

Besides educators, parents are main role players in adolescents' everyday health situation as they can be seen as gatekeepers of accessible health systems. Key stakeholders stated that ***not all parents adhered to their primary responsibility of managing adolescents' health needs***, and that some parents transferred their responsibility to the school during active school hours. One response confirmed this matter: "I am not coming right now...let them lay there until two o'clock." Flynn (2007:25) confirms that there are parents who distance themselves from their responsibility to care for their children in general whilst they are at school by

promptly stating that the child is the responsibility of the school for the time he/she is there or even that the child can take care of himself.

❖ **Manifestation of emotional distress by adolescents**

Learners are frustrated, angry, despaired and depressed due to their inability to cope with stress caused by social circumstances leaving them **emotional distressed**. Adolescents have difficulty to fit in and to perform under peer pressure. Some adolescents talk to a counsellor, friends or an educator, but others rather keep it to themselves. It was obvious that learners whose parents were interested in their well-being, showed less emotional problems and more resilience, which confirms that **resilience and social context have an impact on emotional distress**. One participant's comment on this topic was the following: "If I could think of...umm...what is that runner's name...he made it eventually to the SA's".

Learners who have not been supported emotionally appeared to be more frequently absent and mostly did not perform well academically: "It is to a great extent the parents who are the reason why we get learners at school that are neglected...in every way. The child does not know which way to go..." and, "The problem is, when they come back from treatment and therapy, especially in the senior phase, they have lost so much work". Thapar, A. Collishaw, Pine and Thapar, A.K. (2012:1) report that the depression appears to be worse after puberty and also state that it dominates girls more than boys. Furthermore, depression is more common in low and middle income communities and that psychological distress is one of the main causes.

❖ **Debilitating factors specific to the socio-economic dimension**

Participants mentioned malnutrition, financial restraints, poor hygiene, general neglect, untreated illness and poor attention to primary health care as debilitating factors which specifically had an impact on adolescents' socio-economic and cultural living. Examples such as substance use and abuse, rape, violence and abandonment were reported by some learners: "The...girls specifically, are subjected to pressure to have sex...sometimes they do not have an option..." Mncube and Harber (2013:40) noted that learners blame violence at school on poor

upbringing and the community, whereas Panday, Makiwane, Ranchod and Letsoalo (2009:71) state that young women living in poverty are most likely to have coerced sex, not only at sexual debut but during their lives as well. Violence, rape and sex are outside the school and a social worker has to handle such situations, as stated in one quote: “When it is found that it is a social problem, with the child’s permission, we phone the social worker...” Gracey and Ward (2012:3) state that anxiety, depression, behavioural disorders and more frequent absence from school are results of bullying, problematic family matters and psychological difficulties within a family which coincide with specific debilitating factors of the socio-cultural dimensions.

Participants stated that ***adolescents’ challenging socio-economic circumstances directly influence the school’s core business of education.*** Although most parents do make an effort to come to the school when informed of their adolescent’s ailment, the school also arranges transport to take the learner home. These additional services are time-consuming and replace school work, affecting the core business of education negatively. However, educators and school staff are aware of these existing socio-economic challenges: “It happens sometimes if the parent does not have a car to fetch a sick child, we take them home...”

This time consuming health care to ill adolescents could become an even greater challenge if learners do not have medical insurance. Health care services are more accessible to learners whose parents do have a medical aid than to those who rely on public health services. The consequence of these time-consuming activities is a loss of school time. One participant’s response to this was the following: “...and they will sit the whole day to get treatment in the clinic...the learners miss another day of school if they have to go back to see the doctor...” Although not specifically focused on comprehensive school-health, Bai-lian, En-dong, Yamawuchi, Kato, Naganawa and Wei-jun (2010:574) explored the prolonged waiting time at outpatient departments in general and reported that waiting time at outpatient departments were reduced significantly with an appointment system and flexible doctor schedules.

❖ Responsibilities of parents

According to educators some **parents have a misplaced responsibility** due to the fact that they do not care about their children. On the other hand, some parents do care, but cannot respond as they would like to due to insufficient transport. It then becomes the school's responsibility for the remaining of the day. The following was a remark by one of the participating adolescents: "Mother and Dad are not at home, so no matter if ill, I have to come to school...let them lay there, I will fetch them when the school comes out". It was also reported by one of the educators that parents do send their children sick to school, because there is no one to look after them at home: "Their parents cannot come to fetch them...they cannot go back to class...educators have to look after children that come to school already sick". This misplaced responsibility by parents – sending sick children to school due to insufficient care at home whilst they are employed – could not be confirmed by any other literature.

In contrary to the above, there are **parents who take their responsibility with regard to the management of the adolescent's health status seriously**. Those parents take care of their children's primary health care needs and respond whenever the school informs them about their sick child. Furthermore, they support their children in extramural activities, resulting in a positive school attendance record. Other South African educators agree that children of involved parents are more disciplined and perform better academically than those whose parents are not involved (Mncube & Harber, 2013:102). Parents of a learner with a medical condition provided educators with relevant information about symptoms, emergency treatment and contact details as well as a photo of the learner for further assistance: "The parent wrote a letter with all the information about her condition with a photo on for identification". These photos empowered the educator to respond promptly and decrease the stress level, as was commented: "We are informed about what to expect".

❖ **Positive behaviour by adolescents and key stakeholders involved in the school**

It became apparent that some ***adolescents take control of their own health***. Due to certain medical conditions, some learners developed a sense of responsibility in managing their own medication and emergency treatment until their parents could come to fetch them: “...mostly it is asthma, but those children have their own medication”.

In case where a parent cannot fetch a sick child, the school occasionally arranges transport to take the child home. This was confirmed during an interview with one of the focus groups: “...also took some of them home when the parent could not come to fetch them...” Guevara, Wolf, Grum and Clark (2003) confirmed that children and adolescents educated to self-manage their asthma showed an improved lung function and experienced self-control, with better school attendance. Handling chronic illness, such as asthma or diabetes confidently at school requires that teachers and friends will be well-informed about the condition in order to understand better and to lend the necessary support (Freeborn, Loucks, Dyches, Roper & Mandelco, 2013:5).

Case A’s participants agreed that the school has a supportive culture by encouraging learners to reach their full potential, whether in sports field or academically. The school’s ***responsibility with regard to adolescents’ health management positively contributes towards school attendance***. This entails sponsored personal sport equipment, involving the community to render free medical services to needy learners and providing transport to medical facilities. This was reported as follows: “...by occasion, we took sick learners to doctors in the community that treated them for free...” and “The school has a feeding scheme and on occasion a food parcel was given for the school holiday as well”. Another participant said: “...we delivered the food at the child’s home when he was not there...” The privacy of learners using this service is ensured at all times. Supportive actions and its value are confirmed by the WHO (2011), emphasising the moral responsibility of the community to invest in the health of adolescents in order to give them the best chance to become productive members of society.

❖ **Negative behaviour of adolescents as a plea for help**

Some adolescents ***behave negatively to sexuality, peer pressure and cultural norms, which can be a plea for help.*** Self-mutilation, eating disorders, strange and violent behaviour at school, increasing substance abuse under adolescents and early sexual activities can be ***a plea for help:*** “...or is the fact that I cut myself just a plea for help?” Wilkenson and Goodyer (2011:1) confirm that self-injury can be a form of self-punishment due to severe emotional pain or trauma signal distress to important people in adolescents’ lives. Teenage pregnancies as well as sexually transmitted diseases are the main reasons for girls missing school. This is confirmed by an online article (Chabata, 2012:1) which states that men who pay a large amount of money for “labola” (the “bride price”) see themselves as having the right to be in charge of all sexual activities, even when they are not married yet. In a study done in the Western Cape, (Panday *et al.*, 2009:65) indicated that 72% of pregnant adolescents reported coercive sex and 11% reported rape. In addition, according to pregnant adolescents 3 out of 5 female adolescents were beaten by a boyfriend and 4 out of 5 female adolescents were afraid of being beaten if they refused sex.

❖ **Health services to adolescents by the school**

Although parents’ neglected responsibility towards their children’s health had been discussed as a psycho-social dimension, it is emphasised again mentioning Flynn (2007:25) who states that there are parents who distance themselves from their responsibility of caring for their children in general whilst they are at school by promptly stating that the child is the school’s responsibility for the period they are there or until they can take care of themselves.

Another sub-theme emphasises the treatment of emergency cases. Participants mentioned that only ***basic emergency care can be rendered by the school*** as it has the necessary first aid equipment for minor emergencies: “The first aid kit is rather well-equipped, there are extra things in, for example for burns, etc., in the technical centres there are also first aid kits...” However, these emergency bags are not always fully prepared as participants explained that the DoE provide some stock such as unsterile gloves, bandages, plasters and safety pins, but the school has to

provide the rest of the emergency stock. According to the Occupational Health and Safety Act (84 of 1993) and Regulations, the employer, in this instance the DoE, shall provide first aid boxes containing relevant first aid equipment and stock to promptly treat injuries occurring in a specific workplace. The proposed school-health package, as stipulated in the Integrated School-Health Policy (DoH & DoBE, 2012:14), also indicates the provision of first aid kits to schools as part of on-site services rendered by DoH.

Although it is compulsory to have trained first aid personnel on the school premises, the **emergency care of the school is insufficient**. One of the reasons mentioned is insufficient trained first aid personnel, considering that the DoE arranged first aid training on short notice and the school could not send educators due to unattended classes. The following quotations emphasised this matter: “I would like to see more personnel qualified at first aid level 1...” and “The notice of the first aid course that was arranged by the Department reached us too late...short notice...cannot arrange replacements...we cannot take two educators out of class for two days”.

Participants indicated that their own trained first aid personnel are on first aid duty during sport events. With regard to sport duty, Ransone and Dunn-Bennett (1999:267) determine that when it comes to sport, trained first aid coaches in secondary schools tend to send injured players back on to the field rather than to take them off. Furthermore, because coaches know the learners, they decide whether to send a player off the field or not based on a player’s ability and the stage of the game and not due to the injury. It would be more acceptable if an unbiased person assessed a player and decided whether he/she could continue with the game.

Although the DoE provides a framework for health promotion, the school’s **health education is insufficient** as the school should find informative resources: “The Department did not give clear guidance on the topic and did not provide guest speakers...” A relating matter is that, although health education is a school subject – Life Orientation, not all educators are at ease to present, or have sufficient knowledge of the subject as part of the Life Orientation program at school. They reported that a specialist on the relevant topic addressing adolescents would be

much more effective as information would be more credible. A key stakeholder indicated the following: “Although we discuss relevant topics in Life Orientation, the learners would rather listen to an expert on the topic”.

Prinsloo (2007:167-168) confirms that, in order to present Life Orientation successfully educators should be trained extensively in the contents and the best methods to present the topics. She also states that if an educator does not have high moral standards, information is not as credible as it should be. On the other hand, if parents do not support educators’ input, all the effort is not worthwhile. It was noticed that learners need more health education, especially on sexually transmitted diseases. A group presented a play on a health topic, which had a positive effect, but unfortunately it was not followed up. According to Freeborn *et al.* (2013:13) a considerable difference in school staff and learners’ attitude was obvious when parents, and sometimes the school nurse taught relevant health topics.

When learners do get sick at school they report it at the administrative office where an administrative assistant attend to them by taking them to the sick bay (also known as a sick room or infirmary) whilst informing the parents about their child’s condition. Thus, **administrative staff directly supports ill adolescents at the sick-bay**. Participants’ remarks on health issues were the following: “...the health care at this school is driven by the administration ladies...the learners report to the front desk, they assess the problem...phone the parent if necessary...and monitor them in the sick-bay”.

According to participants the two beds in the school’s sick bay were insufficient to accommodate the number of learners being ill during peak times, such as winter. Even when a bed and an administration assistant are available, there is no trained person to observe all signs and symptoms or to apply the necessary treatment. Participants emphasised the **need for professional health services at school**. Participants expressed the need for a designated area for more beds and equipment to render basic health support to learners who are too ill to attend class and who are waiting for their parents to fetch them, if ever: “I would like to see a well-equipped sick bay with more beds...”; “...to do vital sign observation and to handle first aid and

medical emergency”; “...a school nurse that is in charge of the sick bay and that can help...”

In another emerging sub-theme is that, according to participants, whenever the school calls an ambulance it takes time to arrive. Therefore, the school prefers arranging and paying for a private emergency service or to take the learner to a health care facility themselves. Consequently, the involved educator is not occupied with academic work in class and the ill learner is behind in his/her school work. Due to the ***school's aim to enhance adolescents' active school participation***, it becomes actively involved in the assistance of ill adolescents by taking responsibility for their medical treatment whilst at school. Although the school may assist adolescents by transporting them to health services, educators are not allowed to give learners any medication emergency: “We are not allowed to give medication to the learners”; “In reality it means that we are not allowed to give anti-histamine to a learner when a bee stung him/her.” This leads to the fact that any learner who depends on medication is responsible for keeping and taking it themselves: “...learners may administer medication to themselves”.

Successful self-medication at school mainly depends on shared decisions by adolescents and their parents, for instance, to create an asthma management plan in order for an ill adolescent to cope unsupervised. This is supported by Skinner *et al.* (2004:1). Freeborn *et al.* (2013:12) states that insufficient knowledge about Type 1 Diabetes was the result of poor assistance by school staff and principals, and that it had a negative impact on effective school management. On the other hand, where school staff cooperated with a positive attitude, learners thrived. This is supported by the American Committee on school-health (2001:435) that the response to a learner's medical condition should be a combined team effort, involving administrative staff, the school's first aid team and/or school nurse, parents and community health services.

Another sub-theme arising from the health system is the ***appointment of a part-time counsellor*** by the school – an advantage to most participants. Yet, the counsellor renders her services only once per week, resulting insufficient time and attention for all adolescents referred to her by educators or parents: “...once a week

on Thursdays...”; “...she is extremely busy...”; “...she is fantastic...she knows what she is talking about.”

Furthermore, the counsellor also assists parents with advice regarding their child’s emotional needs. Brigman and Campbell (2003:91) confirmed the valuable input of school counsellors on adolescents’ emotional and psychological well-being at school. They found that interventions by counsellors improved adolescents’ cognitive, social, and self-management skills leading to remarkable academic performance. Langaard and Toverud (2010:35) agreed that full time counselling services had a positive effect on adolescents’ active participation and attitude towards physical and emotional changes in general.

Participants named the need of a professional nurse to manage first aid and minor ailments as well as medical emergencies, such as asthma, epilepsy, a hypoglycaemic diabetes mellitus episode: “...and then she can quickly test the blood sugar...” This service includes the assessment of a learner’s health whilst in the sick bay to see whether he/she is well enough to go back to class or whether the learner’s condition worsens and needs to be referred. Muraro *et al.* (2010:681) agree that schools are not prepared to handle medical emergencies, such as asthma attacks or severe allergic reactions. The partnership between the school, parents, learners, a school nurse and an external medical service, such as a doctor in order to handle an allergic attack effectively, is supported by Muraro *et al.* (2010:681).

The participants also mentioned the need for a professional nurse who is qualified in psychiatric problems and to provide health education to learners, parents and educators: “...and if you could have someone like a counsellor or a school nurse that is capable and committed to help...” Some participants indicated that parents felt assured if a trained professional assisted their child with an emergency: “It is good for the parents to know that there is someone that will look after their children at school...” These needs were taken into consideration when the re-engineering of the PHC service was planned for the Integrated School-Health Programme (DoH & DoBE, 2012:14), namely screening and health education. It is proposed that these

services are delivered by a school nurse of the PHC system of the school-health department.

Participants emphasised the role of the professional nurse who does PHC assessments, such as testing learners' eyesight and hearing, attending to mouth care, general hygiene and minor ailments. Participants' opinion was that early diagnosis of these health needs could enhance learners' abilities to achieve their full academic potential. Furthermore, basic pharmacological treatment should be allowed: "...it should be allowed that those basic medications...paracetamol...anti-histamine...may be administered by the professional nurse in order to avoid learners and educators to miss class to visit a clinic or hospital for treatment of minor ailments".

One of the recommendations to render better medical service to a learner with an allergic reaction was that policy should change in order to provide for well-trained school staff and/or a school nurse to administer all emergency medication at school when needed (Muraro *et al.*, 2010:684). A professional nurse could work on a rotation basis, rendering PHC services to different schools in the same geographical area. The DoH indicated that it was part of the new Integrated School-Health Programme (DoH & DoBE, 2012:7) to provide comprehensive school-health services to all school phases.

In addition to on-site PHC services rendered by a professional nurse, designated comprehensive off-site medical services to learners were also suggested: "...to have a place where you can take a sick learner for treatment..." Although the DoH initiated PHC clinics to benefit adolescents, South African adolescents still do not want to go to these clinics as they do not receive the professional treatment expected from such a public institution. Thus, the clinic setting is unacceptable to most adolescents (Panday *et al.*, 2009:112). Furthermore, school-health services as outlined in Table 1.3 of Chapter 1 will start at quintile 1 and 2 schools (very poor) with a possibility that quintile 3 to 5 schools might be neglected with regard to school-health services for some time (DoH & DoBE, 2012:14). Landro (2012:1) mentioned the global financial difficulty of schools to have their own school nurse

and thus the need for a full-fledged medical clinic or school based health centre where comprehensive school-health services could be rendered.

3.3.2.2 Conclusion statements with regard to Case A

- Case A represents the “integrity of the family” by directing its decisions towards learners’ physical and bio-physical needs. This implies that although the school’s physical environment is well-maintained and wheelchair-friendly; its first priority is to support learners and their families.
- Case A’s demographic area represents diverse cultures and socio-economic status. The complexity of adolescents’ psychological, socio-economic and cultural dimensions as well as parents’ presence or absence are contributing factors towards accessibility and affordability of health services.
- The case considers parents, learners, educators, non-educating staff and members of the community as independent role players in comprehensive school-health services.
- Case A’s internal environment provides basic health services complimented by efforts to extend its support to learners in an external environment.
- The predominant need for comprehensive school-health services includes an active health professional to direct all role players towards a comprehensive school-health programme with special attention to psychological support to adolescents and everybody’s wellness.

3.3.2.3 Case B: Themes and sub-themes from key stakeholders’ experiences on current comprehensive school-health services and perceptions on how it should be provided in secondary schools in the North West province

Data analysis done in two focus group interviews of Case B resulted eight themes with sub-themes spontaneously fitted into the Dimensions Model of Community Health Nursing (Clark, 2008:69-74). It is used as a framework explained in paragraph 1.4.2. Themes and sub-themes are outlined in a summarised table (Table 3.4) after which it is discussed.

Table 3.4: Case B: Themes and sub-themes regarding key stakeholders' experiences on current comprehensive school-health services and perceptions on how it should be provided in secondary schools in the North West province

Dimensions	Main theme	Sub-themes
Physical environment dimension:	❖ The visible physical infrastructure of the school predominately facilitates a healthy environment.	
Bio-physical dimension:	❖ Adolescents with diseases, illnesses and chronic conditions.	<ul style="list-style-type: none"> • Educators are not trained, experienced or capable of diagnosing and treating health needs and medical emergencies. • Auxiliary worker and attentive administrative personnel • Adolescents' absence from class was due to negative health behaviour such as substance abuse, malnutrition.
Psychological dimension:	❖ Adolescents with psychological distress.	<ul style="list-style-type: none"> • Adolescents confide in educators for relief of psychological distress. • Insufficient time.
Socio-economical dimension:	❖ Socio-economic and cultural diversity in health management of adolescents.	<ul style="list-style-type: none"> • Absent parents transfer their responsibilities with regard to their children's health management to the school. • The predominant cause for psychological distress amongst adolescents is their socio-economic status. • Cultural diversity regarding health management responsibilities and behaviours. • Insufficient medical insurance has a negative influence on ill adolescents' access to health services.
Behaviour dimension:	❖ The school's approach to health services derives from a caring culture	<ul style="list-style-type: none"> • Educators care about adolescents' health. • An informed and caring community surrounding adolescents with chronic conditions.
	❖ Adolescents with deviant behaviour due to cognitive, psychological, physical or socio-economic factors.	
Health Systems Dimension	❖ The school's ability to respond to adolescents' health needs.	<ul style="list-style-type: none"> • The school's internal environment provides health services to learners. • Limited external health services to adolescents.
	❖ The school's specific needs for health services to adolescents.	<ul style="list-style-type: none"> • Proactive management of disabilities (cognitive, psychological, physical). • School health services need to be available on school premises. • School health should be comprehensive.

❖ **The visible physical infrastructure of the school predominately facilitates a healthy environment**

Although there are positive and negative comments on the physical environment of the school, the school is neat and its **visible physical infrastructure predominantly facilitates a healthy environment**. The school is easily accessible by taxi and bus and the hostel is on the school premises and walking distance from the school. All buildings are well-maintained with no apparent health hazards. Although school grounds are fenced and sports fields are well-maintained, participants mentioned an area of concern where natural rain water drainage forms a down flow to a stream. Learners are prohibited access to this drainage site, but it still poses a threat during the rainy season. An identified deficit was that buildings are not wheelchair or crutch friendly and disabled learners would not be able to move between classes, even with help: "...learner on crutches with badly broken leg, could not get up the stairs...sat in the office and the educators brought the work for him, but he still missed class."

Te-Wang and Holcombe (2010:1) found that adolescents' perception of a school environment influenced their academic performance and increased their identification with and participation in school activities as well as self-improvement tactics. Mncube and Harber (2013:103) mention that, when school buildings are dirty and falling apart, it is not an environment conducive to learning. The authors also highlight the fact that educators and learners do not feel welcome and cared for under such circumstances and do not feel protected.

❖ **Adolescents with diseases, illnesses and chronic conditions**

Participants were concerned about adolescents' medical conditions, such as asthma and diabetes. Although educators declared themselves available to assist learners in a critical situation, they are **not trained, experienced or capable of diagnosing and treating health needs and medical emergencies**: "...it is outside our realm of capabilities". Cohall (2007:1) confirms this concern about the ability to handle mental health, behavioural health and reproductive health problems. In addition to this, educators are not allowed to supply any medication to ill learners, as they reported: "We have learners with asthma problems, but we are not allowed to give

that learner an asthma pump...” This situation leaves educators frustrated and anxious. According to Peery, Engelke and Swanson (2012:1) parents and educators do not agree on how effective learners manage their illness whilst at school, but when a school nurse provides health education and counselling, and visits classrooms more often parents and teachers perceive an improvement in learners' self-management efforts.

The **auxiliary worker and attentive administrative personnel** are the first contacts to ill adolescents during school hours. Ill adolescents report to an administrative personnel or educator and in some cases the auxiliary worker finds the learner sick in the bathroom. Sick learners are sent to the sick bay where someone stays with them: “S...does a lot of assistance there, making sure the kids are comfortable...until they are better and can go back to class, or their parents come to fetch them or until the school closes, in cases where parents do not come...” Valuable support by an auxiliary worker and administrative personnel is fortified by Forster (1999) who states that when comprehensive health services are offered to learners on the school premises, barriers such as accessibility, transport problems and cost are overcome. Thus, less time is spent away from class (Forster, 1999).

Participants mentioned that **adolescents' absence from class was due to negative health behaviour such as substance abuse, malnutrition** and possible family matters at home. Another contributing factor to consider is insufficient sleep. Participants described adolescents as being in class, but not actively part of the class. In a baseline child health status report by McNall *et al.* (2007:6-7) it is reported that learners who experience malnutrition, physical and emotional abuse or sleeplessness do not perform well academically. Adelman and Taylor (2011:2) associate disengagement from class with feelings of incompetence and worthlessness that may result in boredom, emotional distress, deviant behaviour and learning problems mostly leading to learners dropping out from school.

❖ Adolescents with psychological distress

Educators identified learners' psychological and emotional distress as a continual need to talk to someone about their problems. ***Adolescents confide in educators for relief of psychological distress.*** Psychological distress refers to tension, stress, strain and anxiety (Ridner, 2004:1). Although some adolescents are hesitant to communicate, most of them do confide in an educator, the disciplinary officer or their friends: "They identify the teachers themselves...she can go and talk to her and she knows it will remain confidential". Adolescents mostly share their emotional problems with, and in some instances, see educators as role models and/or parental figures: "So he needs a man sometimes to talk to...the children views you as their parent, they would rather go to the educator with a problem than go back home".

Some adolescents stay alone at home due to working parents and see educators as parents (DoE, 2007:91). Mncube and Harber (2013:24) state that male educators are important role models to male learners as far as masculinity is concerned. Yet, confiding in educators may sometimes involve sensitive information that can pose an ethical dilemma. Lishchinsky (2011:1) found that most educators try to suppress the enormity of some information as it evokes unpleasant emotional feelings in themselves which may influence their ability to perform negatively. Morrow (2007:103) states that educators get too involved with caring with little energy left for teaching.

Contradictory to above-mentioned, some participants stated that educators coped well with the extra stress by counselling learners with emotional and psychological problems: "So far we have coped with everything". Others were of the opinion that educators also needed counselling as they get emotionally drained: "Some teachers get so involved in counselling, that they themselves get tired, they get emotionally drained because they carry this weight..." Adolescents' problems are sometimes too severe for educators to handle: "...we rather don't ask questions because you are scared of the answers..." Together with personal challenges educators often do not have the emotional resilience to listen to adolescents' problems every day, worsened by ***insufficient time.***

According to a group member, it was said that although psychological services by the DoE are available to educators, it seemed as if it was not very accessible and therefore not optimally used: "...the Department's wellness program is there...but you must know who to see...it is a complicated process...you must try to get the personnel member to go...the personnel are in essence, neglected". Educators also did not want to go for counselling, because they feared ridicule. In addition to this, the appointed disciplinary officer had often been so busy with counselling as learners rather went for assistance or encouragement with regard to domestic problems than for disciplinary problems: "...more interviews with children with mental issues than discipline problems..." Cournoyer (2012:1) states that students, who received mental health care in school, had 85% fewer discipline referrals. Fisher (2011) and the DoE (2007) confirm that factors having an influence on teacher stress and burnout, are, but not limited to, poor working conditions, pressure to achieve set goals, learner hostility towards educators and other learners, hyperactivity, lack of interest in school work, substance use, isolation and emotional exhaustion.

❖ **Socio-economic and cultural diversity in the health management of adolescents**

Participants noticed that most parents had not been involved in their children's lives or concerned about their health status. According to educators parents were ***absent and transferred their responsibilities with regard to their children's health management to the school***. Parents did not attend sports events to support their children: "...games, there are no parents whatsoever..." and "...it's only the teacher and the children..." Another concerning issue was that it was difficult to get hold of parents when they were needed whilst adolescents were on a sports or drum majorettes camp. Participants indicated that adolescents became the school's sole responsibility after being dropped off at school. According to educators, parents "...just drop their kids off here and pick them up seven o'clock tonight and the rest is your problem".

Educators reported that their responsibilities could be anything from illness or medical emergencies to adolescents' criminal behaviour. One participant stated

“...phoned the father...son is smoking dagga on the school ground...send him to jail, what must I do?” Although no literature agreed with participants’ remarks about parents transferring responsibilities, it does confirm the positive value of strong child-parent relationships. Undheim (2008:17) mentions that strong connections between adolescents and parents increase their well-being considerably and decrease distress in general. The DoE (2007:71) confirms that parents do not come to the school when summoned for their children’s bad behaviour, such as smoking dagga. Moon and Ando (2009:574) confirm that adolescents with strong family ties tend to have better self-control skills, which might lead to less substance use and better academic achievements. This seemingly distant and uninvolved behaviour of parents in general might be due to poor parenting skills, but also as a result of bad communication with educators as discussed by Flynn (2007:25-26). This includes, but is not necessarily limited to, parents’ own negative school experiences. Parents feel intimidated by teachers’ approach and feel that they are only addressed in case of a problem. On the other hand, educators tend to think that parents do not discipline and guide adolescents. Flynn (2007:25-26) also states that some educators find parents hostile and others underestimate the importance parents’ prompt involvement in a difficult situation.

The result of above-mentioned was that participating educators acknowledged during focus group interviews that **socio-economic factors**, with specific focus on absent or less-interested parents, **were predominantly causing psychological distress amongst adolescents**: “...that is the biggest problem in the whole society, especially in our school, is the non-existence of parents...” According to these participants, adolescents felt abandoned, unsure and unsafe due to the non-existence of parents. A report by DoE on Schools that Work (2007:70) states that young people who live in urban townships face overwhelming family problems and critical social difficulties, which often manifests in bad behaviour, failure at school and a high dropout rate. These learners are often dumped by their parents and have no physical or emotional support. Participants stated that adolescents could not handle stress, became disengaged in class and acted badly: “...too young to cope with some of those problems...he now acts out in class...” Participants also mentioned that adolescents abused substances and in extreme cases, suicidal

attempts occurred: "At home things are not well, and then she ends in your office, she's trying to cut her pulses". The negative effect of absent parents on adolescents' emotional distress is confirmed by McNall *et al.* (2007:7) who states that 1 out of 5 learners' parents and other family members do not talk to them or listen to their opinions and that they do not have an adult to turn to with a problem. Furthermore, 1 out of 10 learners indicated that they do not feel loved or wanted. Insufficient adult support causes psychological distress, high-risk behaviour and poor school performance.

Cultural diversity with regard to health management responsibilities and behaviour was mentioned by participants, from whom it seemed that different cultures reacted differently to their children's health needs. On the one hand, some parents shifted their responsibility of an adolescent's well-being to the school and would often say: "...but he's in your care now. Please take him to the doctor". On the other hand, there are parents who respond immediately. Although not prominent, these parents are, according to participants, always involved at the school. Some of the day scholars and others staying in the hostel tend to behave sexually inappropriate. Poor gender socialisation and life skills at home were reasons given by participants: "...in some cultures the children are not allowed to have girlfriends and boyfriends..."

Panday *et al.* (2009:18) confirms that parents are the main socialising agent, but the opportunity to provide trusted information is lost due to parents that lack both knowledge and skill to talk openly about sex and sexuality with their children. She also mentions that an overly strict parenting style might result in a higher risk for teenage pregnancy. On the other hand, it was mentioned that the increase in teenage pregnancies are due to girls who believe that it is acceptable; they take it for granted that the mother or grandmother will take care of the baby so that they could go back to school: "...you can have the kid, go back to school when I had the kid, mommy and daddy will raise it, or granny will raise it". Panday *et al.* (2009:64) states that only a third of teens return to school after they gave birth. This might be due to a lack of encouragement at home to pursue academic qualifications as well as insufficient information on self-care and family planning. Although adolescents

visited school-based health clinics frequently and consistently used contraceptives, it did not have any effect on the frequency of sexual intercourse (Foster, 1999). Furthermore, it was stated that a school and community-based program lowered the pregnancy rate from 77 to 37 per 1000 learners, ages 14 to 17 (Foster, 1999).

Some participants were not only concerned about teenage pregnancies as such, but also about the classes adolescents would miss. Otherwise, the risk of contracting HIV was an even greater concern: "Fear they will get the HIV", an emotional participant replied. According to Jemmott *et al.*, (2010:10) risk-reduction interventions on sex risk behaviour and health promotion on health issues unrelated to sexual behaviour had a significant effect on the adolescent.

Another concern of educators was the medical emergency cases that required hospitalisation. Their experience was that adolescents with a medical aid were assessed and treated without major problems. On the other hand, ***insufficient medical insurance impeded the treatment of ill adolescents*** as they have less access to health services: "Most parents don't have medical aid". Whenever adolescents need to be taken to public health care facilities by an ambulance taking too long to arrive, the school arranges and pays for a private ambulance: "We call a private ambulance service and we will pay the account." An adolescent and the educator who accompanies him/her miss class whilst the rest of the class are left alone and fall behind on work. One participant said: "The teacher has to leave the class for two hours to take the child to the doctor". Furthermore, the learner as well as the educator stress due to delayed treatment and lost time absent from class. According to Cournoyer (2012:1) adolescents with a medical aid seek help when they are ill and are soon back in class, healthy and ready to work.

❖ **The school's approach to health services derives from a caring culture**

Educators cared about adolescents' health as they referred learners for counselling. As mentioned, Case B pays for private ambulance services to transport a critically injured adolescent to hospital. Although nobody at school is allowed to administer medication: "...the School's Act in 1996, we are not permitted to give him

two Panados”. Educators made an asthma pump available at their own costs and risk to learners in an emergency situation. According to some participants this small gesture resulted in a safe and cared for feeling by adolescents. Cohall (2007:1) concluded from a survey amongst educators and administrators that 70% educators reported that learners approached them regularly with personal and health problems. This figure implies that educators are approachable and a credible source of information. Geierstanger, Amaral, Manssour and Walters (2004:347) state that learners who feel connected to their schools are less likely to engage in risky behaviour and achieve higher academic outcomes.

An informed and caring community surrounding adolescents with chronic conditions has a positive influence on available and accessible health facilities. Learners with chronic conditions in Case B have friends who are well-informed about the conditions, signs, symptoms and appropriate treatment: “...his friends...also know exactly...” Learners keep medicine with them. One specific case was reported of a learner who “carried it around in his tie”. In another case a parent responded immediately to an ill learner’s call from a private cell phone, which enhanced a safe feeling and reduced stress (Undheim, 2008:17).

Contradictive to some parents who are involved and others who see their child’s well-being as the school’s responsibility; participants still agreed that the school had a caring approach towards its learners’ health. Therefore, educators act as facilitators by referring learners to health facilities (Cohall, 2007:1). Both the educator and health professional might experience an increasing workload, leading to possible resistance. Therefore, close collaboration between educators, health professionals and health services is essential to maintain a positive and open relationship (Mohlaby, Van Aswegen and Mokoena, 2010:6; Cohall, 2007:1).

❖ **Adolescents with deviant behaviour due to cognitive, psychological, physical or socio-economic reasons**

Participating stakeholders in both focus group interviews indicated that ***learners’ deviant behaviour was due to cognitive, psychological, physical or socio-economic reasons***. Deviant behaviour relates to poor psychological adjustment

(Herrero, Estévez and Musitu 2006:1) and is in discord with society's norms in general (Hartney, 2013:1). This might result in, but is not limited to, substance use and abuse, physical and psychological abuse, suicide, bullying, gangsterism, violence and poor academic performance (Panday *et al.*, 2009:61, Mncube, 2012:3; DoE, 2007:70; Geierstanger *et al.*, 2004:351). Participants were concerned that adolescents were unhappy, scared, depressed, confused; that they had low self-esteem and low self-motivation resulting in loneliness and unworthiness due to uninvolved parents, abuse and violence at home. These negative circumstances caused an inability to cope with problems and stress: "Children feel scared to approach the parents to say this is wrong" and "Because the parent figure that he has to identify with that has to set the example is non-existing".

These unresolved emotions sometimes emerge in unexpected behaviour (DoE, 2007:70), of which violence, substance use or abuse, increased absence due to illness, higher absenteeism, poor academic performance, teenage pregnancies and a higher dropout rate, are examples. Moon and Ando (2009:574) mention the positive effect of open interaction between adolescents and their parents on substance use and other deviant behaviour. Participants also mentioned that some adolescents preferred to stay in the hostel during holidays rather than to go home: "...hostel children that when it's time to go home, they don't want to go...they rather find a friend to go to". A relating occurrence is some adolescents who stay longer than necessary before going home, "Children also sit here on the grounds till five in the afternoon, because they don't want go home."

Moon and Ando (2009:575) confirm that a safe school environment contributes towards the healthy development of adolescents and the enhancement of their connectedness to the school which in return might have a positive influence on their academic achievements. Literature of Chun and Dickson (2011:12) strongly supported adolescents' deviant behaviour in general as a result of the relationship between parents, learners and the school. These authors concluded that parental involvement, cultural responsiveness and a sense of school belonging had an indirect, but significant effect on learners' academic performance. On the other hand, deviant behaviour can be a result of gangsters outside the school, violence,

emotional and physical abuse by parents, peers (bullying) and sometimes educators' influences and attitudes, leading to substance use (McNall, 2007:6; Mncubu & Harber, 2013:105).

❖ **The school's ability to respond to adolescents' health needs**

The school's internal environment provides health services to learners which include a first aid room with two beds, fully equipped first aid bags and level 1 and level 3 trained learners and/or educators. This sub-theme is described as health services from the school's internal environment as these services are presented by the school on school premises. A participant defined these services: "...thirteen qualified level one first aiders...also additional six Grade 10 learners trained as level one first aid helpers and four additional educators trained at level three first aid". Thus, the school prepares itself by training personnel to handle emergency injuries. Yet, external paramedics are at official school sports events. According to the Occupational Health and Safety Act (Act No. 84 of 1993) and Regulations, at least one person must have a valid certificate of competency in first aid for every hundred on the premises.

The first line for ill learners is the administration office or educators who accommodate learners in the sick bay and phone their parents. Panday *et al.* (2009:89) confirm that South African adolescents do not want to utilise public health services. Reasons are, although not limited to, lack of confidentiality, long travelling distances, inconvenient hours, cost and poor quality of services rendered.

To a large extent, the school depends on public health care services as stated: "...free services at the clinic or at the public hospital..." in order to contribute to adolescents' health as there are ***limited health services available to learners from the school's external environment***. Private health services are not often utilised due to cost. Visits from health care institutions were limited and only nursing students visited the school to do screening tests as part of their training: "Nursing Colleges who needed to train their nurses..."

Although educators had to identify learners with particular needs to be examined, they welcomed these services where health problems could be diagnosed and

learners subsequently referred. Unfortunately, there were no consecutive examinations. In cases where parents had been involved in referrals, there was no feedback on the progress: "...don't know if the mom is taking him somewhere...no feedback..." In the proposed new Integrated School-Health Policy (DoH & DoBE, 2012:14) with specific reference to the School-Health Program/package (Table 1.2) the DoH endeavours to deliver services on the above-mentioned health needs

Case B has access to drug tests and treatment for substance abuse. In order to see to it that adolescents do not miss class, rehabilitation and counselling sessions are offered in the afternoon. It was mentioned by participants that, although rehabilitation was available, most parents did not encourage their children to persist with the treatment: "...rehabilitation course in the afternoon for ten weeks 2-5 (14:00-17:00) and it is R4 500". Social circumstances, mostly contributing to drug abuse, also seldom change. Thus, learners relapse into deviant behaviour, which cause poor academic performance and an increasing dropout rate (Dekeza-Tsomo, 2012:18).

❖ **The school's specific need for health services to learners**

Proactive management of disabilities (cognitive, psychological, and physical) must be implemented in order to prevent disabled learners who come to a mainstream school from failing. Therefore, it is important that Intelligence Quotient (IQ) tests, learning ability tests and physical impairment evaluation are done in the primary school: "...pick up where there are physical problems...test the children's IQ...be send to those special schools". Minor learning problems should be identified and treated in Primary School as it is usually too late when learners get to High School: "...that kid could have a successful schooling career further." In addition to the learning ability test, primary school learners should be screened for eye and hearing problems in order to be treated before it inhibits learners' academic performance: "...see so that he could learn to read, can he hear the teacher..."

A report of a learner's health history and learning abilities should be transferred with the learner to High School in order to inform the staff about any acute or chronic health needs: "...get a child with the profile already from primary school."

Shaw, Glaser, Stern, Sferdenschi and McCabe (2010:12) mention that a reactive school could contribute to an adolescent's total health, better academic results and a better quality of life. Currently sufficient support is given to institutions in need of it by the DoH and DoBE.

Key stakeholders agreed upon **available health services on the school's premises**. This entails a designated area where learners could be assessed, treated and first aid could be administered. A permanent, relevantly qualified health person was also recommended: "...a school nurse...at the school with a basic understanding of health care and mental care...follow-up on cases...school's counsellor or a psychiatrist...we need it very badly". However, participants also negotiated with the public and private sector for health services in their area designated to school-health. According to them, it should be a health institution where ill or injured learners could be sent to: "...have primary places where we can central remove problems". In return, adolescents and educators will spend less time out of class, and follow-up will be easier. A Northern American perspective by Landro (2012) reported extensively on the new model for school based health centres. These centres are inside or adjacent to school buildings and with parents' consent nurses assess, diagnose illnesses, prescribe medication and provide preventative care. Even dental care is provided in some centres.

Participants acknowledged that **school-health services should be comprehensive**. Therefore, the health practitioner, such as a professional nurse should be qualified in mental health as depression is identified as a prominent mental health need amongst adolescents: "...because the psychiatric problems amongst learners are so immense..." According to participants these health services should be on the school premises: "The health professional should do screening...first ears and eyes and backs..."

Key stakeholders of Case B indicated that health services should be available to monitor sick learners, handle emergencies, liaise with learners, parents, health facilities and other members of the multi-disciplinary team. This would help with the coordination of treatment, counselling, screening- and drug tests, assist with health education and reproductive health such as family planning. With regard to

reproductive health, the emphasis should be on sex education and information about medical conditions and HIV in order to empower learners to take responsibility for their own health care. Another need mentioned by participants was that the health professional must be able to identify and treat minor ailments and be allowed to administer medication when needed, for example with an asthma attack or allergic reaction. It was suggested that the professional nurse should rotate between designated schools: "...services on a rotational basis...Grade 3, then Grade 7, then Grade 9". Furthermore, if the school-health nurse stayed in the hostel, she could assist with sick children during the night when parents could not be contacted.

In an evidence-based research study on the value of school nurses working in an urban school system, Baisch, Lundeen and Murphy (2011:74-80) provide evidence that school nurses positively influenced immunization rates, accuracy of student health records and management of learners' health concerns. It further demonstrates that teachers and other staff consider nurse interventions vital to eliminate barriers to student learning and to improve overall school-health.

Participants' needs are echoed in the PHC Re-engineering Program proposed by the DoH and DoBE (2012:1). The South African Government intends expanding PHC services with prominent attention to school-health services. Additional services to be included in school-health are screening for eye, ear and dental problems, updating of immunisation and attending to issues such as contraceptive use, teenage pregnancy and abortion as well as initiating programs addressing HIV and Aids and substance use at school.

3.3.2.4 Conclusion statements with regard to Case B

- As health is interdependent and interrelated between different dimensions, it can be concluded that Case B's physical infrastructure and surrounding grounds contribute to the healthy environment of adolescents and educators.
- As educators and administrative staff are not medically trained they find it difficult to assist learners on their bio-physical dimension with chronic diseases and other medical emergencies, especially when a learner does

not have a medical aid. Chronic diseases, illness and other medical emergencies have a negative influence on learners and educators, increasing stress and causing learners to be disconnected from active school time.

- There is a complex interrelation between adolescents' mental health; parents' concern for their children and the socio-economic and cultural challenges experienced by families.
- Despite the caring approach of Case B, there are blurred boundaries between educators, administrative staff, learners, parents and the community with regard to the facilitation of learners' health.
- Despite efforts from Case B's internal environment closely related to health services available in the school's external environment, there is a need for a health professional as part of a comprehensive school-health service.

3.4 CHAPTER SUMMARY

Chapter 3 analysed and discussed the current status of school-health services from two viewpoints, namely that of Case A and of Case B. These viewpoints were represented by particular stakeholders involved with adolescents, and more specifically with their health. The discussion also involved comprehensive school-health services and how it should be rendered to two selected secondary schools in the North West province in order to ensure adolescents' optimal health and education.

CHAPTER 4

EVALUATION, LIMITATIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

Preceding chapters described how comprehensive school-health services should be rendered to two secondary schools in the North West province in order to enhance the quality of adolescents' health.

An evaluation of the study is given in this chapter, which includes a review of the study, summarised conclusions, limitations of the study and recommendations for nurses working in a PHC context focusing on school-health, nursing education, and nursing research.

4.2 REVIEW OF THE STUDY

The purpose of the study was to make recommendations on comprehensive school-health services in secondary schools, North West province in order to enhance adolescents' health. It was achieved by the objectives indicated in Figure 4.1.

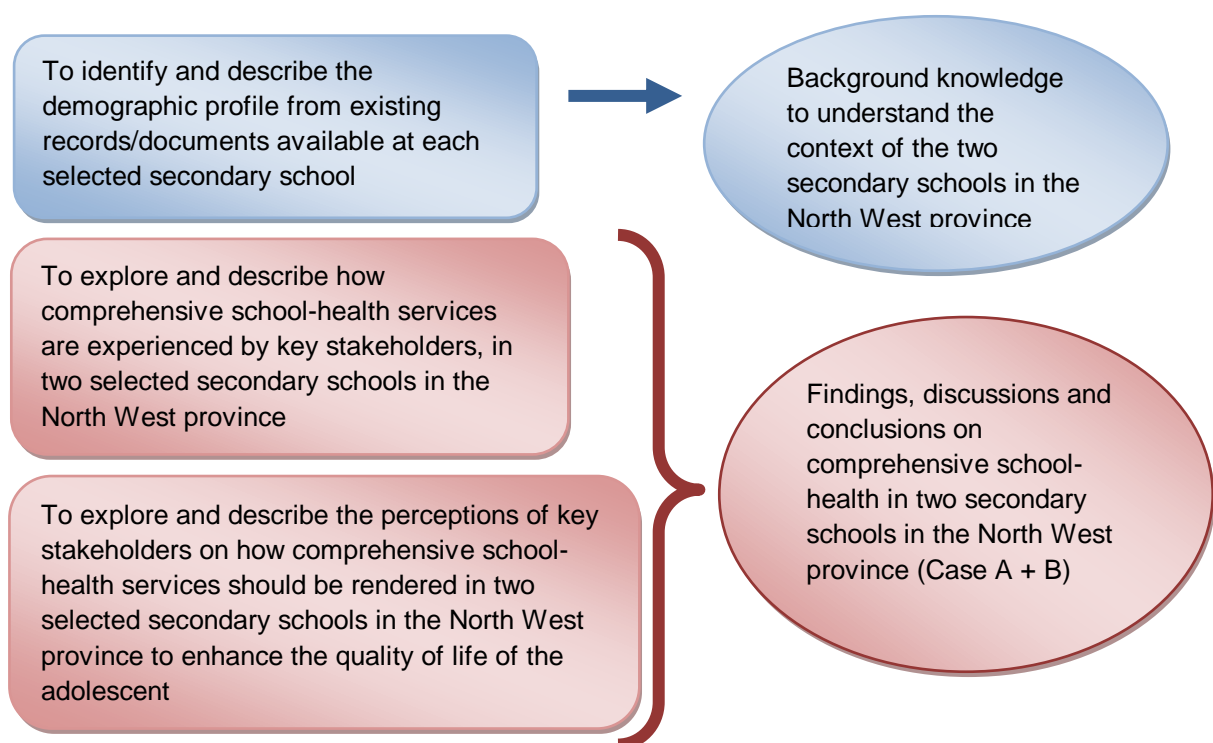


Figure 4.1: Objectives of the study

Chapter 1 provided background information of international and national views on what school-health should entail, with its aim to improve and enhance the quality of learners' health. In future the Department of Health and the Department of Basic Education will join hands to provide comprehensive school-health services for all educational phases by means of the new Integrated School Health Programme (DoH & DoBE, 2012:7). Therefore, PHC clinics are under pressure to encompass school-health services as one of the three main components of its re-engineering program as to promote a culture of learner-centeredness and to provide quality school-health services that meet the needs and expectations of learners, families, educators and the community. An overview of the research prepared readers for subsequent chapters. The introduction and problem statement, research problem, aims and objectives, theoretical perspectives, concept clarification, research design and method as well as ethical considerations and rigour of this research were also discussed.

Chapter 2 explained the methodology used for this research in detail. The context of each Secondary School in the research differed, which added to the richness of data. Therefore, holistic multiple case design, described by Yin (2009:108), had been chosen as it was more advantageous than a single case design when conclusions of the two cases had to be made. With regard to the two involved secondary schools a two case study in this research would refer to the investigation of comprehensive school-health programmes in each school. The Dimensions Model of Community Nursing was used as theoretical framework for this particular research. The research was conducted in a secondary school population with purposive voluntary sampling involving two schools in the North West province, Matlosana sub-district. Firstly, a demographic profile data sheet was compiled from which background information of each school (Case A and B) was gathered. Secondly, focus group interviews were held with key stakeholders who adhered to the inclusion criteria. Those persons were purposively selected and invited to participate in the research.

Chapter 3 was concerned with research evidence obtained from more than one data source for case study designs; a demographic data sheet, focus group interviews

and field notes. Scientific true evidence was determined by using three principles supporting data collection in a case study; multiple evidence sources, a case study database and by the maintenance of an evidence chain. Gathered data of Case A could be divided into nine themes and twenty-two sub-themes whereas eight themes and sixteen sub-themes derived from Case B. Those themes and sub-themes were described, discussed and integrated with various literatures.

Limitations were highlighted and conclusions drawn, which indicated the important role of PHC-personnel with regard to school-health in secondary schools and its enhancement of adolescents' health. It became clear that more emphasis should be placed on the strengthening of the Integrated School Health Program within PHC re-engineering outreach health care to improve the quality of school-health services.

In order to accomplish the purpose of this study, a summary of conclusions and recommendations based on the findings were provided, which served as a starting point for recommendations with regard to school-health nursing practice, nursing education and nursing research.

4.3 SUMMARY OF CONCLUSIONS

Summarised conclusions should enhance adolescents' health by rendering comprehensive school-health services considering nursing practice, nursing education and further research to address identified shortcomings. Similarities as well as differences deriving from the themes and sub-themes of this study were as a result of the demographic profiles and findings of focus group interviews on comprehensive school-health services, as experienced by key stakeholders.

Notwithstanding the fact that demographic profiles as well as discussions with key stakeholders revealed that the physical structure and environment of both schools were safe and conducive to learning and sport activities, it became clear that the complex interconnectedness between adolescents' psychological, socio-economic and cultural dimensions influenced by parents' presence or absence, was a real challenge. These facts also emphasised the influence of accessibility to and affordability of health services on adolescents' health and well-being.

Stakeholders of both cases agreed that inefficient comprehensive school-health services and uninvolved parents influenced adolescents' health negatively. Participants also emphasised the need for a health professional directing key stakeholders towards comprehensive school-health services, with psychological support to adolescents, by all stakeholders educationally involved.

It appeared that adolescents' deviant behaviour decreased and their academic achievement increased due to educators and parents' support. Findings further showed a connection between adolescents' mental health, socio-economic and cultural challenges of families.

According to the researcher the best performance by adolescents and educators depends on regular comprehensive school-health on or near the school premises. It appeared that educators and administrative staff were not medically trained to assist learners with chronic diseases or emergencies. It also became clear that educators could not handle the situation of learners without a medical aid. Chronic diseases, illness or other medical emergencies influenced learners and educators negatively, increasing stress and causing learners to be disconnected from active school time.

Results of this research from an empirical viewpoint, supported by literature made it possible to give a description of this holistic multiple-case study from Case A and Case B; key stakeholders' concern for available comprehensive school-health services unfolded.

4.4 SIGNIFICANCE OF THE STUDY

A holistic multiple case study design, various data sources such as demographic data sheets, focus group interviews (two at each school) and field notes enabled the researcher to obtain rich in-depth data of both cases. Results of the two demographic profiles from selected secondary schools in the North West province, key stakeholders' experiences of rendered school-health services as well as how it should be rendered to these adolescents, enabled the researcher to make recommendations to the nursing practice, nursing education and further nursing research.

4.5 LIMITATIONS

The following limitations were identified in this study.

- Case B's demographic data sheet did not reflect all data (data were estimated), which impeded clear conclusions about learners' illnesses.
- Parents were not well represented in focus group interviews, resulting less rich valuable data.
- Both cases represented urban schools. Results of the case study can only be applied to urban schools in the same district where the research had been done.
- The Integrated School Health Program, referred to in the introduction and background of this study, was launched by the Department of Health (DoH) and the Department of Basic Education (DoBE) near the end of this research and could have been more valuable during the data collection plan.

4.6 RECOMMENDATIONS

The following recommendations are to enhance the availability of comprehensive school-health services for adolescents in selected secondary schools in the North West province:

4.6.1 Recommendations for nursing practice

The following are recommendations for nursing practice, focusing on school-health nursing:

- According to the study, key stakeholders in both cases experienced poor school-health service as well as poor communication with the Department of Education, which can improve through community-based collaboration and partnerships between the DoH, DoBE, other political structures, university structures and community structures like NGO's and FBO's.
- Schools should be informed about health campaigns. A year program of topics could enable schools to prepare in advance.

- Information about opportunities for training in first aid should be provided by the DoBE or DoH to schools well in advanced in order to arrange a substitute for absent educators.
- Stakeholders should be updated on current available school health services as well as the proposed PHC re-engineering program and school-health package and its significance by means of road shows or ward meetings lead by a professional nurse.
- As literature indicate that secondary schools are currently not the main focus of school-health services, an allocated school nurse could enhance such relationships with these schools' key stakeholders in his/her ward by inviting them to community meetings where information could be obtained and challenges with regard to rendered school-health services to adolescents in secondary schools could be discussed.
- This research should be presented at a community meeting to enhance dissemination of information to relevant stakeholders.

4.6.2 Recommendations for nursing education

The following are recommended for nursing education:

- Nursing Education Institutions (NEIs) should revitalise school health nursing as part of the basic nursing education curriculum to introduce the Integrated School Health Program and PHC re-engineering early during training.
- Knowledge and needed skills for rendering school-health services could be enhanced by nursing students visiting schools as part of their clinical hours. Nursing students would become more aware of school-health services as much as adolescents would benefit from regular visits.
- Key stakeholders were concerned about uninvolved parents who had a negative influence on the health and well-being of adolescents. Informative campaigns to educate parents about their primary role in the physical, emotional, psychological and social well-being of their adolescent children

should be held by nursing education institutions as part of a community project.

4.6.3 Recommendations for nursing research

The following are recommendations for nursing research:

- The same or similar case study research could be conducted at urban as well as rural secondary schools and results could be compared.
- A study on collaborative partnership between the DoBE and DoH should supply valuable information about how to enhance the accessibility of comprehensive school-health to adolescents.
- Research to evaluate the implementation process of the Integrated School Health Program within PHC re-engineering could be valuable.

4.7 CHAPTER SUMMARY

The aim of this research was to study current comprehensive school-health services to secondary schools in the North West province and to make recommendations which would improve adolescents' health. It has been achieved by an explorative and descriptive holistic multiple case study. This chapter concluded the research with a review, a summary of conclusion statements, the significance of the research, identified limitations and recommendations for comprehensive school-health services by emphasising the important role of a full time nurse, nursing education and nursing research.

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ANNEXURE A

ETHICAL APPROVAL

Private Bag X6001, Potchefstroom
South Africa 2520

Tel: 018 299-1111/2222
Web: <http://www.nwu.ac.za>

To whom it may concern

Faculty of Health Sciences
Tel: 018 2992095
Fax: 018 2992088
Email: Annamarie.Kruger@nwu.ac.za

12 April 2013

Dear Dr. Watson

NWU-00005-13-P1 "Comprehensive health services in selected secondary schools in the North-West Province"

The applicant responded in a satisfactory way to the amendments requested by the panel members.

Final ethical approval is recommended.

Yours sincerely



Prof. A. Kruger
Ethic Sub-Committee Chair

Original details: Prof. A. Kruger(10062416) C:\Users\13210572\Documents\ETIEK\2013 ETHICS\NWU-00005-13-S1b .docm
12 April 2013

File reference: NWU-00005-13-P1

ANNEXURE B

APPROVAL FROM NORTH WEST DEPARTMENT OF EDUCATION



education

Lefapha la Thuto la Bokone Bophirima
Noord-Wes Departement van Onderwys
North West Department of Education
NORTH WEST PROVINCE

Temane Building
8 O.R. Tambo Street, Potchefstroom
Private Bag X1256,
Potchefstroom 2520
Tel: (018) 299-8216
Fax: (018) 294-8234
Enquiries: Mr H. Motara
e-mail: hmotara@nwed.gov.za

DR KENNETH KAUNDA DISTRICT
SENIOR PROFESSIONAL SUPPORT MANAGER

01 November 2013

Dr M J Watson – Study Leader
Dr P Bester – C-Study Leader
School of Nursing Science
North West University
Potchefstroom Campus

REQUEST PERMISSION TO CONDUCT A RESEARCH STUDY AT TWO SECONDARY SCHOOLS - MRS RONEL DE KLERK STUDENT NUMBER: 10533222

Your correspondence dated 31 October 2013 refers.

The content has been noted.

Noting the fact that the said student already started the research, albeit in a way that this office does not approve, we believe that in the interest of education, we must allow the student to continue and conclude the research.

Please note, for all future interactions, let this office be approached timeously. We are confident that together we will be able to render quality education, as the extrapolations from such research will be of great assistance to education.

Thanking you

MR H MOTARA
DISTRICT DIRECTOR
DR KENNETH KAUNDA DISTRICT

ANNEXURE C

REQUEST TO ACT AS MEDIATOR

Die Park
58 Williams street
Wilkoppies
Klerksdorp
2570
(W) 018-474 9340
Sel: 072 436 0435
roneldk@mmhs.co.za
10 October 2012

Name of school

Klerksdorp

2570

Name of principal

REQUEST PERMISSION TO CONDUCT A RESEARCH STUDY AT YOUR SELECTEDED SECONDARY SCHOOL IN KLERKSDOPR AND PARTICIPATION IN A RESEARCH STUDY BY ACTING AS MEDIATOR AT THIS SELECTED SECONDARY SCHOOL IN KLERKSDORP

I am currently registered for the M CUR (Nursing science) degree at the Potchefstroom campus of the North-West University. As part of the degree I plan to do research on comprehensive health services in selected schools in Klerksdorp in the North-West Province.

The purpose of this study is to:

- To explore and describe the current status of comprehensive health services as experienced by the stakeholders in two selected secondary schools in the North West Province.

- To explore and describe the perceptions of stakeholders on the provision of comprehensive health services in two selected secondary schools in the North-West Province to ensure optimal health of the adolescent.

In order to achieve these objectives, focus group interviews will be held with the stakeholders at both the selected secondary schools in Klerksdorp in the North-West Province.

Role of the mediator is to, on behalf of the researcher,:

- identify the appropriate stakeholders for the focus group
- give the consent forms to the potential participants and explain the following aspects of the consent form;
 - the purpose, benefits and importance of the study
 - the ethical considerations
 - the method of data collection and that the focus group interview will be recorded and will continue for about 45 minutes.
 - that participation is voluntary
 - that all names and recordings will be treated confidentially
- Arrange an interview date and time that will suit the stakeholders and the researcher.
- Arrange for a venue that is private, accessible to the stakeholders, has adequate seating and electrical supply for the recording equipment.
- Introduce the researcher to the participants on or before the day of the interview.

Inclusion criteria for the participants are;

- to be a representative of one of the stakeholder groups, (that is; educational leaders, teachers, peer group leaders, members of the multi disciplinary health team, non-governmental organisations, faith based organisations and household members that will benefit from the action plans that will be proposed) of that secondary school
- to have an interest in and concern about the comprehensive health services available to adolescents in the selected secondary schools in Klerksdorp in the North-West Province

- to be available and willing to participate in a focus group interview
- to be knowledgeable about the health services available to adolescents, or the lack thereof
- to be able to read and write and articulate in English or Afrikaans

The interview must preferably take place before 5 November 2012 due to time constraints with regards to school exams.

The mediator must indicate whom to liaise with, with regards to collecting demographic data.

It will be appreciated if you submit the information on the participants and the arrangements that are made on behalf of the researcher as soon as is convenient. Further arrangements will then be made by me.

If more information with regards to the research is needed, you can contact me at the above mentioned numbers or e-mail address.

Thanking you in anticipation

Kind regards

EPJ de Klerk (Researcher) _____ **Date** _____

Dr. M J Watson (Supervisor) _____ **Date** _____

Dr. P Bester (Co-supervisor) _____ **Date** _____

--

I understand and agree to be the mediator.

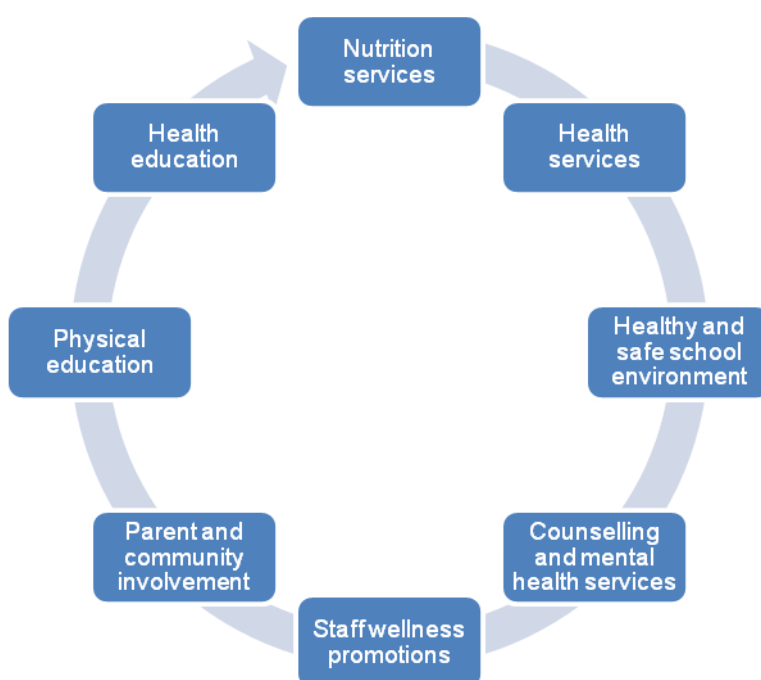
Mediator _____ **Date** _____

ANNEXURE D

DEMOGRAPHIC DATA SHEET

You are requested to provide the researcher with the following information pertaining your school's demography for the study. The mediator will help you to complete the demographical data.

SCHOOL A	SCHOOL B
-----------------	-----------------



Location	In town	Suburb	Township	Farm	
How many learners in	Grade 8	Boys		Girls	
	Grade 9	Boys		Girls	
	Grade 10	Boys		Girls	
	Grade 11	Boys		Girls	
	Grade 12	Boys		Girls	
Total					
Race	Black	White	Coloured	Indian	Other
Funding	How many learners pay full school fees?				
	How many learners pay partial school fees?				
	How many learners are fully subsidised?				

Healthy & Save environment	Amount of class rooms?		Learners per class?		
	Is the maintenance plan up to date?				
	Are the school grounds clean and maintained?				
	How many teachers?				
	How many Fire extinguishers?		When was it last checked?		
	Is the evacuation plan in place?		How many practices per year?		
	Is somebody responsible for occupation safety		If Yes, who?		
	How much rugby, soccer fields?				
	Netball fields?				
	Tennis courts?				
	Athletic field?				
	Hockey fields?				
	Other sport or extramural activities?				
	Save Relaxation area?		If yes/no explain		
	Does the school have a Hostel?	Boys		If yes, give total	
		Girls		If yes give total	
Physical education	Is the subject presented at this school?				
	Do you have an equipped gym?		Do the learners have access to it after school hours?		
Health education	Does the school present Life orientation?				
	Does the school take part in health campaigns?		If yes/no, explain		
	Does the school invite health speakers?		Topics?		
	Other initiatives for 2012? Explain shortly				

Nutritional services	Tuck shop	Sweats	Food	Cool drinks		
	Do you have a Feeding scheme?	Yes	No	If no, why not?		
	Who manages this initiative?					
	How many learners are on a feeding scheme?	Grade 8	Boys			
			Girls			
		Grade 9	Boys			
			Girls			
		Grade 10	Boys			
Girls						
Grade 11	Boys					
	Girls					
Grade 12	Boys					
	Girls					
Medical services	How many learners are on a medical aid?					
	To whom do learners report when sick?					
	Do you have a "sick room"	Yes	No	If yes how many beds?		
	Who looks after the Learners in the sick room?					
	How many school days were lost due to sickness from January to October 2012	January				
		February				
		March				
		April				
May						
June						
July						
August						
September						
October						
What are the 3 main reasons for missing school?						
Have you received any visits from school health services?	If yes, when?		If no, why not?			

	How many people on the premises are qualified first aid practitioners?	First aid level 1	First Aid level 2	First aid level 3
	Do you have an equipped first aid bag?	Yes	If no, why not?	
	Who is responsible for the first aid bag?			
	How far is the school from the nearest clinic or hospital?			
	How many children with known allergies?		Name them and the type of allergies	
	How many children have a chronic disease (e.g. diabetes or asthma)?		Name them and the chronic diseases	
	What is the school's protocol in case of a medical emergency?			
	How many children with physical impairment?		Name them and type of physical impairment	
	How many children with mental impairment?		Name them and type of mental impairment	
Counselling services	Do you have an appointed counsellor?	Yes	No	Comment
Do you have a staff wellness promotion program?	Yes	No	If yes, give details	

Parent and community involvement	Does the school have a parent governing body?	Yes	If no, why not?	
	Is the parent governance body (council) actively involved in the interest of the learners?	Yes	Give a recent example	
Discipline	How many disciplinary hearings did you have from January to October 2012?		What were the 3 main reasons for disciplinary hearings?	
	What are the 3 main reasons for missing school?			

Persons involved in gathering the information as directed by the principal of each school [Case]:

Date	Print name and surname	Signature	Post (e.g. Receptionist)	Witness

Date	Print name and surname	Signature	Post (e.g. Receptionist)	Witness

Date	Print name and surname	Signature	Post (e.g. Receptionist)	Witness

ANNEXURE E

INFORMED CONCENT DOCUMENT

Die Park
58 Williams street
Wilkoppies
Klerksdorp
2570
(W) 018-474 9340
Cell: 072 436 0435
roneldk@mmhs.co.za

Dear Participant,

As an important stakeholder of this secondary school you are invited to participate in the following study:

Comprehensive health service delivery in selected secondary schools in the North West Province

C. Background and Objectives

The department of Nursing Science at the Potchefstroom campus of the North-West University requires a master degree student to conduct a research project, hence this study. To execute this study might hold the benefit that the quality of comprehensive health services for adolescents in secondary schools can be improved.

There is a direct correlation between the health of adolescents and their performance at school and their ability to become productive members of society. The school attendance of adolescents is subsequently influenced by illness, disease, abuse, neglect, risky behaviour, substance use and abuse, poor nutrition and more, with the consequence of a high drop-out rate. To reduce the mentioned challenges of the adolescent in secondary schools, knowledge and understanding of comprehensive health care service may benefit and address the adolescents' needs.

The objectives of the study entail the following:

- To explore and describe the current status of comprehensive health services as experienced by the stakeholders in two selected secondary schools in the North West Province.
- To explore and describe the perceptions of stakeholders on the provision of comprehensive health services in two selected secondary schools in the North-West Province to ensure optimal health of the adolescent.

B. PROSEDURE

If you agree to participate in this study, the following apply:

- You will be part of a focus group (8 to 12 people) and will be required to participate in an informal discussion/interview regarding the above mentioned objectives.
- Your participation will be required once, for a maximum of two hours.
- The focus group interview will take place at the selected secondary school in a venue determined by the mediator, in this case the principal of the school.
- The focus group interview will be recorded in order not to miss some information and to be able to transcribe the interview accurately. The tape will be destroyed after transcribing.

D. RISKS / DISCOMFORTS

You might experience initial discomfort to participate in a group interview, but the interview will be conducted by an experienced interviewer that is also a psychiatric nurse practitioner.

E. CONFIDENTIALITY

- Only authorised persons will have access to the records that is me (the researcher), my study leaders and members of the ethics committee of the North-West University, Potchefstroom campus. All transcribed data will be locked away.
- Anonymity will be maintained in any records or publications that might result from this study. No names of participants will appear on the transcribed data and will be coded as participant A, B etc.

F. BENEFITS

There will be no direct benefit to you from participating in this study. Your participation will help the researcher to explore and describe the current state and availability of comprehensive health services to adolescents in secondary schools. The outcome of the study will help to formulate recommendations and action plans for nursing and basic education, further research and health services.

G. COST

There will be no cost to you from participating in this study.

H. PAYMENT

You will receive no payment for you participation.

I. QUESTIONS

You are free to clarify any uncertainties through the appointed mediator.

J. CONSENT

You will be given a copy of this consent for your own records.

K. PARTICIPATION IS VOLUNTARY

You are free to decline to participate in this study, and may withdraw at any time without any consequences or penalties. Your decision to participate or not to participate in this study will have no influence on your present or future situation.

By signing below, I _____ agree to take part in a research study entitled **Comprehensive health service delivery in selected secondary schools in the North West Province.**

Signed at (place) _____ on (date) _____ 201__

Signature of participant

Signature of witness

Signature of investigator

Signature of witness

ANNEXURE F

TRANSCRIPTION OF INTERVIEW B2

I: Ok, (pause) Thank you very much for everybody that's willing to participate in this focus group interview. I want to open the floor and ask you what is the current status of school health services at this school

Silence for few seconds

I: Who will be our first volunteer to start?

P: I am going to be honest, I don't think we have (shy laugh)

I: Ok, (long pause) tell, tell us why do you think so

P: Well I have a child that is constantly ill, and the best bet is phone your mother and come fetch you, because they can't help him here at all, if my child has an attack not one of them is going to be able to medicate and help him or anything

I: Ok, so as a parent your experience is that, that the level of care that your child needs at school is not existing at this school.

P: Ja

I: You want to, to add something more

P: Oh, it's also just always easier for me to come fetch him myself and come take him home and do it myself, than to expect the teacher or a principle to do it for me, (long pause) especially when it comes to his medication, because I can't expect them to inject him with steroids.

I: Umm, umm, ok.

I: So, you, you as a parent also has an active role in the parents phone you but you do come and fetch your child and you then administer the medicine at home

P: Umm, yeah, it's just easier, can't expect the teachers to do it

I: Ok, (pause) who of you agree that you has to

P: And, and what happens if you're not available

P: No that's what I am always worry about, if I am not around (long pause) the best that you can do for him is to give him anti allergens at that moment, but that's about it

P: and he knows

- P: He knows, he knows, he carries it around in his tie, for incase it happens that I'm not around or he can't get hold of me at that moment, (pause) and all his friends in his close group also know exactly know where they are and so he just carries it with him, it's easier for him as well
- I: So as a learner, he's informed, he's, he has his medication he knows what to do with it
- P: Yes, him and his friends, so they know that if it's too bad that they can help him immediately. Praise God that it's never happened that it's happened at school yet but
- I: Ok
- P: I think our health services internally is incident based, it happens when an incident happens, we have quite a number of teachers who have done the first aid first level course and we have four teachers who have actually done the third level course, so I think we are in a position and we have first aid kits and so on, so were in that position to handle an emergency when it happens, we should be able to handle that, umm but then other than that there's no real education of health or anything like that in our school at the moment, I don't know when the last time was that the nurses came here
- P: Don't they come every year
- P: I think that it was the first year I came here they were here
- P: (some people talking together) when you were in Grade nine, weren't there nurses here, (pause) in the voyeur of the hall
- P: I think, and last year they were also here
- P: Because they always take the LO periods, (some people talking together) ja and then they test the children, hearing, they look for back problems... sight umm what else do they do, and they give the children recommendations of this or that is wrong with you and this is where you can go or tell your parents to make an appointment to go somewhere, (pause) and they and I know they stay for a week because they go through every single child
- I: Ok so, so far from parents (someone making noise) for a child with a chronic condition, (pause) needing specific medication then your experience is that, that sort of service is not existing at this school, and umm, but school is incident based,

the school can handle an emergency and then there, are a history of occasional visits by nurses to do umm sifting tests.

P: Yes

I: Traditional sifting tests

P: Only Grade 9's

I: Grade 9's

P: So if you weren't in the school in Grade 9 then you are going to be missed.

P: That would explain why I don't know about it because my child was never hardly ever in school in Grade 9 (people laughing together)

I: Ok, who's who wants to add to the three points made so far.

Long pause

P: Umm, I was just thinking we, we know how to work if an incident happens there is somebody who can help, but unfortunately how do you get that person to a hospital, because most parents don't have medical aid. So right here to do something now but if it is something that needs to go to a hospital immediately with an ambulance that is a problem

I: Especially for a child without a medical, medical aid that needs to go to a public health care services

P: Yes because the, we phone the parents, and then the parents who's just don't get an ambulance phone Tshepong and their ambulances take an hour, (pause) and in that hour something can go very wrong, we had an incident like that a week ago. So that we can handle, we can put the child on the stretcher and do all the things that have to be done with the neck, but then after that...

I: Umm, (pause) so the school health services here with regard to emergency care is extremely dependent on the transport of that child and

P: If it's nothing major if we can get the child in the car and we take him, we do that, but this child had a neck injury and we couldn't move the child and the paramedic said if they don't take if the child doesn't go now there can be serious consequences.

P: So the reaction was from our staff members this actually happened at another school umm was that we called a private ambulance service and we

signed that we will pay the account and I have just signed today to pay that account, so it's going to be paid out of school fees, so we don't make use of the state ambulances, umm and let me add here the ambulances are extremely fast the private companies, extremely, you speak of minutes and they are here, umm and often they do it for free, if it's a patient that came out of umm, ja or else if it is a patient with a medical aid then it's not a problem.

I: Oh, so far you do have your services rendered by nurses, more for the identification of problems, umm although as a parent umm there are, there might be parents that experience that that services in not rendered or that health services isn't really existing, but there's also the case where parents are phoned to come and pick up their children and that the parent is then the responsible person to render that care. How does that happen in this school, that part of the health service, the role, of the parent?

Phone ringing in background

P: Well I have never been phoned from the school myself, he phones me and says to me mom I am having an attack please come and get me, and then I just come to the office and they know already when they see me they already know and they give me the book because they know and that he is not well

Knocking noise in background

P: I think J... (*miskien moet jy bietjie inkom, as ons die ouers bel as daar iemand in die siekeboeg is..... kom die ouers?*) Perhaps you must come in here, when we phone the parents when their child leis in sick bay, do they come?

P: (*Partykeer hulle kom, partykeer hulle kom nie, miskien*) Sometimes they come, sometimes they don't.

I: (*So partykeer kom ouers, maar hulle kom ook partykeer nie.*) So sometimes the parents come and sometimes they do not come.

P: I don't think they have got transport, some of them don't have transport and they don't have money from the extra taxi to come to town to fetch their child and they leave the child

Long pause

P: Ja, we often unfortunately send the child home in the afternoon with his normal transport when we actually feel the parent should have collected him not when he's in dire straight of cause (many agree together) but (pause) and then let me say

there may be there's a bit of a culture thing here also, it's true, all white parents, parents with white children will immediately make a plan to come and collect their children and many, many black parents will also, but black parents will more often say to you but he's in your care now, please take him to the doctor, and then it means that the teacher has to leave the class for two hours to take the child to the doctor because he is in our care, it's quite true, especially if it's a hostel it's a hostel child, then we do go the extra mile, but that that was a problem today, that we call the parent and he said but take the child to the doctor he said that we had her there already yesterday, we had her at the hospital already yesterday and then he reluctantly in the end came and collected the child.

I: So, besides the parents because I definitely hear that you are an involved parent, but we also do have non-involved parents and umm it's it can be a cultural difference between cultural groups but at the end the responsibility of that ill child becomes the school's and the parents hand that responsibility over to the school, whom of you want to agree with that or add to that?

P: (Some agree together it is true) it's the truth

I: Do you want to add something to that?

P: I agree, it is the school's responsibility

Long pause

I: Ja

P: Especially with the girls who are who are who are suffering who are struggling with their menstruation pains they can't come in today, sick and they lay there.....we used to call their teachers to come in and assist them, there is no tablet to give the like pain killers ...just....

I: So the child will come and say I experience pain, the teacher is called or the educator is called but the educator is not allowed to give medicine

P: Medicine, yes

P: Well it's in our, our situation as well umm I I run well I don't run the drum I am their dressing room mom in they my care and the child comes and she's sprained her ankle, paramedic wrapped it for her but he can't give her medication, I am not allowed either, I have to phone that's child parent, before I can't even give a panado, if a child is injured I am not allowed to touch that child unless a fourth grade first aid, I've got a second grade, so I'm not allowed to touch her child, but we now

with the seniors with the high school girls, they are all seventeen, and that they can say ok I'll phone my mom quickly and I'll speak to the mother and say ok she's like give them what u need, if we away for a week same thing, they sign a consent form that I'm allowed to medicate their children, I mean if their child has got a stomach bug and I first have to phone you from where we were in Cape Town when everybody had stomach flu, I can't phone thirty seven parents every half an hour and ask can I give your child medicine now, can I give your child medicine now. And it is a problem, I am not going to give your child a schedule seven medication or something, but it is a problem that you can't get or always get hold of their parents either, and that is a big problem, or they reckon their children are gone for a week they are going to go on a holiday for a week and they switch their phones off. We have that happened lots. (laughing together) ja. (Pause) Or like last year, they arer you're problem whether you are finished earlier or not, you keep them.

P: Ja

I: So it's again that the responsibility that's handed over to the school, and the parents that's not involved in what's happening there and then you do agree that the responsibilities handed to the school if the child is ill it must be taken care off (pause) and that the teacher or the educator is called when a child is in the sick bay and the educator must relieve this child's pain but is not allowed to administer any medication.

P: That is correct

I: So if we look back now we can see that there actually initially it was quiet and when I opened the question it was quite difficult I have to say to you your honesty to get you to respond but we have now a few things on the table, we do have the fact that umm there are a basic service of nurses for the Grade 9's that they do give that service of identification of sifting tests and identification of possible problems, if you've missed that opportunity you've missed it. And then the University argh sorry, the school is very much geared for incident related health problems, should there be an emergency you do have trained level two or four, I am not quite sure what the figure is...

P: Level 3, it's quite high

I: Ok, so you do have that amongst your staff and you do have two kits available, so you can play tremendous role in stabilizing the situation and then it's either phoning the parent or if the ideal is having your medical aid patient or the child that can be

transferred with a private ambulance service and that we hear now the school also is available to do a private ambulance transfer as well

P: Ja because we have the finances, (pause) I don't know what the township school does, we have luckily have the finances

I: Umm, Yes

P: And also umm we had a teacher that suffers from asthma, so luckily we always have an asthma pump, otherwise we might not have had that

I: Because the teacher suffers from asthma you have the asthma pump

P: Ja, she always makes sure that there are a few pumps here, that I don't, don't think they would have been if it weren't for her unless we had a real problem and realize that was our need, that was a whole in our system.

I: Yes, ok, from what we have said so far we also indicated the, the interesting thing that was also a theme on the table from the previous group and that is the involvement of the parents and that parents play a crucial part in the health care of the child and that *your un-involved parent has a responsibility* to the school, whether that is for medication whether it is to go to a doctor or to a hospital, that responsibility becomes the school's, *you do have your involved parents that will respond to a call* and they will come and pick up the child, and due to various reasons you will see that more amongst the white parents. Ok, anything that you want to add to the status of health services at this school.

Long pause

P: So far we have coped with everything, nothing has really happened that we couldn't cope with.

I: Now I want to ask you, what should how should this school service health service really look like, (pause) what is your perception, if we talk about a school health service for this school, what, how should that be, how should it look, what must be available?

P: Umm, we now said that was like when we were in school, we always had a nurse, that could cover everything, I mean if a child like had a asthma attack that nurse would be able to had a little tank of oxygen or something to help that child, I know of one school that I've medicated myself with at competitions because her lungs are very, very weak, and if there isn't a pump available for her there should be one in at

least in the office or a nurse to be able to help her, we have rushed a child to a hospital from a competition before because of her condition

P: If I to this lady, she puts her son's tablets that he needs in his tie, how can the child suffering from asthma's parent not make sure they have a pump in the first place, so I feel that's the parents responsibility in the first place, and the school will only be able to help in an emergency, if the pump doesn't help then we rush the child to a hospital or get an ambulance, but it's not the school's responsibility to have a hundred pumps because there are a hundred children suffering from asthma, it's the parent must make sure that the school knows my child suffers from asthma like we know about her child he's got this problem, and please excuse him or this is what happens, but now you must sit and guess what is wrong with the child because it is not on the form of the parent whom did not do any trouble to say my child suffers from this and that.

I: So in this ideal school health service for this school you have more involved parents that will take responsibility for their children's health

P: Yes, so that you wanting the school health service will know what you need in that service, what do we need, what do we have at this school, we have a child with asthma we must do that we have a child with that we must do that, you know, but if you don't know (talking together) you don't know about thing how can you be prepared for them.

I: And then you have indicated that the traditional school nurse situated at the school during school time, is the ideal solution to be available for emergencies and also non-emergencies.

P: Ja, for those poor children that's parents that are not interested, and I know of quite a few that in this school that just drop their kids off here and pick them up seven o'clock tonight and the rest is your problem.

P: I just don't see in all the years I have been teaching that a school nurse is ever been necessary, so to employ somebody to sit in an office and this child comes with this pain and that child comes with that pain and then to give a disprin here, or I don't see the need in that, we have been coping for so many years, I don't see why employ somebody just for that.

P: Ja, if we are only speaking of physical health here or are we speaking of mental health as well, because I think here the two of you can come in, I think we see far

less learners with physical illness, than what we see learners with emotional illness, that we see a lot, I think.

I: So the need is not necessary for a person being here to physically treat, but also for the mental part.

P: More so, I think

P: Ja, umm umm, what do they call that?

P: Vocational guidance offices or what were they?

P: No, umm umm

I: A Counselor

P: Ja, (pause) that man who's children's wife died, in Orkney

P: Ja

P: He did that

P: Ja, I know about that

I: Whom of you want to exaggerate a bit more about the mental health need

P: I have think a lot of teenagers need to talk to someone, not all of them can talk to their parents or to some teachers, they're to scared, to scared they're going to get into trouble for it, I mean especially the youth that's in the Hostel, you see how many of the kids who can't talk so they talk to their friends and their friends give them the worst advice possible.

P: That is true, the teachers are there for us, we can talk to the teachers.

P: There's some teachers that you're too scared to talk to, I think you have to be honest there, I am too scared to talk to some of the teachers (laughing)

P: You see, that's what I say, she said that the teachers are there to talk to, they don't have that of letting to talk to my mother or my father, I am too afraid, I can't tell that in front of them I can't say something in front of them and that's the reason why they are coming to us

I: Ok

P: So they can't talk about the things that are bothering them in their hearts, they can't talk about that, because their parents don't agree with them, and they don't listen to

them at all, and that's the reason why these kids are coming to the teachers because they feel comfortable with us to talk to us

I: So at this school, it's for the *teachers are more approachable for the children to come and talk to than their parents*

P: And they identify the teachers themselves, it's true, she cannot she won't come to me but she will have identified one or two teachers that she knows and she can go and talk to her and she knows it will remain confidential and she might even be in a bit of counseling

(Long pause)

P: And we've just had this disciplinary officer at school, but the need is more counseling than discipline, they also go to her with all their problems, so she needs to sit and listen to that instead of doing the discipline, so we see that need is very big.

I: Ok, is that something that came up because of the role of the disciplinary officer that came in?

P: No, the need was there before that, the school had a sports organizer at some stage, and we quickly realized we don't need a sports organizer, we need a counselor, then we felt, no, we first now need the disciplinary officer, so we appointed her, but the natural, no naturally the learners now with the problem also going to her is if she is available, she's there, she's got an office, she's got a phone, so our next post will be a counselor, but we think that the department should have the most posts, once again, this is a fact, will we probably afford it, the moment we want to, but I think the school with even greater problems than us can never afford that

I: So the *Counselor will play a very big role in this ideal school health service.*

P: Yes, much more than medically, physically, mentally, absolutely

I: Ja, what other what other services if you can dream now of this ideal school health services, what else (pause) would you like to see at this school, (pause) if you have your office with your *counselor paid by the department*, what else do you think (pause) what do you think

Long silence (cars driving in background)

- P: Well suppose you could always go in the way, say if you are dreaming big, besides the counselor have someone that give family planning because the kids are falling pregnant left right and center in the high schools, it's terrible, in our day when you fell pregnant you left school, you didn't finish school, you left school, and it was your own fault for not getting help, now in the schools are thinking birth control is not necessary, I'll have the kid, I'll go to school, have the kid, go back to school when I had the kid, mommy and daddy will raise it, or granny will raise it.
- P: I also want to add there, in umm the culture, the black culture, the children are not allowed to have girlfriends and boyfriends at all, so as a result when they get to school or there's a activity after school or whatever, that is the ideal time to get together with the opposite sex, so they make the most of that time, and that's where the pregnancies come from, because at home they are not allowed to mix with the next sex, they can't have a boy coming over visiting tonight, or this afternoon, it's not aloud, it's taboo, there's no boyfriends or girlfriends, so when they get the opportunity they go overboard, that's the majority, there might be a few parents who are different but that's what their parents believe.
- I: Ok, so *family planning*, due to different reasons, will be a good added extra to the school health service.
- P: Yes, definitely, definitely, even sex education (others agree, talking together).
- P: We need something like that now, it's happening more and more and more
- P: And I mean it's no use just quickly running into a clinic for family planning because you sit there for hours and there may be a aunt sitting next to you, so you just leave it
- I: Too scared who's going to see you there
- P: Wat wil jy se.
- P: (*Ek net ingevill het by jy nou gesê het, die kinders wat ...*) I just want to add to what you sad, the children thet ...
- I: (*Te ver gaan*) That went too far?
- P: Ja, my fear is this, when they get pregnant, they didn't, they (long pause). I fear they will **get the HIV (became emosional)**
- I: Umm, umm, (*Jy kan Afrikaans praat*) You can speak Afrikaans.
- P: That's my big fear that.

I: Umm, umm, (*so saam met die family planning lived the HIV*). So with the family planning lives the HIV.

P: Umm

P: (*So daar moet met hulle gepraat word daaroor met die kinders, meer...*) So the children need a talk about it (HIV), they need that more

P: (*Meer baie*) Much more

P: (*Want ons sit hier en ons dink alles is reg, maar als is nie reg nie*) We sit here and think all is right, but all is not alright.

P: (*Meneer hier kan ek inkom en sê, kyk ek gee LO en ons praat baie oor en ek kan se ek praat met my kinders prontuit ek praat met hulle, ek noem wat genoem moet word so, ek praat met hulle, wat hulle my vra antwoord ek hulle, so met die gevolg is dan is dit moeilik om, jy het sensitiewe kinders ook in jou klas, so jy kan nie heeltemal presies praat soos wat jy wil nie want more oormore bel 'n ouer en se hoor hier roep die onderwyseres in, sy praat onbenullige goed met my kind, of my kind kan dit nie hanteer nie, so mens moet kyk mooi waar jy daai streep gaan trek, dan moet jy eerder dit met die kinders wat dit kan hanteer een kant mee praat en die wat bietjie meer emosioneel is ander kant toe vat*) Sir, I can come in here, look I give LO and we talk a lot, I talk to the point with the learners, I say what need to be said, I answer what they ask me, but is difficult to always exactly what you need to say for the are sensitive learners in class that cannot handle it. You will get a parent that phones to say call the teacher, she is talking nonsense to my child. Where do you draw the line, then you should rather pull the children aside that can handle it and then talk to them, and those that are more sensitive, take them to the other side.

P: Ja and how do you decide that?

P: (*Jy sien*) You see...

I: (*Hoor ek ook daarso dat omdat jy die onderwyser is*) Do I also hear, because you are the educatrt.. I'm sorry because you are the educator you have this class in front of you and your primary **role is to educate** but you do have these needs from the children coming to you

P: Ja

P: Especially in the subject because she handles that

P: (Ja ons het partykeer groot probleme waar die meisie na my toe sal kom en se juffrou ek en my ma baklei verskriklik, wat moet ek doen, en dan moet jy met daai kind praat, dat die kind naderhand in trane is, en dan kom se jy vir die kind gee jy vir die kind 'n oplossing en kom oor twee dae na my toe kom ons kyk verder wat kan ons doen, so ja, jy hoop altyd jy bereik jou doel in daai kind se lewe, dis belangrik) Yea sometimes we have big problems, like where the girl would come to me and say that she and her mom is fighting allot, what must she do. Then I have to talk to that child and give her advice and invite her to come to again after two days, and then we look what we can do further. So yes you always hope that you reach your goal in that child's life, it is important.

I: Umm

P: (En die meisiekinders praat nie teenoor meisiekinders, praat nie met enige iemand nie, jy moet daai ou vertrou, so hulle sal jou eers mooi uitkyk voordat hulle met jou gaan gesels, want te veel van hulle het al seergekry, te seergekry.) And the girls do not talk to anyone, they have to trust that person, they will first watch you before they will talk to you, too many of them got hurt, hurt badly. That's all that I want to say.

I: Umm

P: (laughing together)

I: It must be some kind of a trustworthy relationship, *trusting relationship* before the child will actually engage and discuss a deeper conversation with an educator.

P: They also write it I teach English and they write it in their SA's as well, I've also received many SA's where the children say how they then how they were raped or how they were abused by an uncle or the father or how the father hits the mother, and all those things they say in those SA's when it gets to things like that, it's true.

P: **Especially to our black children....**

P: Ja

I: Ok, so so far if we look at the ideal school health services for this school they say it will be wonderful if there could be for example a counselor that can be employed to focus predominantly on the mental health of the children and that umm yes there is a need for the physical part, the medication part, but so far you have actually coped quite well.

P: Yes

- I: Ok, and then there is a big part of the school health service that's actually present in the relationship between the children with the educators, they the children identify the educators, and they will select who they will come and talk to, and then in that discussion and that relationship, there's a little bit of counseling sometimes going on, but it is still limited by the fact that this is an educator and this is a child or a learner in part of a bigger class, and then the claim is very prominently is the need for family planning, sex education and HIV and aids information health education, that must be communicated more to the adolescence, and umm we also spoke about the different unique cultural behaviors, that is a reality that that we need to take into consideration for our health problems that might be at this school, like for example in front of parents the adolescence are not allowed to engage in any relationships with the opposite gender, the social times that they do have are then is not taken or done correctly.
- I: What else, anything that you want to add to that?
- P: I just don't think it's fair on the poor teachers, they have enough on their plates to now still also have to cope with the children's emotional problems and it's not fair on them either
- P: I feel that I can also add here is people who really really never ever give any problem of the **Indians**, they don't get ill, they don't have behavior problems, they, we just know of nothing, or they just go under the radar the whole time, the only Indian girl is that, what's her name, the black hair, Grade eleven, her dresses are always too low or too short.
- I: Ja, she is an exception.
- P: C, that one, ja (Talking together and soft, can't make out) (laughing together) but otherwise (talking together), bit otherwise they have no problems.
- I: So again we see that it's it's it's an organization with mixed cultures, we can see these behaviors amongst cultures.
- P: And if you should have what she was saying is sex education and you must or really go deep into things then they will have to be excused from class.
- P: Ja
- P: It's totally against their religion as well to even listen to it never mind discuss it.
- P: I want to strengthin a her point, umm, I am holding back, I can talk a lot more but one person shouldn't take over.

I: (Shy laughing)

P: The teachers play a major role, I think their role is underestimated, umm, ok some teachers will walk in teach maths and only teach maths but other teachers do their education while they are teaching and are open for counseling and things like that, what she said is true, some teachers get so involved in counseling, that they themselves get tired, they get emotionally drained because they carrying this weight, others and I am one of them, we have reached the point where we rather don't ask questions because **you are scared of the answers**, you don't ask why what, what's going on at home because maybe he tells you and then you didn't want to hear that, umm, so we are carrying a heavy burden, some teachers more than others but that's because we are all different, we are different people, umm, but it's true, the teachers are carrying a major burden

P: Ja it is, ja I can see with M as well, I'm also taking over now with this, with my son, he has one or two teachers that he will go and pour his heart out to, he'll come home and tell me ma I spoke to this teacher about this and this I hope you don't mind, but he talks to me as well but we are a household of woman, he is the only boy in our entire family, and I am divorced and we live with my mom and so he needs a man sometimes to talk to, he'll talk to me about, I can't really give him much of advice so he has one of the teachers that he can talk to about everything , which I am very grateful to, but it's also not fair on the teacher, because he can't turn around and say it's me, (*nou ek het nou M so gese of so gese*) nou m.. said this or that, because it will break their confidence again.

I: So I'm actually hearing two conflicting messages, to be honest, on the one hand it's the message to say it's fine, you, you are doing well, we are fine, it will be nice to have a counselor, but on the other hand I am do hear the message that some teachers can get over involved in counseling, some teachers are less involved with students, but being an educator, (pause) working with children of that's out of adolescence can be a quite burden, and in some cases you develop to a point where we don't ask questions because you are afraid of the answer, I hear something conflicting, I don't know if you agree with me

P: It is true

I: Yes

- P: We can get that counselor, if the department is going to help this school to pay for the counselor, but if the department say this school must pay for the counselor it's going to be difficult.
- I: Umm, ok.
- P: (very soft, can't hear)
- I: But you agree that a counselor will be a good asset.
- P: Yes, definitely
- I: Ok
- P: I think it will help the teachers in general as well, I mean you as a teachers you sometimes really just want to switch off, I mean I work with children everyday but I am not a teacher, and sometimes you just wish, I want to listen to your heart story, but I also have a tough life, I also had a bad day and you don't always want to just hear all how sad they are for the day you also thinking someone must **listen to me** for a change.
- P: (laughing) Ja, a few teachers will keep the counselor busy (people laughing together)
- P: *(Weet jy ek kan dalk net se ja ons raak moeg ons is almal net mense, almal van ons wat hier sit is net mense ons raak maar moeg, maar dit is ook maar goed om 'n oor te gee as daar geluister moet word, want van hierdie kinders skree uit in hulle nood skree uit die hart na jou toe om net bietjie om te gee. Ja dit moet eintlik vir jou a passie wees om met hulle te werk, en party het probleme wat ons nie eers van weet nie)* You know I can just say yes we do get tired, we are all just human, but it is good thing to offer an ear when someone school listen. They sometimes shout from their hearts, there anguish out and just need some understanding. Yes it should be your passion to work with these children, some have problems that we don't even know of..
- P: *(En dan kom dit per ongeluk uit)* And then it comes out by accident.
- I: *(En dan bring ek dit net weer terug vir die)*, the the, I am bringing it back, the ideal health school health service will be to capture that, by having a *counselor, which can be also be assisting teachers* in the sense of assisting children that will be available to teachers as well, (pause) said with a smile.
- P: Ja, why not do it (laughing together)

P: And and especially because if we look at our school children that had a medical aid, when I see there is a problem with my child I can take him to a psychologist or psychiatrist by my medical aid, but what does the next parent know, nothing, because he never see his child, so he or she don't even realize but my child is changing, my child is different, because we realize it, because when we phone parents it's always just, oh but this isn't the same child that's at home, because then the child has a split personality, here the child is like this and at home the child is like that, because the parents work all day it is as simple as that.

I: Umm, umm

P: (Some parents don't even talk to their parents after school.)

I: So there is always a *disconnectedness between the child and the parent*, that don't know each other, you wanted to add on that.

Woman making noise in background

P: (Man speaking too soft, can't hear)

I: Ja, Ja

P: Because their friend are always there to listen, whether they are good friends or bad friends.

I: Ja, ja, the hostel brings a good social support

P: Yes

P: The social, the hostel gives you a family that you don't have. I'm a hostel brat, so I know. (shy laugh) (Pause) I know of some hostel children that when it's time to go home they don't want to go, they'd rather find a friend to go to or some event that they can go so that they don't have to go home.

P: Because they know what's going on at home.

P: Umm, they know what is going to happen when they get there.

P: Or what is what is going on, and umm is my father abusing my mother or and I'm not supposed to know about that.

I: Umm, umm

P: When in, when we're in exam's some children write two subjects a week, so they don't have to come to school the days they don't write, those children will come to school from seven to five rather than going home and doing what must be done at

home..... but children also sit here on the grounds till five in the afternoon because they don't want go home, and it's not only because it's a bit dangerous, it's not always that dangerous in the township but umm, but they just rather don't want to be alone.

P: It's safe more at the school.

I: Umm, umm

P: The poor principal, he cannot rest, really.

I: Laughing, I think that is an important point, because having the school being aware of this keeping the gates open for these children until five o'clock, isn't that already part of a school health service?

P: But there is no one to look after them.

I: Yes

P: Something goes wrong then who's fault is it, should we stay on the grounds till then?

I: Umm, umm

P: Then who is going to look after our children?

I: If I can probe you a little bit more what is your opinion about the role of food, and feeding scheme, nutrition, when it comes to school health services.

P: Speak too soft, (cell phone make message tones).....

I: Very, (pause) very.

P: We have our own here at the school we feed children if we know about them, there might be many that we don't know about.

I: They are too proud.

P: Then we probably would give them food, those that need food get food every day, even though it is just a few sandwiches.

P: And there's also nobody that can keep an eye on to say that child is very underweight, why, I mean you as a teacher will say something is wrong, and you will probe it to yourself, and there is no one who is going to walk up to that child and say are you hungry, or do you need food? Till the hostel kids they have the accessibility of the hostel, if they really hungry they go to the kitchen and they go and ask for a piece of bread.

P: Really, hey.

P: "Ja"

Laughing and talking together in background

P: And umm, there also busy with subsidies at the moment and there were children and parents come and say they can't pay school fees can they get a subsidy, and then there we found out the children don't have food and that's were we come in with the feeding scheme..... and that's also going in such a way that they never get marked to other children that don't even know who they are.

I: Umm, umm, ok and your perception about the work wellness, wellness of the staff, should they be part of the school health service.

P: Oh definitely, a healthy teacher .is a healthy student.

P: (Man laughing at background)

P: Hey I just did a project on that, (laughing) I remember

P: A teacher is a is a weird species, umm, if you have people that arrive here and they want to make you jump up and down and they want to test your (making sound) things like that, they immediately kind of build up the wall, and now that happened last year, and however the teachers then participated, it was the medical aid gems that did that, once again and I have mentioned this a few times because I think it has a major impact, once again this governing body can budget an amount of money for teacher motivation, so we are actually helped to do things during the year financially, which I think is a positive influence on our wellness.

I: Umm, umm

P: What happens at other schools I don't know, but here we at least have that.

P: If I can come in there, umm, a lot of teachers need a wellness and all of that because of all the stress they are working under, but at this specific school our stress is half as much as other schools, because we have nobody shouting in their ears to be the best at everything, accept just effective teaching, whether our rugby team, soccer team, hockey team once we loses, it doesn't matter, whether you have eighty A's or only one A it doesn't matter, you did your best, so you don't have anyone breathing in your neck, saying get more A's, all you kids must get eighty percent, why are your rugby team not win?....., why is your children not rest properly, there is nobody moaning about nonsense, the main thing is the main thing,

and because of that we don't have all that stress, we don't have to worry oh no goodness we can't do this interview my hockey team must go practice because we lost one on Saturday, otherwise and then I will be in trouble on Monday,.. and that is what happens some times every Headmaster wants his school to be the best.

I: So umm, what I am hearing is that you spoke about there *is money available for teaching motivation*, and that links with and say if I am hearing this correctly but *there's a culture in this school of being a good teacher*.

P: Yes

I: Which links with *being motivated and you can hear now that it's decreasing their stress levels*

Silence

I: What do you say J...?

P: I agree (laughing)

I: Ok, well I think umm, I can summarize to say that R... made a picture, I think the picture of the services and the besides probing you on nutrition and wellness you actually did mention most of the services here, and something that came out in this discussion that was not part of the previous discussion is the safe environment, that the children experience that this is a safe environment which is part of a basic school health service and yes although you can't really look after that child after the school is out and they are on the premises, having a *safe premise* is part of a school health service.

P: If I could just add that what happens at this school is that..... everybody is excepted for what they are and who they are, if you owned a top 10 good luck to you, if you got North West Colors, great I'm so happy, but it's not that you are absolutely everything the school depends on you

I: Umm

P: Even you that's doing nothing except maybe picking up a paper you are also important..... We don't have that real difference from the Doctor's son or the Boilermakers son, umm he's top 10 you aren't, we don't have that.

I: Umm, so I hear a lot more.

P: Everybody is equal

- I: Appreciation?
- P: Yes
- I: Equal appreciation?
- P: Mmm, yes, I am sure the children feel like that, because they they all seem so happy, a part from your one or two that are not happy but they generally are happy, and when we had the lady here we had Miss...
- P: United Nations South Africa.
- I: Umm, umm
- P: And she said she never ever had so much appreciation and welcome that she received in the school when she was here last week, all the other schools are stiff..... even don't clap, she's stupid you know here, why, yippy, hello.
- I: Umm, umm
- P: You know they really treat people when they come here, it's your birthday as well they scream and shout, to some people it sounds like annoyed, and actually just being nice.
- I: Ja, Appreciative, R..... it's going to be very interesting to look at the two cases, which we will declare at the end, but ja, I think that will come out as a difference between the two cases
- P: But everywhere we go everybody talks about our school as the friendly school, I mean you know we go all the way, we go all over the country, and that people think ok I won't mention names, other schools in Klerksdorp they refer to them as "the snob school" or the unfriendly school, but we've always been referred to as the happy school and well behaved school (shy laughing together) and then they meet us on the final night when everybody has lost their minds and they are all tired, and they still they're still champion, the other school is sitting there with their...
- P: Ja It's true, it really is true, you will see our sports teams walking off the field after losing smiling bigger than the team that won (everyone laughing together)
- P: Ja
- P: It is
- P: And the others are all fighting and crying and we still laughing and singing about it because it was fun anyway, you were there.

- P: I used to say all the time when they asked me how we Headmaster, I tell them that we don't have a headmaster in our, school we have a father
- I: Umm, ok
- P: He is neutral.. speaking softly
- I: Ok, so *school management plays a big role in the culture* of the school and the safety of the environment and the some of these school health services that we have already discussed
- P: If I can say something about school the management, I think if you ask these few children who are all on the school management team they won't know, because if it's not you know I'm now on the school management team and now you must not sit next to me, they don't know because we are all equal, they know who is the headmaster and the deputies, but they don't know who are the rest of the people on the school team, do you, there are six of them, they don't know, (pause) because it doesn't matter we all work year around.
- I: Ja, it's almost a less herargical structure, ja. (Pause) Ok, I think that we conclude then on a positive note, I think the presence of the principle here was actually good for you to hear.
- P: Ja
- I: Was it the feedback
- P: Ja, for sure
- I: Yes, yes, and umm thank you very much for participating, the process will be now that I will download this and send it to R... in MP3, she will transcribe it and do the analysis, the result that you will get back will be an integrate discussion between the two cases.
- I: Thank you very much.

ANNEXURE G

FIELD NOTES

NAME	DESCRIPTIVE NOTES	REFLECTIVE NOTES	DEMOGRAPHIC NOTES
Focus group interview: A1.	<p>The interview started late and it seemed as if it was difficult to get all participants together for it was school time and the educators seemed a bit flustered and unsure of what to do and where to sit. They settled down quickly and seated themselves where they felt most comfortable. All the participants joined in the discussions. One educator came 30 min. into the interview and after she was orientated by the interviewer, to what was said, she enthusiastically participated. The interruption did not seem to have any affect on the flow of the discussion. One of the two learners in this group did not contribute any information. The interview was conducted mainly in Afrikaans.</p>	<p>I felt concerned that there will not be enough participants available to form a focus group and felt relieved when we could start with the interview. Although the participants were eager to take part in the discussions, they clearly indicated their disbelief that someone will take serious note of their needs. At the end of the focus group interview all the participants seemed relaxed and I felt pleased.</p>	<p>The interview was held on the school premises in the “restaurant” class. The area was already prepared for us with a table and comfortable chairs enough for all participants as well as beverages. The air conditioner was on and kept the class at a comfortable temperature. At one time you could hear the school bell in the background but it was not a disturbance.</p>
Focus group Interview: A2	<p>The focus group started on time and the participants seated themselves. It was interesting to note that in the beginning of the focus group interview, it seemed as if some of the participants were reluctant to take part in the discussions, but they did participate fully later on. The two learners in this group were quiet at first but when their opinion was asked, they participated fully and by the end of the interview they were participating spontaneously. The</p>	<p>At first I was worried that some of the participants were not engaging in the discussion but felt relieved when they reacted positively on the interviewer’s prompting. I felt pleased in the end because the participants seemed relaxed and light hearted.</p>	<p>The interview was also held on the school premises in the “restaurant” class and the interior stayed the same. Fresh beverages were organised for the second focus group.. The air conditioner was on and kept the class at a comfortable temperature.</p>

	interview was conducted mainly in Afrikaans.		
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General notes:

During both interviews of Case A, I came under the impression of the concern the educators have because of the gap in health care available to adolescents and the impact it has on the physical and emotional state of the learners and eventually on their academic performance. It seemed as if the educators themselves sometimes need the opportunity to ventilate. It became apparent that discipline in especially your conduct is seen as a priority through which the school endeavours to create an environment in which learners and educators can perform to the best their ability.

NAME	DESCRIPTIVE NOTES	REFLECTIFE NOTES	DEMOGRAPHIC NOTES
Focus group interview : B1	On arrival, there were already some participants waiting in the interview room. The participants displayed a joyful attitude which was carried throughout the interview. We started on time and the participants responded spontaneously. During the interview one left the room twice which caused a disturbance but the flow of the discussion were quickly resumed. The same participant at times seemed bored and another participant did not take part in the discussions spontaneously and another only offered an input when he was prompted. The interview was conducted mainly in English.	I felt optimistic at the sight of the enthusiastic participants and enjoyed the positive atmosphere during the interview.	The conference room was prepared for the focus group interview with enough comfortable chairs for all the participants. The room had natural light and the air-conditioner was used to ensure comfortable room temperature. The room was in a part of the school building where noise was limited.

<p>Focus group interview : B2</p>	<p>Me, the interviewer and the participants entered the room at the same time and everybody seated themselves around the table where they felt comfortable. The interviewer had to prompt the participants to start the discussions. It was interesting to note that one participant felt that the school coped well with the health needs of the learners, where as the other participants strongly indicated the need for comprehensive health care for adolescents while at school. One of the participants did not take part in the discussions and another spoke very softly that made it difficult to hear. One participant enthusiastically took part in the discussions up to the end of the interview. One participant became emotional when she spoke about the risk to the adolescents to contract HIV and AIDS. The interviewer acknowledged her feelings and she was able to compose herself. At the end of the interview all participants seemed relaxed.</p>	<p>This group appeared to be subdued and at times I experienced tension between some participants. As the interview progressed the tension subsided and the participants became more spontaneous in their responses. One participant got emotional it was heartbreaking to witness her tears of concern. At the end of the interview I felt satisfied and appreciative towards the participants for their willingness to participate wholeheartedly.</p>	<p>The conference room was also used for this interview and all the interior aspects staid the same. No noise disturbances occurred.</p>
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General notes:

At this school I recognised the effort of management to emphasise a culture of happiness in order not to add extra stress to the already emotionally burdened learners and educators. During the two interviews I noted the educators' concern for the lack health care available for the learners as they offered their input. After the interview some of the participants indicated that they feel better now that they had an opportunity to ventilate and that they would like to do that again in future.

ANNEXURE H

INFORMAL DISCUSSION WITH CONCERNED PARENTS AND EDUCATOR

For the purpose of confidentiality, no names will be used. I will refer to Mother 1, 2, 3 and Educator.

Mother 1:

Her daughter of 17 years had an operation to remove a tumour from her brain. (She indicated the medulla oblongata region). Although the child recovered remarkably well and got permission to attend school fulltime 4 months after the operation, she had physiological symptoms to cope with (Impaired vision in her right eye, a rested pulse of 120 beats per minute and infrequent black outs and seizures, that she could predict)

In lieu of this, her academic average was 90%. Although the girl coped well, her mother was concerned because there was no trained person to assist her daughter if she felt sick. Her classmates stepped in and tend to her daughter during a seizure and observe and report every detail of the episode as the doctor asked.

The mother said that she would have felt more at ease if there was a trained person on the premises to assist in situations like hers and to help the teachers in that they do not have to focus on sick children.

Mother 2:

Her teenage daughter fell pregnant during her grade 12 year. When the pregnancy started to show, the girl was instructed to arrive at school after the other children were in class so that they could not see her. She had to sit in the sick room and wait for teachers to bring the school work to her, which sometimes did not happen.

The mother expressed her need for a medically trained person on the premises to educate the teachers to have a better understanding of the special needs of children. According to the mother, the “hide-away-in-shame situation” left an emotional scar on her child.

Mother 3

Her daughter was in GRADE 12 and fell pregnant. In contrasted to mother 2's situation, this girl was accommodated in "n professional and confidential manner. The headmaster took it on himself to co-ordinate the school work when she no longer could attend class. The girl went through Grade 12 exam and delivered safely and without trauma.

The Educator

He indicated that they as teachers and educators have an immense need for a medically trained person on the premises because teachers are not allowed to give even a panado to a child.

He further indicated that although teachers care, the fact that the classes are full and the time to complete the curriculum is limited, teachers do not have time to tend to sick children or to follow up on them. They furthermore are not trained to do so. He said that if there is someone to look after the health needs of the adolescents, the teachers can focus on teaching and together they can produce healthy and happy educated young adults.

ANNEXURE I

TURNITIN ORIGINAL REPORT FOR EPJ DE KLERK: 11311738

11/13/13

Turnitin Originality Report



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ANNEXURE J

LANGUAGE EDITING DECLARATION AND QUALIFICATIONS

15 November 2013

DECLARATION OF TRANSLATION AND PROOFREADING

I, GERDA SUSARAH FOURIE, Identity Number: 580910 0017 08 5, herewith declare that I translated the Abstract from English to Afrikaans, as well as proofread the dissertation

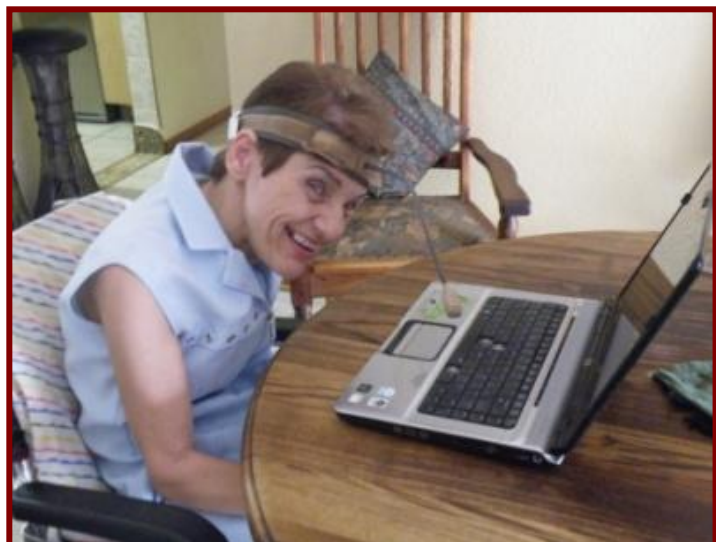
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North West province**

by

EPJ de Klerk

B.A (UNISA) – 1985

Diploma in Translation (UNISA) – 1987



(Signed) GS Fourie

Cell: 082 971 4961

Universiteit van Suid-Afrika



*Ons verklaar dat
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Diploma in Vertaling

*op 21 April 1988
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GERDA SUSARAH FOURIE

Naanhyk

Vise-Kanselier

PRETORIA



[Handwritten signature]

Dekaan

M. H. L. Ockhoff

Registrateur