

**Caregivers' experiences in accessing health care services for their
school-going children in low resource communities of
KwaZulu-Natal, South Africa.**

By

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the Discipline of Psychology.

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DECLARATION

I hereby declare that this dissertation is entirely my original work, unless otherwise indicated in the text. All citations, references and borrowed ideas have been duly acknowledged. This dissertation has not been submitted to any other University for any degree or examination purposes.

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LIST OF ACRONYMS AND ABBREVIATIONS

- AIDS** – Acquired Immune-Deficiency Syndrome
- ANC** – Africa National Congress
- CBOs** – Community Based Organisations
- CHWs** – Community Health Workers
- COC** – Community Outreach Centre
- CSTL** – Care and Support for Teaching and Learning
- DBE** – Department of Basic Education
- DOH** – Department of Health
- DSD** – Department of Social Development
- EFA** – Education for All
- GSHI** - Global School Health Initiative
- HFA** – Health for All
- HIV** – Human Immunodeficiency virus
- INP** - Integrated Nutrition Programme
- ISHP** – Integrated School Health Policy
- LMICs** – Low-and Middle-Income Countries
- NGOs** – Non Governmental Organizations
- NHI** – National Health Insurance
- NSHP** – National School Health Policy
- PHC** – Primary Health Care
- PSNP** – Primary School Nutrition Programme
- RDP** – Reconstruction and Development Programme
- SBHCS** – School Based Health Care Services
- SHPs** – School Health Programmes
- SONA** – State of the Nation Address
- UNESCO** – United Nations Educational, Scientific and Culture Organisation
- UNICEF** - United Nations Children's Fund
- WFP** – World Food Programme
- WHO** – World Health Organisation

Structure of the dissertation

This dissertation consists of three different chapters.

Chapter One: Introduction

This chapter introduces the study. It provides a brief history of the school health initiative in South Africa and other background information relevant to the study. This chapter also states the purpose of the study, outlines the research objectives and the research questions. This chapter provides the reader an insight into this dissertation.

Chapter Two: Literature Review

This chapter provides a review of literature relevant to the study. The literature is discussed under a number of sub-headings which include school health initiatives, access to health care services, caregivers' involvement in children's health care services and caregivers' perception of quality of care. The Aday and Andersen's (1974) framework for the study of access to health care services is presented as the theoretical framework for this study.

Chapter Three: Journal Manuscript

This chapter is a journal manuscript prepared for submission to *BMC Pediatrics*. It consists of six different sections which are: the abstract, background to the study, methods, results, discussion and the conclusion.

CHAPTER ONE

INTRODUCTION

Background of the study

The Global School Health Initiative (GSHI) launched by the World Health Organisation (WHO) in 1995 is a broad innovation and key strategy for achieving improved health and ability to learn for school-going children (WHO, 1995). The World Health Organisation defines a school health programme as a combination of services ensuring the physical, mental and social well-being of school-aged children in order to maximize their learning capabilities (WHO, 1996). The WHO (1998) argues that school health programmes are cost effective ways of improving children's health and their ability to learn. A key component of the GSHI is the "Health Promoting School" which is defined as "one that is constantly strengthening its capacity as a healthy setting for living, learning and working" (Nutbeam, 1998). The design and implementation of the GSHI was guided by the Ottawa Charter for Health Promotion (1986), the Jakarta Declaration of the Fourth International Conference on Health Promotion (1997) and the WHO's Expert Committee Recommendation on Comprehensive School Health Education and Promotion (1995) which all have their roots in the Alma Ata Declaration (1978) [See Box 1 for key policy developments].

These initiatives have been accepted globally and have influenced the development of school health programmes in different countries. The programmes include the creation of health promoting schools, training of school health workers, development of school-based health and nutrition programmes and school-based water, sanitation and hygiene programmes (Alice, Joan, & Cheruto, 2016; Mason, Sanders, Musgrove, & Galloway, 2006; Maier, 2000). According to UNICEF (2000), a child's ability to attain his or her full potential is dependent on the synergistic effect of good hygiene, nutrition, health and appropriate education. This underscores the need to adequately plan and implement programmes to achieve good health, nutrition and hygiene for all school-going children.

Following the first democratic elections in South Africa, which brought the African National Congress (ANC) into power in 1994, a number of policies were developed to address the existing racial disparities in the country. A key policy initiative was the introduction of the National Health Plan in 1994. The policy adopted the primary health care

philosophy and the Integrated Nutrition Programme (INP). The primary health care initiative was aimed at addressing inequality in accessing health care services, while the INP was aimed at solving nutrition problems and promoting food security among the marginalized populations (Labadarios, Steyn, Mgijima, & Daldla, 2005). In 1994, the South Africa's Primary School Nutrition Programme (PSNP) was introduced which formed part of the presidential lead project of the Reconstruction and Development Programme (RDP) (Van Stuijvenberg, 2005). An evaluation of the feeding scheme conducted in 2000 however revealed some shortcomings which includes absence of a national guideline stating the amount of micronutrients to be provided and inconsistencies in the time and days children were fed in schools (Louw, Bekker, & Wentzel-Viljoen, 2001; DoH, 2002).

In 2003, the first National School Health Policy (NSHP) was jointly developed by the Department of Health and the Department of Education (DoH & DBE, 2012). However, an evaluation of the policy conducted in 2009 revealed that the 2003 National School Health Policy was faced with many challenges that undermined its development and implementation (Shung-King, 2013). This prompted a renewed focus on school health by policy makers and researchers. The introduction of the National Health Insurance (NHI) initiative and the Re-engineering of Primary Health Care Strategy which outlines school health services, district based specialist team and primary health care outreach teams as its three priority streams for the new PHC initiative, as well as several global and national initiatives focused on child and maternal health such as the Education For All (EFA) - Dakar Framework for Action, Millennium Developmental Goals and the expansion of HIV testing and treatment for all South Africans together helped re-focus attention on school health in South Africa (Pillay & Barron, 2011; Shung-king, Orgill, & Slemming, 2014). [See Box 1]

In order to address the shortcomings of the NSHP, the Integrated School Health Policy (ISHP) was developed in 2012. The policy aims to provide health care services such as health assessments, health education, referral and follow-up that will address the health needs of school-going children and enhance their learning potential (Shung-King, 2013). Despite the marked improvement in the implementation and management of the ISHP (Shung-king, Orgill & Slemming, 2014), especially with the substantial mass screening, some salient aspects of the policy such as management of referral services and involvement of caregivers in the children's health management have not received research attention.

Box 1. Timeline of key policy developments and events relevant to school health services in South Africa.

Date	Key policy
1978	International Conference on Primary Health Care, Alma-Ata, USSR. (Declaration of Alma-Ata)
1984	World Health Organisation - Target for "Health For All": Targets in support of the European regional strategy for Health For All.
1986	The Ottawa Charter for Health Promotion. The first international conference on Health promotion.
1990	UNICEF - Strategy for improved nutrition of children and women in developing countries.
1994	World Health Organisation declaration on "Education For All"; meeting learning needs.
1994	ANC unveils National Health Plan premised on a primary health care philosophy.
1994	Department of Health develops the Integrated Nutrition Programme (INP).
1994	The development of the South African Nutrition Policy- Integrated Nutrition Programme.
1994	Department of Health develops the Primary School Nutrition Programme (PSNP).
1994	President Nelson Mandela announces the introduction of free health care in public health facilities for pregnant women and children under the age of 6 years.
1995	World Health Organisation- introduces the Global School Health Initiative.
1995	The Government embarks on building primary health care facilities across the country.
1995	Department of Health develops the Immunisation Policy- The Expanded Programme on Immunisation in South-Africa.
1996	Government extends free primary health care to all users of public health facilities.
1997	Jakarta Declaration on leading health promotion into the 21 st century.
1997	Promoting Health through school initiative. Report of a WHO expert committee on comprehensive school Health Education and Promotion.
2000	Focusing Resources on Effective School Health (FRESH): A comprehensive school health approach to achieve "Education For All".
2000	World Education Forum; Education For All (EFA) Dakar framework for action.
2000	United Nation Millennium Declaration: Millennium Developmental Goals
2002	UNICEF & WFP – The essential package. The integrated package of cost-effective intervention to improve the nutritional status and health of school children.
2002	Department of Health adopts the Health Promoting Schools Initiative.
2003	Department of Health develops the first National School Health Policy and implementation guideline.
2009	Department of Health and Department of Education jointly introduces the New Health and Basic Education Policy reforms.
2010	Department of Health releases the discussion document on Primary Health Care Re-engineering.
2011	Department of Health releases the green paper on the National Health Insurance initiative which includes primary healthcare re-engineering.
2012	Department of Basic Education, Health and Social Development launches the new National Integrated School Health Policy, a component of the primary health care re-engineering initiative.
2014	South African Government and the Department of Health declare the 4 th -8 th March of every year as the school health week.

According to the National Department of Health, the major health barriers to learning for children in South-Africa includes malnutrition, lack of basic infrastructure such as water and sanitation provisions, poverty and disabilities including impaired hearing and vision, and gross locomotor dysfunction (Shung-King, 2013). Several authors have emphasized that these barriers impact on children's attendance, performance and participation in school as well as their overall development (Taylor-Robinson, Maayan, Soares-Weiser, Donegan, & Garner, 2015; Mhurchu et al., 2013; Seirawan, Faust, & Mulligan, 2012). School health services are therefore vital as they attend to the health needs of school-going children by focusing on interventions such as early diagnosis, treatment, referral, prevention of any form of health problems and health education (DoH & DBE, 2012). Furthermore, a study conducted by Taylor and colleagues (1995) to evaluate the school health services provided in schools in KwaZulu-Natal over two decades ago, before the development of the first school health policy in South Africa, revealed that parents and teachers described school health services as helpful in identifying and treating health problems they will otherwise be unaware of, which can negatively impact on the children's participation and performance in school (Taylor et al., 1995).

Issues around poverty, cost and access to health services in South Africa were part of the discourse in the national health insurance policy. Despite substantial progress in redressing inequity in the health sector in the country since 1994, disparity in the distribution of health care services remains very wide (Benatar, 2013; Harris et al., 2011; Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009). The primary health care re-engineering policy however desires to further narrow this wide gap by striving to achieve universal access to basic health for all (DoH, 2015). The primary aim of the school health policy is to optimise the health of school-going children by addressing health problems that impacts on learning and thereby enhancing their learning potentials (DoH & DBE, 2012). However, one key barrier to achieving this aim is access to health care services (Shung-King, 2013).

Access is defined as the opportunity and freedom to use services. It encompasses the circumstances that allow for appropriate service utilization, achieving equitable health care services and the provision of affordable services for the entire population (O'Donnell, 2007). Access to health care services in South Africa remains considerably unequal especially in the low resource communities, as health resources (human and infrastructure) remain scarce (Coovadia et.al, 2009; Harris et al., 2011; Mayosi, & Benatar, 2014; Marten

et al., 2014). It is important to understand the experiences of caregivers in accessing health care services for their school-going children as they play important roles in the management of children's health. Caregivers are people who care for, nurture and look after one or more young children. Furthermore, many young children do not live with, or are not looked after by their biological parent, therefore a caregiver can be a biological parent, relative or a legal guardian (WHO, 2004). They are likely to be the first to notice signs and symptoms of health problems and are usually motivated to get the help needed by the children (Oberländer, & Elverdan, 2000). In addition, primary caregivers become active members of the health care team because they are the closest to the child (Vander-Meulen, 1985).

While a review conducted in 2013 analysed the improvements and the key differences between the 2003 school health policy and the ISHP (Shung-king, Orgill & Slemming, 2014), there is still little to be found on the perspectives of the beneficiaries of the school health initiative. Specifically, little research attention has been paid to understanding the experiences of caregivers of school-going children in accessing health care services. Consequently, the aim of the study is to explore caregivers' experiences in accessing health care services for their school-going children in low resource communities of KwaZulu-Natal, South Africa. The findings of this study could inform the implementation and management of the ISHP and the primary health care re-engineering policy as well as practices that will improve access to health care services for school-going children in low resource communities. The findings will also contribute to the literature on school health in South Africa and globally.

Objectives of the study

The aim of the study is to explore caregivers' experiences in accessing health care services for their school-going children in low resource communities of KwaZulu-Natal, South Africa specifically within an integrated school health programme. In order to achieve this aim, the following are the main objectives of the study;

- To identify the factors that influence access to quality health care services for school-going children within an integrated school health programme.
- To describe the factors that influence caregivers' health seeking behaviour for their school-going children participating in an integrated school health programme
- To explore caregivers' perceptions of the quality of care accessed by their school-going children participating in an integrated school health programme.

Research Questions

The study attempts to answer the following questions;

- What are the factors that influence access to quality health care services for school-going children within an integrated school health programme?
- What are the factors that influence caregivers' health seeking behaviour for their school-going children participating in an integrated school health programme?
- What are the caregivers' perceptions of the quality of care accessed by their school-going children participating in an integrated school health programme?

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CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

Introduction

In this chapter literature relevant to the study were reviewed. The literature is discussed under a number of sub-headings: school health initiatives, the concept of access to health care services, caregivers' involvement in children's health care and caregivers' perceptions of quality of care. The chapter starts with a brief history of school health programmes both globally and in South Africa, as well as the policies relevant to the school health initiatives. The challenges faced by caregivers and the barriers to accessing health care services for their school-going children were discussed under the concept of access. Under the caregivers' involvement in children's health care sub-heading, the roles caregivers play in ensuring the complete well-being of school-going children were described. Furthermore, the means through which caregivers access health care services as well as their attitudes towards accessing health care services for school-going children were discussed under the caregivers' health seeking behaviour sub-heading. Their perception of the quality of care is important in evaluating the effectiveness of the school health programme. Finally, a discussion of the Aday and Andersen's (1974) framework for the study of access to health care services provides a theoretical framework for understanding access to health care services.

School health initiatives

The Global School Health Initiative (GSHI) launched by the World Health Organization (WHO) in 1995 formed the foundation on which school health policies implemented across different countries are built. The design and implementation of the GSHI was guided by the Ottawa Charter for Health Promotion (1986), and the WHO's Expert Committee Recommendation on Comprehensive School Health Education and Promotion (1995). Both of these initiatives have their roots in the Alma Ata Declaration of 1978.

In 1978, WHO and United Nation Children's Fund (UNICEF) held a joint conference in Alma Ata in the former Union of the Soviet Socialist Republic (USSR) where health was strongly affirmed "as a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity" (Hall & Taylor, 2003, p.1). At the Alma Ata conference, access to health care services was declared a fundamental human right and the conference also established the goal to attain the highest possible level of health for all by

the year 2000 (Baum, 2007). Health for all was identified as an important global goal which requires the joint action of the health sector and many other social and economic sectors (Alma Ata Declaration, 1978). Furthermore, the primary health care initiative was introduced at this conference to address inequity in the distribution of acceptable health care services. This initiative also aimed to enhance access to healthcare services by involving the relevant communities (Baum, 2007).

In response to the growing expectation for a new public health movement around the world, the first Health Promotion international conference was held in 1986 in Ottawa (Potvin & Jones, 2011). At the Ottawa conference, a charter for action to achieve health for all by the year 2000, which built on the Alma Ata declaration, was presented and it became known as the Ottawa Charter for Health Promotion. The Ottawa Charter defined health promotion “as the process of enabling people to increase control over their health” (WHO, 1986, p.1). Certain determinants of health were emphasized which include peace, adequate income and economic resources, food and shelter, education, a stable ecosystem, sustainable resource management, social justice, and equity. To achieve these, three basic prerequisites for health promotion were identified. These are advocating for health, enabling people to achieve their full health potential and mediating between the different sectors in the pursuit of health (Ottawa Charter for Health Promotion 1986; Nutbeam, 1998). These prerequisites are supported by the health promotion priority action areas identified at the conference which are building healthy public policy, creating health supportive environments, strengthening community action, developing personal skills and reorienting health services (WHO, 1986).

The GSHI was mainly influenced by, and designed based on the recommendations of these two events. The GSHI is a comprehensive innovation and a significant strategy to achieving improved health together with the ability to learn for school-going children. It comprises a range of services that ensure the physical, mental and social well-being of school-going children which has the potential to maximise learning capabilities (WHO, 1996). A major component of GSHI is the “Health Promoting Schools” initiative. A health promoting school is defined “as one that is constantly strengthening its capacity as a healthy setting for living, learning and working” (Nutbeam, 1998, p.3). According to WHO (1998), school health programmes are cost effective ways of improving children’s health and their ability to learn.

The significance of school health programmes (SHPs) was further emphasized during a strategy session at the April, 2000 World Education Forum jointly organized by WHO, UNESCO, UNICEF and the World Bank in Dakar, Senegal. It was established that implementing an efficient school health package which includes the provision of nutritious meals and a hygienic environment is key to achieving education for all (EFA) (UNESCO, 2000). The goal of EFA is to ensure that all children have access to quality basic education which implies creating healthy and protective environments that will enhance children's ability to learn (UNESCO, 1990). However, certain barriers impede the efficacy of SHPs, at the international, national and local levels. These barriers include: i) inadequate planning, acceptance and understanding of the importance of SHPs, ii) inadequate collaboration and coordination among international and national stakeholders, iii) lack of a sense of ownership, responsibility and accountability, iv) inadequate recognition of the roles of the health and education sector to improve SHPs, and v) lack of adequate resources (human, financial, material and organizational infrastructure (WHO, 1996).

While South Africa's history is characterised by socio-economic, geographical and racial inequality which undermines the success of several health initiatives (Coovadia et al., 2009), SHPs have gained prominence in recent times. This can be ascribed to the intervention of the democratic government. In 1994, the then President Nelson Mandela declared during his State Of The Nation (SONA) address that a nutrition feeding scheme would be implemented in every primary school with the aim to mitigate short-term hunger and to improve the health of school-going children (Van Stuijvenberg, 2005). This led to the development of the first school health related programme in South Africa, the Primary School Nutrition Programme (PSNP) (DoH, 2002). In the same year, President Mandela announced the introduction of free health care services in public health facilities for pregnant women and children under the age of 6 years, which was subsequently extended to all users of public health facilities in 1995. All these initiatives formed part of the presidential led reconstruction and development programme (RDP) (Kautzky & Tollman, 2008).

According to the United Nations Educational, Scientific and Culture Organization (UNESCO) (2002), poor health and malnutrition results in low school enrolment, absenteeism, poor academic performance and early dropout from school. The feeding scheme was therefore effective in improving learning capacity, school attendance, as well as addressing micronutrient deficiencies among school-going children (Van Stuijvenberg, 2005). However, an evaluation of the 1994 feeding scheme conducted in 2000, revealed

some shortcomings which include the absence of national guidelines on the amount of micronutrients to be provided in the food and inconsistencies in the time and days children were fed in schools. Another shortcoming of the PSNP is the inadequate collaboration between the department of health and that of education (DoH, 2002). These challenges undermined the aim of PSNP which is to address micronutrient deficiencies and also mitigate short term hunger (Louw, Bekker, & Wentzel-Viljoen, 2001). These shortcomings were however addressed by transferring the PSNP to the Department of Education in April 2004. This change in policy enhanced the effective implementation of the school feeding programme and also encouraged a healthier collaboration between the two departments (DoH, 2002). To further address existing health discrepancies, the Department of Health adopted the health promoting schools initiative in 2002. Although the GSHI was launched in 1995, South Africa only launched its first school health policy almost a decade later. In 2003, the first national school health policy (NSHP) was jointly developed by the department of health and that of education. The policy emphasized the need to integrate school health programme into other district health services and this led to the inclusion of school health services in the primary health care package (DoH & DBE, 2012).

The 2003 national school health policy was evaluated in 2009 following the introduction of the new health and basic education policy reforms jointly developed by the departments of health and education. The evaluation revealed that the policy faced many challenges that undermined its efforts and this prompted a renewed focus on school health. These challenges include; inadequate political support, inadequate coordination between the school health programme and the health promoting schools, limited health service package and coverage as well as inappropriate monitoring and evaluation (Shung-King, Orgill, & Slemming, 2014). The primary health care (PHC) re-engineering document and the green paper on national health insurance (NHI) which were released in 2010 and 2011 respectively by the Department of Health both encouraged a re-focused attention on the school health policy (Pillay & Barron, 2011). Furthermore, the PHC re-engineering policy incorporated school health services as one of the three priority streams. Subsequently, the new integrated school health policy (ISHP) was jointly developed by the departments of Basic Education, Health and Social Development in 2012 (Shung-King, Orgill, & Slemming, 2014). Presently in South Africa, these three (3) policies; PHC re-engineering, the NHI and the ISHP, which will be subsequently discussed extensively all work together to improve access and equity to health care services for children and the entire population (Pillay & Barron, 2011; DoH, 2011).

Primary health care re-engineering

Primary health care emerged in response to the new proposals for health and development in the late 1960s and early 1970s (Cueto, 2004). It is referred to as the preferred approach or strategy to providing health care and was launched at the international conference on primary health care at Alma Ata, 1978 (WHO/UNICEF, 1978). Primary health care was identified as the key to attaining the HFA goals, equity in health care delivery and improvements in the social determinants of health (Baum, 2007). PHC was described in the Alma-Ata declaration as: *“essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. PHC forms an integral part of the country’s health system and one of its main focus is the social and economic development of the community. It is the first level of contact that individuals, families and communities have with the health system. PHC brings health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process”* (Alma Ata, 1978, p.1). The PHC approach acknowledges health as a basic human right and it is the most effective means to equitably deliver this right (Hall & Taylor, 2003; Naledi, Barron, & Schneider, 2011)

Primary health care encompasses promotive, preventive, curative, rehabilitation and supportive services which are provided by professionals from different disciplines within the health system. These services are aimed at addressing the physical, mental and emotional factors that influence well-being and impact on individuals’ health (Starfield, 1998). Primary health care is designed to provide easy access to quality health care services in all communities. Primary health care is utilised in most low- and middle- income countries and has been accepted as the best model for delivering basic health care in order to manage and combat the burden of diseases in marginalised communities (World Bank, 2011).

The PHC approach was also embraced by the South African government and it formed the foundation of the health policy developed by the democratically elected government in 1994. It has remained the foundation of the health care delivery system in South Africa (Pillay, 2003). However, several additions have been incorporated into the PHC system. These include offering health care services at no cost, initially to pregnant women and children and subsequently to the entire population. Although South Africa deviated to a

selective approach to health care delivery about a decade ago due to the dual challenges of the legacy of apartheid and the growing burden of the HIV epidemic, however, it is currently experiencing some reforms through the PHC re-engineering strategy (Pillay, 2003; Mayosi et al., 2012). Primary health care reengineering was developed in response to the mandate of the National Health Council (NHC) to improve health outcomes by restructuring the health system. It is one of the plans in the five years health sector ten point plan referred to as ‘overhauling the healthcare system’ (Naledi, Barron, & Schneider, 2011). A health ministerial delegation visited Brazil in 2010 to learn from other countries and came back with the vision for re-engineering of the primary health care system (Pillay & Barron, 2011).

The PHC re-engineering aims to help the health system in South Africa find its focus by: i) providing health care services that will improve and maintain all aspects of peoples’ health in the communities, ii) motivating the health care team to be enthusiastic by equipping them with appropriate skills and iii) creating an environment where all available resources are utilised (Naledi et al., 2011; DoH, 2011). Moreover, PHC re-engineering is committed to achieving four main outputs which are: i) increasing life expectancy, ii) decreasing maternal and child mortality, iii) combating STIs including HIV/AIDS, and opportunistic infections such as tuberculosis (TB), iv) and enhancing health systems effectiveness. PHC re-engineering hopes to achieve these outcomes through three streams of interventions namely: municipal ward-based primary health care agents, integrated school health programme, and district clinical specialist support teams (Naledi et al., 2011; DoH, 2011).

Primary health care outreach teams

Primary health care outreach teams are viewed as a pivotal part of the PHC re-engineering strategy. At least one team will be provided for each electoral ward which will be linked to a PHC facility. The team will consist of about 4-6 community health care workers (CHWs), one enrolled nurse and will be led by a professional nurse (Pillay & Barron, 2011; Naledi et al., 2011). The CHWs will visit about 1000-1500 households (approximately 6000 people) and will assess the health status of individuals in each household. They are also to provide health education and offer curative, rehabilitative and referral services (Naledi et al., 2011; Pillay & Barron, 2011). They are to screen and identify health problems common in the communities as well as providing early interventions, follow up and support services to people (DoH, 2011; Naledi et al., 2011).

School health services

The school health policy pays more attention to schools in quintiles 1 and 2 (the poorest schools). In addition, only a selected range of services will be prioritized due to inadequate resources and shortage of nurses to cater for all the 29,000 schools in the country (DoH, 2011). Grades 1 and R were initially prioritised by the 2003 school health policy for different services such as immunisation, screening, health promoting interventions that focuses on sexuality and reproductive health education as well as sexually transmitted infections including HIV/AIDS (DoH, 2011; Naledi et al., 2011). However, these services have been extended to other grades so that all school-going children can be attended to at least one year in each academic phase (Shung-King, Orgill & Slemming, 2014).

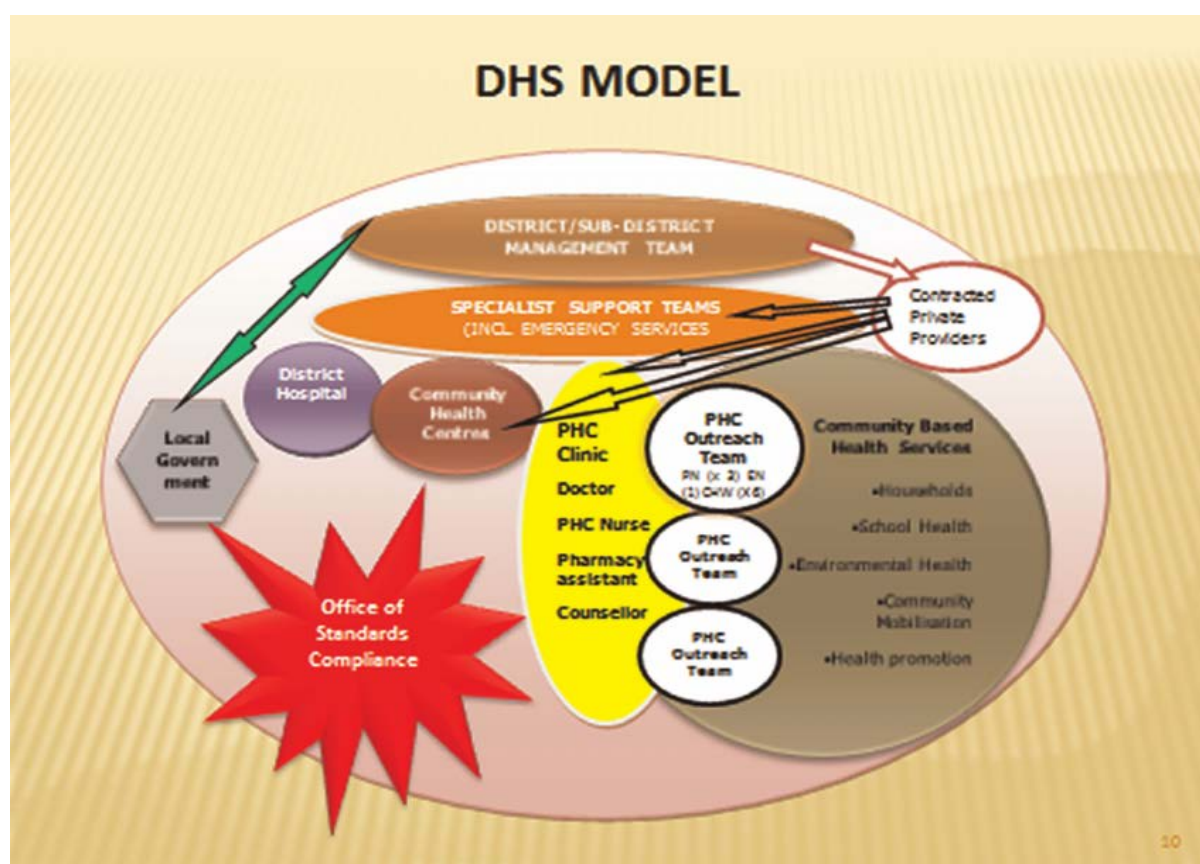


Figure 2.1: The district health system model (Pillay & Barron, 2011).

District-based specialist team

In order to improve maternal and child health, the National Health Council decided to provide every district with a team of specialists consisting of a gynaecologist, paediatrician, anaesthetist, family physician, professional midwife and primary health care nurse. The basic function of the team is to strengthen clinical governance at the PHC level, ensure that

treatment guidelines and protocols are available and appropriately used. They also ensure that essential equipment are available and well utilised, hold mortality review meetings, support, supervise and mentor clinicians and monitor health outcomes (Pillay & Barron, 2011).

The integrated school health policy

The WHO defines school health programme as a range of services that ensure the physical, mental and social well-being of school-going children in an effort to maximise their learning capabilities (WHO, 1996). A number of health conditions such as hunger, malnutrition, micronutrient deficiencies, malaria, polio, intestinal infection, eye defects, dental problems, and HIV/AIDS impact on the well-being of children in every country of the world (WHO, 1996). These conditions compromise learning capabilities and also threaten the psychosocial, physical and emotional well-being of children thereby making learning difficult (Grantham-McGregor et al., 2007). Some of these health conditions not only kill young people in their most productive years but also prevent many children from growing into productive and capable citizens. These also undermine the effort to educate the present generation and rob the nations of the benefits of education provided to the previous generations (Gachuhi, 1999; Richter, 2004). Under these circumstances, education and health policy makers have embraced health promoting programmes in schools. Schools are no longer viewed as just learning centres but also supportive centres for the provision of essential health services and education (DoH & DBE, 2012).

The integrated school health policy is located within a legislative, policy and programmatic context. ISHP was built on legislative acts such as the Children's Act of 2005, the South African School Act of 1999 and the National Health Act of 2003 (DoH & DBE, 2012). South Africa being a signatory to the Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Children, pledged to put children first and give the highest priority to their needs (Shung-King et al., 2000). According to section 28 of the Bill of rights in the constitution of the Republic of South Africa (1996, p.11), "every child has the right to family care or parental care, or to appropriate alternative care, to basic shelter and social services and to be protected from maltreatment, neglect, abuse or degradation". Children's right to health care services is stated in two sections of the South African constitution: section 27 contains the right of all South Africans to access health care services and section 28 (1) (C), the portion of the bill of rights dealing specifically with children's rights, states that children have "the right to basic health care services" (Leatt, Shung-King,

& Monson, 2006). The ISHP outlines the roles of all the departments involved in implementing the policy with the aim to ensure that a strong school health service operates according to clear standards across the country (DoH & DBE, 2012).

Children are likely to face many health challenges during their formative years in South Africa as a result of the effect of apartheid. These effects include socio-economic inequity and also the four concurrent epidemics that currently confront the country: poverty related illnesses, HIV/AIDS, violence and injuries leading to premature deaths and disability, and the increase of non-communicable diseases (Mayosi et al., 2012; Coovadia et al., 2009; Savage, 1990). However, providing special attention to children's health during their formative years will improve not only their survival, growth and health, but also their learning outcomes and development (Majnemer, 1998). Therefore, the school health policy was developed with the aim of helping children address these health challenges so that they can reach their full potentials (Shung-King, 2013).

School health programmes are believed to have the capacity to advance public health, social and economic development as well as education (Bandura, 2004). During the World Education Forum held in Dakar in 2000, four basic components were recommended for the implementation of an effective school health programme. These components include health related school policies, a healthy physical learning environment emphasizing safe water and sanitation, skill – based health education and school – based health and nutrition services (Torres, 2001). The school year provides an ideal opportunity for health education and interventions as most children spend close to thirteen formative years in school. The age range for school-going children is between 6 and 18 years. Children spend approximately 200 days and 1000 hours in school every year. If properly implemented, one could argue that the school health programme is the most effective way of ensuring absolute well-being of the children (Shung-king, Orgill, & Slemming, 2014). School health programmes have received strong attention from the Department of Basic Education (DBE) since 2009. The DBE have since adopted the Care and Support for Teaching and Learning (CSTL) framework, which provides a multi-sectoral response to addressing issues around children's well-being through key areas of intervention. These key areas of intervention are health promotion, nutritional support, infrastructure, water and sanitation, psychosocial support, co-curriculum support, material support, curriculum support, safety and protection as well as social welfare services (Shung-King, et al., 2014).

The health promotion intervention component on the CSTL framework provides a point of intersection for school health and the health promoting school initiative. The framework also specifies the roles of each of the initiatives so as to ensure an effective and synergistic implementation and coordination of the policies (Shung-King, et al., 2014). One of the roles of the health promotion aspect of the framework is to educate children on health issues. Children who are educated on health and socio-economic factors have the potential of passing the health information and models of healthy behaviours learnt to their families and even the community at large. Ultimately, this influences their health behaviours (Shamagonam, Reddy, Ruiter, McCauley, & van den Borne, 2006). School health services also provide preventive services that help in identifying avoidable health problems that may constitute barriers to learning (Shamagonam et al., 2006).



Figure 2.2: The care and support for teaching and learning framework (Department of Basic Education, 2012).

According to Shung-King et al. (2014), the assessment package which is the most substantial activity of the school health initiative was extended to all learners in 2012. All

learners will now be screened and assessed at least once during each of the four educational stages. The assessment package includes screening for vision, speech and basic hearing, oral health, anaemia, mental and psychosocial health, micronutrient deficiency as well as chronic illness. Furthermore, referral and follow-up services are offered to learners identified as requiring comprehensive health care services that cannot be provided in school. As stipulated by the ISHP, the school health nurses should build relationships with the learners' caregivers and provide them with adequate information about the school health care services (DOH & DBE, 2012; Mulaudzi & Peu, 2014). The nurses are to seek the caregivers' consent to screen school-going children and thereafter educate them about the children's health condition. However, I could not find any study conducted in South Africa that examines the relationship that exists between the school health nurses and the caregivers in the context of the ISHP. This study is therefore pertinent as it explores caregivers' perception of care quality of care which involves exploring the nature of relationship that exists between the caregivers and the health nurses. In addition, it explores how this relationship influences access to adequate health care services for school-going children.

In situations where the children are in need of further assessment and treatment, the nurses are to refer them to the appropriate health facilities, provide referral letters and arrange with the facility to ensure that learners are attended to at the appropriate times (DOH & DBE, 2012; Shung-king, 2013). The departments of health, education and social development, and some community based organisations (CBOs) are to collaborate to facilitate access to the required health care services particularly in providing transportation and financial assistance. Information about the nature of collaboration between these institutions and how it influences access to health care services could provide insight that will inform improvements to the school health services. However, recent studies that have explored this issue in the South Africa are limited.

A study was conducted by Edwards-miller & Taylor (1998) to evaluate school health services in KwaZulu-Natal province but, this study was carried out several years before the first school health policy was developed. Nevertheless, this study revealed that caregivers' lack of financial capability to access treatment and purchase medications as well as means of transportation to referral facilities constitute major barriers to accessing health care services for school-going children. Despite this findings, the referral system is still not adequately defined, the available routine information provided by the school health nurses and other stakeholders on school health does not reveal whether the referral system is well

structured and adequately managed (Shung-King et al., 2014; Shung-King, 2013). This study therefore explored this aspect of the school health initiative in order to understand the nature and state of the referral system and how it influences access to health care services for school going children.

The concept of access

Studies conducted globally provide evidence that school-based health care services (SBHCs) improve access to health care services for school-going children through the range of services provided (Kaplan, Calonge, Guernsey, & Hanrahan, 1998; Johnson, & Hutcherson, 2006; Allison et al., 2007). Furthermore, a study conducted to evaluate school health services by Taylor et al. (1995) in the Kwazulu- Natal province revealed that school health services in South Africa enhances access to health care services for school-going children. Access is important in evaluating the performance of health care systems around the world (Levesque, Harris, & Russell, 2013). However, access to health care services remains a complex concept with different definitions across authors (Levesque et al., 2013).

The Oxford dictionary defines “*access as a way of approaching, reaching or entering a place and also the right or opportunity to reach, use or visit a place*”. According to Levesque et al. (2013), access within the health care system, relates to the utilisation of health care services, and can be defined as the opportunity or ease with which individuals are able to use quality services in relation to their needs. Aday and Andersen (1974) argue that access is determined by the characteristics of a population (family income, insurance coverage and attitudes towards medical care) and the health delivery system (the distribution and organization of health resources). Penchansky and Thomas (1981) define access as entry into the health care system and the utilization of health care resources. Some other authors define access as the characteristics of factors influencing entry into and use of the health care system (Gulliford & Morgan, 2013; Levesque et al., 2013).

Access is often attributed to the characteristics of the health care system or the characteristics of people in need of health care services (Penchansky & Thomas, 1981). However, it is important to incorporate both the characteristics of the health care system and the people in need of health care services in order to effectively describe access to health care services. In an effort to provide a better understanding of the concept of access to health care services, Penchansky and Thomas, (1981, 1989) identified five different dimensions of access. These are: affordability, availability, accommodation and

acceptability. Affordability refers to willingness and the ability to pay for health services while availability refers to the amount, type and quality of health care services provided. Accessibility refers to the geographical distance as well as convenience and time of travel to the health care centre. Accommodation refers to the perception of the quality and adequacy of health care services in terms of skills or supplies. Lastly, acceptability refers to comfort with health care providers (Akinyemiju, McDonald, & Lantz, 2015). Together, these dimensions influence health seeking behaviours and they provide a useful lens for understanding access.

Individuals in need of health care services may have access to the services and yet encounter difficulties in utilising them. According to Donabedian (1972), the evidence of access to services is the utilisation of the services and not the mere availability of such services. Utilisation can be measured in terms of the extent to which health care services are used, which is determined by different individual, community and health system factors (Valentine et al., 2003). Barriers to utilising health care services result from the interaction between the characteristics of the individuals or communities in need of the services and the service providers (Gulliford & Morgan, 2013). Aday and Andersen (1974), describe five determinants of health care access. These include: health policy, characteristics of the health care delivery system, population at risk, utilisation of health services and consumer satisfaction. I provided a detailed discussion of these determinants in the theoretical framework theme.

Caregivers' involvement in children's care

The care of a child is not limited to the biological parents as many young children do not live with, and are not looked after by their biological parent. Therefore, a caregiver can either be a biological parent, relative or a legal guardian (WHO, 2004). A caregiver is someone who cares for, nurtures and looks after one or more young children. Caregivers play important roles in the management of their children's health conditions. They are often the first to notice the signs and symptoms of the health conditions and are usually eager to get the help needed by the children (Oberländer & Elverdan, 2000). Children depend on their caregivers to attend to their health needs, as they do not have the independence or means to seek health care by themselves (Boulter & Rickwood, 2013). When children experience health challenges, they rarely seek professional help directly. Instead, they turn to their caregivers for help (Rickwood, Deane, Wilson, & Ciarrochi, 2005; Wilson, Deane, Ciarrochi, & Rickwood, 2005).

Although, children can access certain health care services, particularly school-based services, without the assistance of their caregivers. However, they still have to rely on the intervention of their caregivers for consent to access certain health care services such as surgeries, going to the referral facilities and the use of medications. The extent of caregivers' involvement however depends on the age of the child and the nature and severity of the child's health problems. Young children who are yet to attain the age of maturity are not likely to seek health care services without their caregivers' intervention (Farmer, Burns, Angold, & Costello, 1997). Caregivers become active members of the health care team because they are the closest to the children. The uniqueness of a caregiver's roles in caring for a sick child is holistic in nature as no other member of the health care team is consistently aware of all the facets of the child's life.

Globally, different studies have shown that caregivers' roles are invaluable in children's health care and management process and their active involvement is principal to achieving the desired health outcomes (Talley, Fricchione, & Druss, 2014; Richter, 2015; Moreau, Pound, & Eady, 2015). However, the literature on caregivers' roles and involvement in children's health care in South Africa is scant. Although, South African researchers have paid much attention to caregivers' roles in providing care for children living with HIV/AIDS, AIDS orphans, and adherence to antiretroviral therapy among children (Moodley, Myer, Michaels, & Cotton, 2006; Davies, Boule, Fakir, Nuttall, & Eley, 2008; Boon et al., 2009; Kuo & Operario, 2010; Kuo & Operario, 2011), little is to be found on caregivers' roles in accessing health care services for school-going children within the school health initiative context. However, caregivers encounter some challenges in actively participating in the care process due to inadequate information and education on the children's health condition. In order to address some of these challenges, Vander-Meulen (1985), argues that there is a need for the health care professionals and caregivers to communicate adequately as this will help caregivers assume their rightful role as members of the health care team.

Caregivers' health seeking behaviour

Health seeking behaviour can be described as series of therapeutic actions taken to improve a health condition which is initiated by symptom identification and extends to devising a strategy for treatment action (Ward, Mertens, & Thomas, 1997; Ahmed, 2005). Help-seeking behaviour which is often used interchangeably with health seeking behaviour "*is an act of actively seeking help from other people. It is about communicating with other people*

in order to seek understanding, advice, information, treatment, and general support to address a problem or distressing experience. Help-seeking is a form of coping that relies on other people, and is therefore often based on social relationships and interpersonal skills” (Rickwood et al., 2005). Appropriate health seeking behaviour has a great potential to reduce the occurrence of severe and life-threatening child-illnesses (Taffa & Chepngeno, 2005). The effective management of a child’s health condition requires caregivers’ timely recognition of the health problem, the decision to seek help and the appropriate utilisation of health care services (Malik, Hanafi, Ali, Ahmed, & Mohamed, 2006). However, decision making on where and when to seek help is a complex process (Kelner & Wellman, 1997; Betsch & Haberstroh, 2014). Health seeking is prompted by an unusual sign or symptom or any other irregularity that is perceived to be a sickness or a threat to an individual’s well-being (Oberländer & Elverdan, 2000).

Previous studies have shown that socio-demographic, economic, environmental, behavioural and disease related (prevalence and severity) factors influence health seeking behaviour (Goldman & Heuveline, 2000; Taffa & Chepngeno, 2005; Ahmed, Tomson, Petzold, & Kabir, 2005; Ogunlesi & Ogunlesi, 2012). Caregivers are likely to seek immediate help if the child’s health condition is severe and they have adequate means to access quality health care services for that particular health condition (Oberländer & Elverdan, 2000; Romay-Barja et al., 2016). Most people delay health seeking because they experience difficulty in making decisions on the type of care services to utilise. This is however determined by the affordability, availability and proximity of health care services (Oberländer & Elverdan, 2000). Caregivers especially those residing in the low resource communities have limited access to health care resources. They often resort to traditional treatments and never seek help from the bio-medical health system (Kelner & Wellman, 1997, Romay-Barja, 2016). However, some explore several means of treatment including traditional and bio-medical ones. This practice is referred to as medical pluralism.

Medical pluralism is a common practice in low resource communities. In most societies, people seek diagnosis and treatment from different sources ranging from self-care (home remedies), traditional healers (herbalists/ spiritual healers), para-professionals (medical assistants) to medical professionals (nurses, doctors and other specialists) either at primary health centres or at hospitals (Ahmed, 2005). Thurston et al. (2015) described three stages of health seeking behaviour. These include: problem recognition, decision to seek help, service selection and utilisation (Goldsmith, Jackson, & Hough, 1988; Thurston, Phares, Coates & Bogart, 2015). It is however unclear whether caregivers go through these stages

consecutively (Featherstone & Broadhurst, 2003). Some caregivers never begin the process because they are unable to recognise a problem (Teagle, 2002), while others may experience some barriers as a result of stress associated with health-seeking (Johnston & Mash, 2001). Caregivers are likely to identify a health condition and seek health care services when a child is experiencing a severe and persistent pain that interferes with the child's normal functioning (Zwaanswijk, Verhaak, Bensing, Van der Ende, & Verhulst, 2003). Therefore, one can argue that the school health initiative is valuable in identifying certain health conditions that caregivers are unable to identify. Despite this body of knowledge about caregivers' health seeking behaviour little is known about the health seeking behaviour of school-going children in low resource communities in South Africa within the school health initiative context. Therefore, this study seeks to fill an important gap in the literature by exploring caregivers' health seeking behaviour before and after children participate in the school health programme.

Pathways model and the health care utilisation model (socio-behavioural model).

The pathway model is useful in describing the determinants of health seeking behaviour. The model is used in predicting health care choices, as it depicts health seeking behaviour as a dynamic process (Pandey, 2012). It describes the paths that individuals follow from the recognition of symptoms to the roles of significant others (family and friends) and to the use of different health care services (Ahmed, 2005). However, in the course of utilisation, people move from one sector to the other. The pathway model emphasizes the importance of significant others in accessing health care services, utilisation of health care resources, negotiation and management of health conditions. Caregivers are the significant others that children mainly depend on to make decisions on where, when and how to access health care services. The model presents logical steps taken in seeking health care services and the socio-cultural factors that affect the sequence (WHO, 1995).

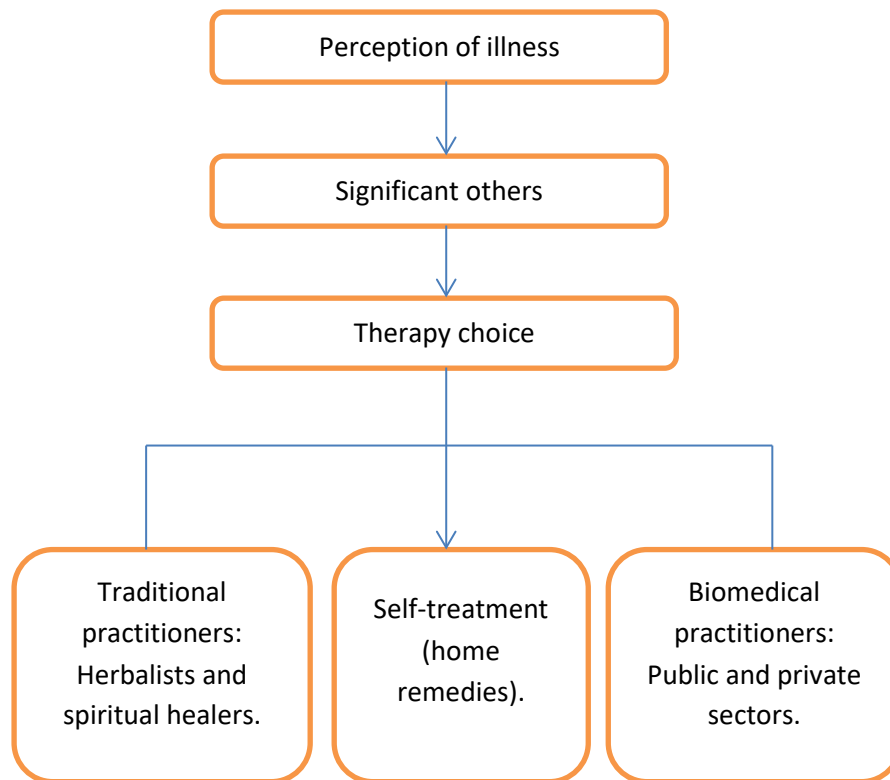


Figure 2.3 Socio-behavioural model (Ahmed, 2005).

Caregivers' perceptions of quality of care

It is important to understand caregivers' perceptions of the quality of health care services provided by both the school health programme and the different referral sites in an effort to improve access to quality health care services for their school-going children. Moreover, the information obtained from assessing caregivers' experiences and perceptions of the quality of health care services obtained by their school-going children has the potential to stimulate and guide the effort to improve the quality of health care services (Baltussen, Ye, Haddad, & Sauerborn, 2002; Price et al., 2014). Andaleeb (2001) argues that, patients' perceived quality of health care services has a relatively strong influence on the decision to utilise health care services. As such, expanding access and reducing cost are insufficient to encourage utilisation of services if confidence in the quality of health care services is low. Furthermore, studies conducted in some countries such as Nepal, Bangladesh, Uganda and Vietnam have shown that despite the substantial investments in the public health sector to improve access, service utilisation remains low because of patients' negative perceptions of the quality of care services (Andaleeb, 2001; Paalman, 2004; Bakeera, Wamala, Galea, State, Peterson, & Pariyo, 2009).

According to Parasuraman and colleagues (1990), service quality is often based on a customers' judgement. The authors define service quality as customers' perceptions of the services rendered by a service provider and their evaluation of the services in comparison with their expectations. A service quality model (SERVQUAL) was developed by Parasuraman, Zeithaml & Berry (1985, 1988, 1991) to provide a better understanding of the construct service quality. The model describes five dimensions to understanding service quality. They are reliability, responsiveness, assurance, empathy and tangibility. Reliability is the ability to execute the promised services consistently and accurately while responsiveness is the degree of willingness to provide prompt services to the customers Assurance refers to the knowledge, skills and expertise of the people involved in delivering the services and their ability to earn the customers' trust and confidence. Empathy refers to the attention and care received by the customer from the service provider while tangibility refers to the physical facilities such as the infrastructure, laboratories and equipment involved in delivering the services. (Parasuraman, Zeithaml & Berry, 1985, 1988, 1991; Andaleeb, 2001; Irfan et al., 2012; Ramez, 2012)

Furthermore, Donabedian (1988) describes three attributes of the health care delivery system, which are: structure, process and outcomes of the health care system. Structure refers to the organization and availability of both material resources (infrastructures and equipment) and human resources (qualified health personnel). Process refers to the way care is provided and received (practitioners' activities in diagnosing and treating health conditions and patients' activities in adhering to the instructions given by the professionals). Lastly, outcome refers to the effect of care on the health of the patients (Rademakers, Delnoij, & de Boer, 2011; Bristow, Chang, Ziogas, & Anton-Culver, 2013; Moor, Lavoie, Bourgeois, & Lapointe, 2015; Ayanian & Markel, 2016).

Several activities in the health care delivery system contribute to the overall assessment of service quality (Irfan et al., 2012). Gronross (1984) grouped these activities into two domains, namely: technical and interpersonal aspects of quality of health care. On one hand, technical quality is defined as the application of the science and technology of medicine such as diagnosis and surgical procedures to the management of health conditions (Dursun & Cerci, 2004). On the other hand, functional quality can be defined as the psycho-social aspects of the health professionals-patient interaction. It involves the health professionals' approach of delivering services to patients (attitudes of doctors and nurses to patients, cleanliness of the facilities, quality of hospital food etc.) (Ramez, 2012). However, service quality is assessed based on the functional attributes as the majority of patients lack the

medical expertise for evaluating quality based on the technical attributes (Dursun & Cerci, 2004). People's expectations for high quality health care service have increased over the years. Therefore, health service providers need to deliver superior quality of services that will satisfy their patients.

Previous studies have established that high quality care service is associated with better developmental (social, cognitive, health) outcomes while low quality care service is associated with poor developmental outcomes (Ceqlowski & Bacigalupa, 2002; Jones et al., 2016). Ensuring high quality child care can reduce preventable health conditions such as diarrhoea, malnutrition, pneumonia, malaria, HIV/AIDS, and injuries etc. These diseases result in over 20 million yearly deaths among children in most African countries (Opwora, Laving, Nyabola, & Olenja, 2011). School health services, nutrition programmes, health education and health promotion programmes are therefore designed to improve the health and developmental outcomes of school-going children (Shung-King, 2013). However, a key concern is the quality of services provided by these programmes.

The available evidences on perceptions of quality of care for school-going children were obtained from the school health team (nurses, teachers, and principals), policy makers, researchers and other health professionals (Opwora, Laving, Nyabola, & Olenja, 2011). However, despite that the fact that caregivers play important roles in accessing the health care services provided by the school health initiative for their school-going-children, no research study have been conducted to explore their perception of the quality of health care services obtained by the school-going children. Therefore, new evidence on the perceptions of the quality of health care services provided by the school health programme for school-going children is needed from caregivers. Caregivers play important roles and actively participate in child care, given that, it is important to understand how caregivers define the quality of health care received by their children at the various stages of the health care system. Moreover, understanding the quality of the different pathways to care from the caregivers' perspective will help expand our current understanding of quality of health care services available to children. It will also help identify the major barriers to obtaining high quality care services for school-going children (Ceqlowski & Bacigalupa, 2002; Jones et al., 2016).

However, several factors can influence caregivers' definition of quality of care. The major factors are related to the characteristics of health providers which are: the relationship and level of communication that exist between the caregiver and health care providers, safety

and security, confidentiality, warmth, sensitivity and flexibility (Jones et al., 2016). Other factors such as the cost of obtaining health care services (which may include: cost of transportation, cost of health services and cost of medication), proximity (travel time) and waiting time influence caregivers' decision to utilise care services (Shah et al., 2014; Chimbindi et al., 2015). Socio-cultural factors can also influence caregivers' perceptions of quality of care. Although the health facilities may be accessible in terms of distance and cost, if the services being offered do not satisfy the socio-cultural expectations of the caregivers, they will define the quality of services provided as low and are unlikely to utilise such services (Ceglowski & Bacigalupa, 2002; Opwora, Laving, Nyabola, & Olenja, 2011).

Theoretical framework

In this section, I provide a detailed discussion of Aday and Andersen's (1974) framework for the study of access to medical care. This framework is suitable for this study as it provides a useful lens for exploring the determinants of access to health care services and the utilization of the services. As mentioned earlier, the authors identified five interconnected components that determine access to health care services. The components are categorised into input and output components, they are: i) input components such as health policy (policies relevant to school health in the case of this study), ii) characteristics of health delivery system (attributes of their community (rural-urban), availability of services and health personnel in the community), iii) characteristics of the population at risk (their attitudes, perceptions, beliefs, culture, customs, income, need for care or severity of illness and social support). The output components are: iv) the actual utilisation of health care services and v) consumer's satisfaction with these services (Aday & Andersen, 1974). The authors argue that the enabling components of the population at risk often determine the degree to which health services are utilised. Enabling components describe the means individuals have available to them for use of services.

The components of the framework

The health policies related to the school health programme includes: the national insurance policy, the primary health care re-engineering policy and the integrated school health policy which have been discussed earlier. These health policies focus on health resources, their organisation and distribution as well as the process of financing the health system.

Health care delivery system

Health delivery system has two main components – resources and organisation. The resources are the labour and capital invested in health care delivery which includes health professionals, infrastructure, and also extend to the number and distribution of these resources in an area (Bustamante et al, 2012). Organisation describes how the system utilises the available resources. It refers to the way medical personnel and the infrastructures are being coordinated and managed. Organisation can be broken down into two components which are entry and structure (Aday & Andersen, 1974). Entry refers to the process of gaining entrance into the health care system (travel time and waiting time) and the process of continuing care while structure refers to the system that guides the patient after entry into

the system to ensure that their needs are adequately met. The care delivery system has to be well coordinated in order to be productive and accessible (Aday & Andersen, 1974).

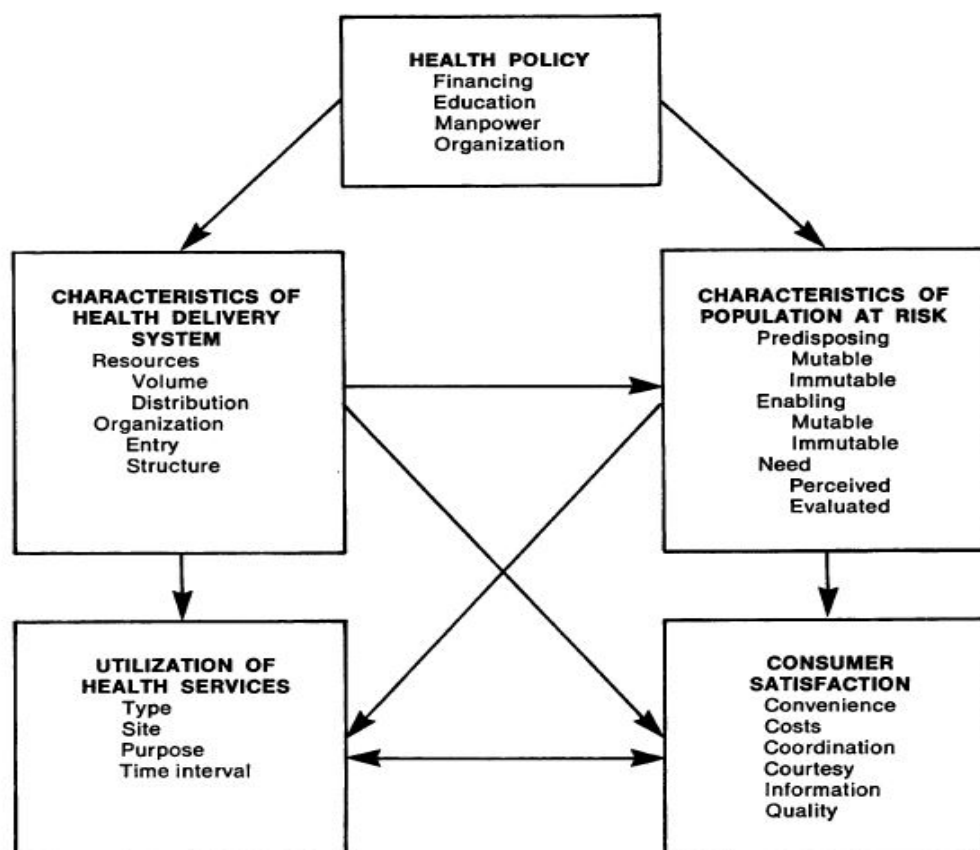


Figure 2.4 Framework to the study of access (Aday & Andersen, 1974).

Characteristics of the population at risk

The characteristics of the population at risk are defined by the predisposing, enabling and need factors which determine how an individual utilises available health care services. The predisposing factors are the variables that describe the tendency of an individual to utilise the available resources. These variables exist before the onset of the illness and they include age, sex, race, religion and values concerning health and illness (Bustamante et al., 2012; Delamater, Messina, Shortridge, & Grady, 2012). The enabling factors are the means (specific resources) that are available for individuals to use such as income and insurance coverage as well as the attributes of the community in which the individual reside (rural or urban) (Andersen, 1995). The need component refers to the type and severity of the illness for which care services are required. Need for care can either be perceived by the individual or evaluated by the delivery system. Therefore the need components of a child's health

determines the help seeking behaviour of caregivers (Aday & Andersen, 1974; Andersen, 1995).

Utilisation of services

Aday and Andersen (1974) characterised utilisation of health care services in terms of type, site and purpose of the required health care services as well as the time interval involved in accessing the health care services. Type refers to the kind of services received and who provided it while site refers to the place where the care was received. The purpose refers to the nature and pattern of care required whether preventive, curative (illness-related) or custodial care. The time interval can be expressed in terms of contact, volume or continuity measures. Contact refers to whether a person entered the health care system at a given period of time or not, while volume refers to the number of visits in a given time interval. Lastly, continuity refers to the degree of linkage and coordination of medical services (Aday & Andersen, 1974). It is important to evaluate all these components of utilisation because a poorly organised and fragmented system of accessing health care services will result in ineffective treatment which can be mistaken for lack of appropriate access to health care services.

Consumer satisfaction

Consumer satisfaction is very vital in assessing the quality of health care services. Assessing patient satisfaction is important for continuous quality improvement (Nkrumah, Yeboah & Adiwokor, 2015). Consumer satisfaction refers to patients' perceptions of the health care system (Aday & Andersen, 1974; Lonial & Raju, 2015). It can be evaluated by considering dimensions such as access to health care, convenience of care, cost and coordination of care, attitudes of the health professionals, amount of information given to the patient about the nature and management of their illnesses as well as the quality of care received as described by the patient (Aday & Andersen, 1974; Simon et al, 2015).

In this study I draw on various components of Aday and Anderson's framework. In doing so, I seek to use these concepts to help illuminate factors that influence caregivers' access to quality health care services for their children in schools participating in the integrated school health programme. Although school-going children are the population in need of the health care services provided by the school health programme, they do not have the autonomy to access care. Therefore, exploring caregivers' experiences in utilising the services provided by the school health initiative is deemed the most appropriate way to understand access to

health care services for school-going children in the low resource communities in South Africa due to the role caregivers' play in accessing care for school-going children as earlier discussed. These could provide insights into factors that influence caregivers' health seeking behaviour for their school-going children.

The study largely focuses on the primary health care re-engineering policy and the integrated school health policy. Both policies are relevant to the school health programme and they serve as the enabling components for accessing health care for school-going children in low resource communities. Other enabling factors may include family characteristics such as caregivers' income, as well as the distance and the means of transport to health care centres. Aday and Andersen (1974) argue that the more the enabling factors, the higher the tendency to utilise the available health care services. However, the need factors are the psychosocial attributes of caregivers which determine their tendency to seek health care services for their school-going children. These psychosocial factors may include: attitudes, values, knowledge and perceptions of the severity of the children's health condition(s).

It is equally important to explore the health care resources available to school-going children as well as the structure and organization of the health care services provided by the school health programme. In this study, I explore how the different components of the school health programme influence access to health care services from the perspective of the caregivers. These two components to a large extent determine entry into the health care system, access to appropriate health care services, utilisation of the health care services and the continuation of care for the school-going children. The framework equally provides insight into how the amount and type of information the caregivers have about the children's health conditions and their understanding of the type of health care services required to improve the health condition impact on caregivers' decision to seek health care services for the children. Furthermore, the distance to the site of referral and the attitudes of the health professional also influence access to quality health care services for the children.

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CHAPTER THREE

Journal manuscript

Caregivers' experiences in accessing health care services for their school-going children in low resource communities of KwaZulu–Natal, South Africa.

A more concise version of this study is presently being prepared for submission to *BMC Pediatrics*.

Authors' contributions

I (Gbotemi Aloro) was responsible for the conception and design of this study with guidance from my supervisor (Dr. Olagoke Akintola). I collected data for the study with the help of Londiwe Mbatha, Zanele Majola and Alpheus Zwelakhe Makhathini who served as research assistants. I conducted the data analysis and drafted the article under the guidance of my supervisor who reviewed and provided comments and suggestions on various drafts of the paper. I also received guidance and comments from Dr Musbau Titiloye.

Abstract

Background: Accessing quality health care services is critical to addressing the different health challenges school-going children especially those in the low resource communities are prone to. The school-based health care services provided through the integrated school health policy (ISHP) have been expanded since 2012 to meet the various health needs of school-going children. However, caregivers still encounter certain challenges in their effort to access health care services for their school-going children. This study therefore explored caregivers' experiences in accessing health care services for their school-going children.

Methods: Qualitative interviews were conducted with 17 caregivers of school-going children in three low resource communities of KwaZulu-Natal province. Four of the participants were caregivers' of children who were treated onsite (in school), nine of the participants were caregivers of children who were referred for further treatment and have accessed health care services and the remaining four participants were caregivers of children who are yet to access health care services.

Results: The study shows that the school health programme enhances access to quality health care services for school-going children in low resource communities. Access is enhanced by the provision of school-based health services such as screening the children for various health conditions, immunization and treatment for minor ailments and referral of children in need of more comprehensive health care services to the appropriate health care sites. Despite the fact that the school-based health care services enhance access to health care for school-going children, the study reveals that certain factors constitute barriers to access. Factors such as caregivers' low health literacy, inadequate communication, financial constraints, distance and transportation to the referral sites, still impedes access. Inadequate health information dissemination system and transportation to the referral sites are the major issues of concern. The long waiting time due to long queues and the unwelcoming attitudes of some of the health professionals at the health facilities also constitute major barriers to access.

Conclusion: Although ISHP has expanded its coverage and the range of services provided, the study suggests that effort should be made to implement interventions that will adequately address these barriers to access. Especially, in the areas of communicating with caregivers, providing financial support for transportation, improving the attitude of the

clinic staff and providing follow-up services for children that are referred for further screening and treatment from school.

Keywords: Access, caregivers, school-going children, school-based health care services, school health programme, integrated school health policy, low resource communities, South-Africa.

Background

In recent years, policy-makers in most low–and middle-income countries (LMICs) have intensified efforts to eradicate disparities in accessing quality health care services (Amin, Shah, & Becker, 2010). In many of these countries, the provision of basic preventative and curative health care services has been established as a basic human right (Ngwena, 2000; Brennan, 2007), and has therefore become a policy priority in these countries (Chen, Peng, Lee, & Liu, 2015; Chitah & Jonsson, 2015; Dimitrov, Kiem, Jerome, Johnston, & Schiffer, 2016). Furthermore, the availability of adequate health care services has been recognized as an essential requirement for the growth of any country (Patel, Trivedi, Nayak, & Patel, 2010).

Although South Africa's history is characterised by socioeconomic, geographical and racial inequality, several health policies and initiatives have been explored since the inception of the democratic government in 1994 (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009). These policies aimed to address the disparity in the provision of health care services and to improve access to quality health care services especially in low resource communities (Kautzky & Tollman, 2008). Some of the pro-equity initiatives developed by the democratic government include the restructuring of primary health care, introduction of the national school nutrition programme to alleviate hunger among school-going children, development of health infrastructure in rural and peri urban communities and the provision of social welfare grants to the disadvantaged population (Van Stuijvenberg, 2005; Akintola, 2015).

A critical strategy for achieving the mandate to address inequality and universal access to health care services for all South Africans was the extension of free health care service for all the users of primary health care centres in the country in 1994 (Naledi, Barron, & Schneider, 2011). In the last two decades, the government in collaboration with non-governmental (NGOs) and community based organizations (CBOs) have been expanding the range and coverage of health care services, especially for the marginalized communities (Jacob & Coetzee, 2015). These communities have received increased attention due to the fact that they are characterized by low levels of education, unemployment, low socioeconomic status, low skill base, the majority of people residing in these communities are dependent on social grant and they have limited capability to access adequate health care services (Coovadia et al., 2009; Akintola & Chikoko, 2016).

Currently, the South African Department of Health is instituting policy reforms commonly referred to as the re-engineering of the primary health care system (DOH 2011; Pillay and Barron, 2011). One of the three major streams of intervention through which the re-engineered PHC system hopes to achieve its aims is the integrated school health programme (Naledi et al., 2011; Pillay & Barron, 2011). The school health initiative provides a range of services to ensure the physical, mental and social well-being of school-going children (WHO, 1996). School-going children especially those living in low resource communities are prone to different health challenges which could impact on the children's learning capabilities and prevents them from reaching their full potential to grow into productive and capable citizens (DOH & DBE, 2012). Since children spend most of their formative years in school, the integrated school health programme therefore provides comprehensive health packages that will meet the health needs of the school-going children (Shung-king, Orgil, & Sleeming, 2014). The school health teams made up of professional and enrolled nurses are responsible for the health care services which includes: i) learner's assessment and screening ii) on-site services such as de-worming, immunization and treatment of minor ailment and health education iii) follow-up and referral services (DoH & DBE, 2012). The school health nurses equally build relationships with the children's caregivers as they play important roles in the management of their children's health.

Caregivers are people who care for, nurture and look after one or more young children (WHO, 2004). Children rely on their caregivers to access health care services, especially those that are not available in schools, which make them become active members of the health care team since they are the closest to the children. The caregivers play unique roles in their children's health care as no other member of the team is consistently aware of all the facets of their children's lives (Richter, 2015). However, caregivers encounter different challenges in accessing healthcare services mainly due to financial constraints and inadequate information about the health condition (Yin et al., 2012). These challenges result in delay to seek health care and hence deterioration of the children's health condition (Vergunst, Swartz, Mji, MacLachlan, & Mannan, 2015). According to Taffa and Chepngeno (2005), appropriate health seeking could potentially reduce the occurrence of severe and life-threatening child-illnesses and most of the health conditions can be effectively managed if adequate health care services are obtained. However, effective management of a child's health condition requires caregivers' timely detection, decision to seek help and the appropriate utilization of health care services (Malik, Hanafi, Ali, Ahmed, & Mohamed, 2006). An understanding of caregivers' experiences in accessing health care services for

their school-going children in low resource communities could help inform the integrated school health policy and interventions aimed at improving access to quality health care services for school-going children.

However, little is known about the experiences of caregivers in accessing health care services for their school-going children within an integrated school health programme in low resource communities. In this study I sought to explore the experiences of caregivers in accessing health care services for their school-going children who are participating in an integrated school health programme. Specifically, I sought to answer the following questions: 1) What are the factors that influence access to quality health care services for school-going children within an integrated school health programme? 2) What are the factors that influence caregivers' health seeking behaviour for their school-going children participating in an integrated school health programme? 3) What are the caregivers' perceptions of the quality of care accessed by their school-going children participating in an integrated school health programme?

According to O'Donnell (2007), access is the opportunity and freedom to use needed services. Andersen (1995) subdivided access into potential, realized and equitable access. Potential access refers to the availability of health care resources. Realized access refers to the actual utilization of the available health care resources and equitable access depends on the predisposing factors which includes demographic characteristics, social structure and individuals' health beliefs. This study draws on the Aday & Andersen (1974), framework for the study of access to medical care. The framework provides a useful lens for exploring the factors influencing access to health care services. The components of the framework are health policy, characteristics of the health delivery system, characteristics of the population at risk and utilization of health care services. This study drew from various aspects of all the components of the framework. By drawing on these components of access, the study aimed to explore caregivers' experiences and the factors that influence their access to quality health care services for their school-going children through the lens of the integrated school health programme.

In addition, this study focused on the primary health care re-engineering policy and the integrated school health policy because both policies facilitate access to health care services for school-going children especially in the low resource communities of South Africa. These policies define the health care delivery system which describes the available health resources as well as the structure and organisation of the health care services delivered to

school-going children. The screening, treatment, referral and follow-up services made available to school-going children in the country are guided by these policies. I therefore sought to explore how the different components of the health care delivery system especially school health services influence access to health care services. It is documented that school health services to a large extent determines school-going children's entry into the health care system, utilisation of the health care services as well as the continuation of care (Shung-King, 2013).

Aday and Andersen (1974) postulated that the characteristics of the population at risk are defined by the disposing, enabling and need factors. The predisposing factors are the factors that may influence individuals' perception about the need to seek health care services and how individuals cope with their health challenges. These factors include: age, sex, religion, culture, educational level etc. The enabling factors are the resources individuals have available to utilize health care services. These factors include: i) family characteristics such as income, insurance coverage, distance and transportation means to the health care centre ii) community characteristics such as the attributes of the community (rural/urban). The authors argue that more enabling factors will amount to greater access to and utilization of the health care services. The perceived needs component refers to the psychosocial factors that determine individuals' tendency to access health care services. These factors also influence individuals' decision to seek health care services. The need factor includes: attitudes, values, knowledge and perception of the severity of the health condition(s). This study equally explored the actual utilization of health care services by the caregivers by asking about the type of care accessed, the site (hospital or primary health centres) where care was accessed as well as the time (before or after SHPs intervention) care was accessed. In addition, the study explored caregivers' perception of quality of health care services obtained by their school-going children which depicts their satisfaction with the health care services assessed.

Methods

Study setting and context

This research is part of a larger research project with the broad aim of assessing the process of implementing the integrated school health policy (ISHP) in South Africa. This component was carried out in three low resource communities located within the EThekweni and Harry Gwala districts of KwaZulu-Natal province. These communities are characterised

by high unemployment rates and a low skills base where most people depend on government grants for income (Akintola & Chikoko, 2016). Schools in these communities fall within the quantile 1-3 categories where fees are not paid because they are believed to have the most disadvantaged learners. Entry into the communities was facilitated by the school health nurses who work for the Community Outreach Centre (COC), a community based organisation (CBO) affiliated to St Mary's Hospital in Mariannhill.

Community outreach centre (COC) partners with the departments of health and education in implementing the school health initiative in some low resource communities of KwaZulu-Natal province. COC provides school health services in the primary and secondary schools located in these communities. This study however focuses on primary school-going children. The organisation employs and train nurses to carry out the school health programmes. The nurses are then assigned to schools in the different communities where the organisation provides school health services. They provide onsite health care services such as screening, treatment of minor ailments, immunisation, health education as well as referral and follow-up services for school-going children in the communities. The school health nurses work conjointly with school teachers, principals, and other stakeholders including caregivers. Furthermore, the school health nurses send letters to obtain consent to screen and treat the children in school from caregivers. After the screening, the nurses invite caregivers to school through phone calls or by sending letters to inform and educate them about the children's health conditions. In cases where the children are in need of more comprehensive health care services, they refer them to the nearest primary health centre or hospital, depending on the type of service needed. The nurses also provide follow-up services by visiting the children at home to monitor their improvement and further educate the caregivers. The school health nurses keep records of all the school-going children that are screened, treated and referred for further treatment. The record includes the contact details of the children's caregivers. School health nurses also have existing relationships with these caregivers, and these make them the most suitable gatekeepers for community entry.

The project supervisor, who is the principal investigator of the larger project, was commissioned by the management of the CBO to document the school health programme implementation process. This existing relationship paved the way for easy access to the school health nurses and community entry. The nurses working in the communities were thus introduced to the researchers working on the project. I then liaised with the nurses who agreed to help with community entry and the identification of potential participants.

Study design

This study utilized a qualitative research design to elicit information to enable the study attain its set objectives. A qualitative design has the ability to generate in-depth information about caregivers' experiences in accessing health care services (Henning Van Rensburg, & Smit, 2004; Polkinghorne, 2005). A qualitative design is suitable for this study as it explores the lived experiences of caregivers thereby enabling the researcher to capture the richness of human experiences such as how the real world is lived and felt (Polkinghorne, 2005). Little is known about caregivers' experiences in accessing health care services for their school-going children in the low resource communities of KwaZulu-Natal, South-Africa. A qualitative research design allows the researcher to explore events within the participants' natural, social and cultural settings (Merriam, 1998; Cleary, Horsfall, & Hayter, 2014). According to Maxwell (1998), qualitative studies seek to understand: 1) the meaning of life experiences, 2) the particular context within which people act, and 3) the process by which events or actions take place. The design therefore provided me with an opportunity to gain a deep insight into caregivers' experiences in accessing health care services for their school-going children.

Study participants

Since the aim of the study was to explore the experiences of caregivers in accessing health care services for their school-going children in low resource communities of KwaZulu-Natal, I therefore developed a set of selection criterion for recruiting the study participants (Ulin, Robinson, & Tolley, 2005). The selection criterion were as follows; a caregiver must be responsible for at least one primary school-going child (Grade R – grade 7), and must be resident in one of the peri-urban communities where the study was conducted. In order to include participants with a range of experiences relating to the research topic (Ritchie, Lewis, Nicholls, & Ormston, 2013; Ulin, Robinson, & Tolley, 2005), I recruited participants belonging to two categories: i) caregivers whose children were screened and treated on site (in school) and ii) caregivers whose children were screened and referred for further assessment and treatment. The latter category was further sub-divided into caregivers who went to seek treatment for their children and those who did not. I intended to recruit 5 participants for each category, but only 4 caregivers whose children were treated onsite, 9 caregivers whose children were referred and have accessed health care services and 4 caregivers of children who are yet to access health care were available and willing to

participate in the study. Table 3.1 below show the categories of caregivers who participated in the study and the number of participants in each category.

Table 3.1 Participant categories

Participant categories	No of participants
Caregivers of children treated onsite	4
Caregivers of children referred and accessed care	9
Caregivers of children referred but yet to access care	4
Total number of caregivers	17

Prior to the interviews, the school health nurses provided a list of potential participants (caregivers) and this increased the opportunity for selecting information-rich participants (Palinkas et al., 2015). The school health nurses further helped to identify caregivers who met the selection criteria. Thereafter, a non-probability purposive sampling technique was used to recruit the study participants. I adopted an intensity purposive sampling strategy in selecting 17 participants who were chosen specifically for their potential to provide in-depth information due to their insight and previous experience (Robinson, 2014). Intensity purposive sampling is used when a researcher is interested in selecting a small sample of information rich participants, individuals who have special knowledge and experience in the research topic area (Miles & Huberman, 1994). The small well-informed individuals have the potential to provide interesting, insightful and honest information based on real life experiences (Ulin et al., 2005, p. 57). The demographic characteristics of the participants are described in Table 3.2 below.

Table 3.2 Participants' Characteristics

Communities	Name of schools	No of participants interviewed	No of school-going children
Community A	Primary school A	4	4
	Primary school B	4	4
Community B	Primary school C	3	3
Community C	Primary school D	6	13
Total		17	24

Data collection procedure

Qualitative data for the study was collected using semi-structured interview guide. Three research assistants who are proficient in both isiZulu and English were recruited and trained to help with data collection. We used semi-structured interview schedule which allowed interviewers flexibility to collect in-depth information (Smith & Osborn, 2007; Creswell, 2013). The interview schedule used was initially constructed in English and then translated into isiZulu by the research assistants. The interview schedule was constructed after a review of literature on caregivers' health seeking behaviour, access to health care services and the integrated school health policy. In addition, Aday and Andersen's framework for the study of access to medical care was also reviewed (Aday & Andersen, 1974).

Following Akintola and Chikoko (2016), I used particular themes extracted from the literature and Aday and Ansersen's framework which relates to the health seeking behaviour of caregivers in low resource communities and access to health care services to framing open-ended questions. The open-ended questions offered the interviewers the opportunity to probe by asking follow-up questions. The interview questions covered themes such as the demographic information of the caregivers and their children, health seeking behaviour and caregivers' experiences in accessing health care services. In order to frame questions relating to caregivers' experiences in accessing health care services, I used themes extracted from the review of Aday and Andersen's (1974) framework and the relevant literature on access to health care services in South-Africa.

During the interview, we asked questions about the child(ren)'s health condition, caregivers' previous health seeking behaviour for their children, factors that influence access and the utilisation of available health care resources as well as the challenges they encounter in accessing care services for their children. Questions around health seeking behaviour were repeated in relation to the school health care services, particularly focusing on how it has influenced their attitude to seeking health care services. Furthermore, we asked questions about their perception of the referral system and their description of the health care services provided in school. The interviews were conducted in the participants' homes for their convenience, as participants were more comfortable in their own space. The interviews were conducted in isiZulu and each interview lasted from 30 to 45 minutes. An audio recorder was used in recording the interviews and this allowed the interviewers to pay full attention to the proceedings of the interview. Recording also enabled deep interaction with the participants and provided the interviewers the opportunity to obtain in-depth understanding

of the participants' experiences. All the interviews were later transcribed and translated into English.

In order to ensure the trustworthiness of a qualitative research study it must answer the credibility, dependability, confirmability and transferability questions (Ulin et al., 2005). Therefore, in order to ensure rigour for this study, credible sources of information and methods were used in carrying out the study. Due to the fact that I am not a native speaker, I employed three research assistants who are proficient in IsiZulu and English to help conduct the interviews. Prior to data collection, I organised training workshops with the research assistants. This was to ensure that each of them were given the same training and information at the same time, in order to ensure uniformity in the research procedure. I provided the research assistants with detailed information about the study context, study settings and the study participants. Each of them read through the study proposal and a number of previous studies that have been conducted in the context of the study in order to have a basic understanding of the research.

Furthermore, the purpose and aim of the study were stressed during each of the meetings. The interview schedule which was initially constructed in English was jointly translated to IsiZulu by the research assistants during one of the meetings in order to achieve accurate translation that is agreed on by each of the research assistants. Furthermore, I provided detailed description and justification for the entire steps taken during the course of the research. The research question, interview schedule, interview transcripts as well as the study findings and conclusion were reviewed severally to ensure they align with the focus of the study. Caregivers were purposively selected from three communities so as to increase the likelihood of transferability. Nonetheless, different contextual factors may affect the transferability of the findings of this study.

Data analysis

The data was transcribed verbatim so as to ensure accuracy of transcription. It was later translated to English by the same research assistants who conducted the interviews so as to ensure credibility. I analysed the data following the five step process of thematic analysis recommended by Braun and Clark (2006). The first step involved familiarising oneself with the data, which was done by reading through all the transcripts several times. After obtaining an overall sense of the data from all the transcripts, the second step was that of generating initial codes. Thereafter, I made notes that were similar to the participants' words

so as to ensure that the analysis is grounded in what the participants were saying (Watson, McKenna, Cowman, & Keady, 2008; Ulin et al., 2005).

The third step was transforming the codes into emergent themes. Fourthly, the themes were reviewed to encapsulate all the themes emerging from the entire data set (Braun & Clark, 2006; Watson et al., 2008). After completing this process, the results were compared and revisions were made across all the transcripts in an iterative way. The themes were then re-named. The fifth step involved improving the quality of data and the rigour of the analysis, which was done through looking for connections between the themes in order to cluster them together in a meaningful way. I clustered the themes into main themes that cut across all the transcripts. Sub-themes were also developed to accommodate some themes which were peculiar to some transcripts (Watson et al., 2008). Once the entire transcript had been coded in this way, the themes were extracted and listed.

Ethical considerations

To ensure that the research was ethically sound, the larger project was granted full approval under protocol number - HSS/1507/015. This particular study was granted full ethical approval with the reference protocol number - HSS/0570/016 by the Human Social Sciences Research Ethics Committee of the University of KwaZulu-Natal [HSSREC]. Moreover, both the departments of health and that of education in Kwazulu-Natal province granted the larger project permission to carry out the study. Prior to the interviews, the interviewers sought the participants' informed consent through an informed consent letter. The contents of the letter were explained to the participants before obtaining informed consent from them. The interviewers also provided a detailed explanation about the nature of the study to each participant and assured them of both confidentiality and anonymity. They also sought and obtained permission to use an audio-recorder from each of the participant. All interviews were confidential and the respondents remained anonymous as the interview transcripts were labelled using pseudonyms.

Results

Caregivers' socio-demographic characteristics are presented in Table 3.3 below. An overwhelming majority (n=16) of the total number of participants (n=17) were females. The participant's ages ranged from 27 to 70 years and majority of the caregivers were between 27 and 32 years. Most of the participants were the children's mothers (n=8), followed by grandmothers (n=5). Majority of the participants were unemployed (n=7), only (n=4) are employed while others were either self-employed, pensioners or receiving government

grants. The study participants were providing care for 24 children attending primary schools. A slightly larger number of the children (n=13) were females and the ages of the children ranged from 5 to 15 years.

Table 3.3 Profile of caregivers

Gender	Frequency	Percentage
Male	1	5.88
Female	16	94.12
Total	17	
Age		
15 - 20	0	0.00
21 - 26	0	0.00
27 - 32	5	29.35
33 - 38	4	23.53
39 - 44	1	5.90
45 - 50	2	11.76
51 - 56	2	11.76
57 - 62	1	5.90
63 - 68	1	5.90
69 - 74	1	5.90
Relationship with children		
Mother	8	47.05
Grandmother	5	35.31
Aunt	2	11.76
Stepmother	1	5.88
Father	1	5.88
Employment status		
Unemployed	7	41.18
Employed	4	23.53
Self employed	3	17.65
Grant receiver	2	11.76
Pensioner	1	5.88
Total	17	

The findings have been categorised into three main themes with associated sub-themes. The three main themes are caregivers' health seeking behaviour, access to health care services for school-going children and caregivers' perceptions of the quality of health care services. A summary of the themes and subthemes arising from the data is presented in Table 3.4 below.

Table 3.4 Summary of themes and subthemes.

Main themes	Sub-themes
1. Caregivers' health seeking behaviour	<ul style="list-style-type: none"> • Caregivers' knowledge of the health conditions <ul style="list-style-type: none"> ○ Caregivers' understanding of child's health condition ○ Caregivers' involvement in child's care • Previous health seeking behaviour <ul style="list-style-type: none"> ○ Common health practices: neglect (no action), medical pluralism, self-care/treatments, traditional practices. ○ Reasons for previous treatment ○ Outcome of previous treatment • Current health seeking behaviour <ul style="list-style-type: none"> ○ The influence of the ISHP ○ Treatment on-site, referrals
2. Access to health care services	<ul style="list-style-type: none"> • Characteristics of health care facility, caregivers and school-going children. <ul style="list-style-type: none"> ○ Choice of health care service provider. ○ Factors influencing the utilisation of health care services. • Accessibility <ul style="list-style-type: none"> ○ Geographical distance ○ Travel time ○ Waiting time ○ Transportation • Affordability

-
- Cost of hospital visit
 - Acceptability
 - Attitude of health care professionals
 - 3. Caregivers perceptions of quality of care assessed
 - Perceptions of school health programmes
 - Communication between the school and the caregivers.
 - Referral system
 - Follow-up system
 - Perception of quality of care (screening, testing and treatment)
 - On-site
 - Referral sites (primary health centres and hospitals)
 - Outcome /improvement in health condition/ effectiveness of care services assessed.
-

Caregivers' health seeking behaviour

Results under this section have been grouped into different sub-themes that represent the factors that influence caregivers' health seeking behaviour. These are the caregivers' understanding of their children's health condition, the identification of the health condition, and the caregivers' previous and present health seeking behaviour. The health conditions mentioned were also grouped into two categories as major and minor ailments as shown in Table 3.5.

Table 3.5 Children’s health conditions

Health conditions	Frequency(N)	Percentage
Major ailments		
Skin conditions (rash, scabies and sores)	8	26.7
Eye problem	6	20
Ear problem (wax impaction, infection and hearing loss)	4	13.3
Teeth extraction	3	10
Asthma	2	6.7
HIV	2	6.7
Epilepsy	1	3.3
Minor ailments		
Stomach ache/worm	2	6.7
Headache/ fever	1	3.3
Cold/flu	1	3.3
Amenorrhoea/menstrual pain	1	3.3

N.B The frequency (N) will not add up to the total number of children because more than one condition was diagnosed for some children.

It is important to note that some of the children were diagnosed and treated for more than one health condition on-site. Children with major ailments were mostly referred to primary health centres and hospitals for further screening, treatment and management while those with minor ailments were mostly treated on-site. Moreover, the school health nurses sometime gave the children medications to take home.

Caregivers’ knowledge of the health condition(s)

The school health nurses identified most of the health conditions during the routine health assessment process. Majority of the caregivers mentioned that they were not aware that their children had a health condition and would not have noticed the problem if they weren’t screened at school.

The health condition was first noticed in school. I didn’t know he was suffering from eye problem before I got the letter (caregiver G - Primary school C).

The problem was discovered when the mobile clinic came to their school (caregiver F - Community A).

The problem was discovered in school, he fell sick in school (caregiver Q - Primary school D).

However, some of the caregivers mentioned that they were aware of their children's health conditions before they were informed by the school. These caregivers noticed the symptoms but could not ascertain what the problem was until the children were screened in school. Therefore, they could not take step to seek the appropriate health care services for the children. This was the case with a mother whose child had an eye problem, she said:

I saw the signs before the school informed me about the eye problem. But I didn't know what it was before the school sent the letter (caregiver C - Primary school B).

In some cases the children complained about the health condition to their caregivers before they were screened and treated in school. However, the caregivers mentioned that they didn't realise the severity of the health condition until the school informed them about their children's health condition. A grandmother whose grandchild had a teeth problem said that:

The child complained about the problem to me before she was screened in school. I thought the teeth was going to come out itself until the nurses sent a letter to inform us that she will be taken to the hospital (caregiver M - Primary school D).

In some instances, caregivers and/or their neighbours noticed the children's health condition. Some caregivers were able to recognise the health conditions. A mother of a child with skin rashes mentioned that:

I (the mother) and my neighbour saw the rash before the school sent a letter to us. I knew skin rash is a serious health condition (caregiver - D Primary school A).

However, other caregivers could not ascertain what the health condition was until the children were screened at school. These caregivers could not determine the severity of the health condition and therefore did not realise the need to seek health care services for the children. A mother of a child with an eye condition mentioned that:

I knew about the eye problem before she was screened in school. Her eyes get very red and itchy at times but I didn't know it was a serious problem (caregiver C - Primary school B).

Caregivers' understanding of children's health conditions

Majority of the caregivers demonstrated a fair understanding of their children's health conditions. Those who identified the health condition(s) described the symptoms the children presented before they were screened in school. Although, some of the caregivers had no idea what the symptoms were when they initially noticed that their children had a health challenge, other caregivers could recognise the health problem due to their previous experiences. A caregiver whose grandchild had knee tumour said:

He started limping and limping but as time went by, we realized that the swollen knee was not deflating, his mother also had it when she was younger, it is called tumour (caregiver E - Primary school A)

Some of the caregivers who could recognise the health problem made some attempt to treat or manage the conditions but these weren't sufficient to alleviate the respective health conditions. Caregivers whose children had skin rashes said:

I knew it was an infection, so I was careful with his clothes. I washed it separately because I didn't want the other children to be infected. I have seen it on my neighbour's children, so I know its contagious (caregiver J - Primary school D)

It's been long. I think two months ago, it was like she was burning. I know it is contagious and the things of the affected person must be kept away from others so she stayed at home for a while because people with rashes need to be kept away from others until they are healed (caregiver D - Primary school A).

Caregivers' involvement in children's care

Most of the caregivers were actively involved in their children's health care. They mentioned that their decision to seek help for the child was influenced by the impact the health conditions had on the children. These include pains, discomfort, academic setback, absenteeism which results in poor academic performance, isolation from other children and behavioural disorders. A mother whose daughter had a severe eye defect mentioned that:

She is not supposed to be in her present grade, her mates are in high school now. She started school early but because she couldn't see the board clearly like other children, she had to repeat some grades (caregiver C - Primary school B).

Another caregiver whose child suffers from a psychological disorder stated:

If it was not for his illness (epilepsy) he probably would have completed primary school. He stayed at home, without learning for about three years because the fits were regular. And when something upsets him, he just gets angry even here at home when he starts we can't control him we have to get the neighbours to assist us (caregivers I - Primary school A).

Most of the caregivers were concerned about their children's state of health. Majority of the caregivers expressed the psychological impacts the children's health condition(s) have on them. The psychological impacts mentioned are depression, helplessness, dissatisfaction, confusion, and exhaustion. These psychological impacts are aggravated by the caregivers' inability to access the appropriate health care services. These are some of the caregivers' expressions:

I'm worried about him, but I'm tired of complaining about his injuries (caregiver O - Primary school D).

I'm not happy about their health condition but I'm helpless at the moment (caregiver P - Primary school D).

The caregiver whose child suffers from a psychological disorder reported that the child misbehaves sometimes due to his health challenge. She narrated a scenario when the child fought a teacher in school and she was invited to school by the principal. She said:

I had to apologize to the teacher on his behalf, and you know we were in a room full of teachers and my heart was so sore. I just became emotional and began to cry and I walked out (caregiver I - Primary school A).

Previous health seeking behaviour

Caregivers who were aware of their children's health conditions before the intervention of the school health programme made different attempts to improve the child's health condition. They engaged in different health care practices ranging from self-care to seeking treatment at the health facilities closest to them. Some claimed to have treated such conditions in the past and used the knowledge gained from their previous experiences in treating the children. Others sought advice from their friends and neighbours. They took the children to the PHC centres close to them and also used *muthi* (traditional medicine)

obtained from traditional healers. A caregiver stated that her reason for exploring both means was that she wanted the child to recover quickly. They also mentioned that they used other forms of treatment, for example, using warm salt water to swab a child's knee tumour and using herbal ointment on the child's skin to heal skin rashes etc. A caregiver of a child with skin rashes said:

I took the child to a traditional healer, who gave us some traditional medications and ointment. I would sometimes use the herbal ointment on her skin. I will also give her some of the traditional medicine to drink, wash her cloths separately and spread outside to dry. I later took her to the clinic. I used everything I could lay my hands on.... I used both, because I wanted her to be healed quickly (caregiver D - Primary school A).

Other caregivers however mentioned that they tried several traditional medications but there was no improvement in the children's health condition until they were screened, treated and/or referred for further treatment by the school health nurses. A caregiver whose child attends primary school B narrated his experience of treating the child's skin condition with various traditional herbs before the child was referred to the Community A primary health care centre by the school health nurses:

We actually tried taking the child to a traditional healer and it didn't work, but we did not give up at all because this needs to be conquered. I actually tried the natural herbs but they didn't help. I tried umdoni and umgadankawu (name of herbs) and they didn't work..., we only started seeing improvements when he started taking the medications from the clinic (caregiver A - Primary school B).

Caregivers who weren't aware of the child's health condition made no attempt to seek health care services for the children. Some mentioned that they recognised and treated the symptoms of other health conditions the children had. However, they could not recognise the presence of the major ailments that were identified by the school health team. This could be because a comprehensive medical assessment procedure is needed to identify those health conditions. A good example of these health conditions is eye defect.

Each time she complained of anything (headache, flu or fever) I usually take her to the clinic and she gets treated. But concerning her eyes problem I didn't do anything because I was unaware (caregiver C - Primary school B).

A few of the caregivers also indicated that their reason for not seeking health care for the children was because they thought the conditions will resolve naturally. A caregiver who is responsible for eight grandchildren, whose ages ranged between 5 and 13 years, stated her reasons for not accessing health care services for five of the children before they were screened and treated by the school health nurses:

No, I didn't try anything. I don't want to lie. I haven't tried anything because the child with teeth problem is still in a stage of developing new teeth, so I thought the teeth will go out. I tried applying muthi (traditional medication) on the one with skin rash. I just told the one with cold to cover herself properly (caregiver M - Primary school D).

Despite the fact that the caregivers explored several treatment options, they did not associate the children's health conditions with their traditional or cultural beliefs. This suggests that caregivers are aware of the biomedical health risk factors associated with their children's health conditions. Although the caregivers' knowledge of the children's health conditions are inadequate but could have been influenced by the integrated school health programme. A caregiver whose son was diagnosed with an eye defect mentioned that:

I don't think is eye problem has anything to do with our tradition or any ritual. I also don't think traditional treatments will be better than going to the clinic (caregiver G - Primary school C).

Another caregiver whose daughter had skin rashes also stated that:

I'm not certain about the traditions beliefs about the disease but I don't think it relates to any traditional or religious beliefs (caregiver D - Primary school A).

Health seeking behaviour after screening

After the children were screened in school, some were treated on-site while others were referred to public health facilities for further treatment. Majority of the caregivers of the school-going children referred for further treatment took their children to the referral sites to seek health care services for the children.

I later took her to the hospital after she was referred by the school nurse, and she is fine now (caregiver B - Primary school B).

I took him to the clinic the day after I was called (caregiver H - Primary school C).

However, a few of the caregivers declined the advice to take their children for further health care interventions. Two grandmothers stated that they take care of many children and are not strong enough to go through the stress of taking the children to the referral centres. One of the grandmothers stated that taking the child to the hospital is the mother's responsibility. She claimed to have done that in the past for her children and that she shouldn't be doing the same for her grandchildren. Although, the child lives with her and she takes care of the child's other needs, she did not want to over extend herself to take the child to the hospital. She said:

I can't go through that anymore. I did it for his mother and her siblings. It's his mother's responsibility...., she must come and take him to the hospital. I'm no longer strong to go through that stress (caregiver O - Primary school D).

Another grandmother complained about the challenge of taking her many children for treatments given her illnesses.

I have eight of them living with me, it's sometimes too much for only me to handle. I don't have the time and my health is also not strong enough. They referred the ones with eye, ear and teeth problems as well as the one with HIV to the hospital but I haven't taken them (caregiver I - Primary school A).

Financial barriers and time constraints are the most common reasons mentioned by caregivers for not taking their school-going children for health care services. The grandmother with eight children mentioned that she is not financially capable and that she needed to stay at home to attend to her business which is the major source of income for the family.

I don't have the time to take them. I have to sell ice-cream at home to feed them. That is where I get money from. I also don't have money for transportation (caregiver M -Primary school D).

Another caregiver stated that he is waiting for his salary to be paid before taking the child for medical treatment.

The only problem we had was only that we had no money. I don't have money. I have been waiting to have money to just take him to the hospital (caregiver A - Primary school B)

Some of the children with minor ailments were treated on-site by the school health nurses. Other children especially those with eye and teeth problems were however taken for further treatment at the hospital by COC (the community based organization) and the mobile clinic. Some of the caregivers mentioned that:

The mobile clinic took the child with the eye problem to the hospital. She was given medications. The child with flu was also given some medication from school (caregiver M - Primary school D).

The child was taken to the hospital from school. They gave her medications and also promised to give her glasses (caregiver F- Primary school A).

Access to health care services

Access to adequate health care services for school-going children is the primary objective of the integrated school health policy (ISHP). As earlier stated children were screened in school and were either treated or referred for further treatment. Majority of the children were referred to the primary health centres within the communities, but a few of those with severe health conditions were referred to public hospitals. COC provided transportation to the referral sites for some of the children while others were taken to the health facilities by their caregivers. The caregivers described the health facilities in terms of accessibility, affordability and acceptability which are grouped into sub-themes below. According to Aday and Andersen (1974), these factors influence the utilisation of health care services.

Accessibility

Accessibility was described in terms of distance, transportation and waiting hours. Some caregivers mentioned distance and cost of transportation as major barriers to accessing health care services for their school-going children. They described the health facilities as being far and that they have to wake up very early in the morning to get to the facilities before they get crowded. Some caregivers also mentioned the difficulty they experience when seeking transportation to the referral sites. A caregiver who resides in Community A and accesses treatment for her child with epilepsy at a health facility that is 16km away from the community, described the distance as far. She indicated that the taxis' routines are not

flexible which makes hospital visits quite challenging. She also added that she could not take the child for treatment for some months because the taxi route was changed. She further stated that the cost of transportation which is approximately R60 for a round trip is expensive and that she cannot afford the cost. The child therefore could not access his monthly medications and his epilepsy fits became more frequent and severe.

I found myself missing appointments because the hospital is far from here and the taxis stopped going directly to the hospital. I sometimes do not have money for bus fare because I come from far and the transport fare is expensive. The transport fare cost R15 to the hospital and R15 back to community A for each of us... which amount to R60 for each visit (caregiver I - Primary school A).

The challenge of distance and cost of transportation was also mentioned by another unemployed caregiver who is responsible for eight grandchildren. The caregiver resides in community C and one of the children was referred to a clinic in another community. The distance between the two locations is about 26 km, and the cost of transportation is about R30 for each person per visit. The other four children were referred to the community clinic and the transport fare costs R20 for each of them. She lamented that the cost of transportation was high and she could not afford it. She attributed her failure to take the children for the needed treatments to these causes.

I don't have the transport fare to take the children for treatment. I'm unemployed I depend on the grant and this ice cream I sell. It's even difficult to feed them at times, so that's why I'm unable to take them. It's expensive because one was referred to a clinic which is far from here and transportation costs about R50-60 for both of us, the others were referred to the clinic here it will cost R20 for each person (caregiver M - Primary school D).

However, a few of the caregivers said that the health facilities (primary health centres) the children were referred to are close by. However, they stated that they cannot afford the cost of transportation.

The clinic is not far if we take a taxi but we cannot afford the taxi although it costs R7 for each person so we usually walk and it takes very long to get there and come back (caregiver J - Primary school B).

Majority of the caregivers indicated that they experienced long waiting hours at the clinic due to the large number of people served by these facilities and the shortage of health professionals at the facilities. As a consequence, some of the caregivers could not access health care for their children because of the long waiting time, and the long delays at the clinics.

We wait for a long time and I get very exhausted, the queues are always very long, I had to leave the clinic on a particular day because it didn't look like they will attend to us after waiting for so long (caregiver F - Primary school A).

It takes the whole day, we have to leave home at 5:45am to catch the bus, to get there early because of the long queue, we only come back home in the evening (caregiver I - Primary school A).

Another caregiver mentioned that adequate information about the structure and organisation of the facility is not provided, which include information about the right queues to join. Yet, some noted that the queues are shorter on some days.

I will say it took time because at hospital, especially when you're old like me, you take time going around in circles, sometimes you wait and wait and it is not pleasant to scoot along the benches, but I have to endure it because the child was sick (caregiver E - Primary school A)

Affordability

Majority of the caregivers mentioned financial constraints as a major factor that constitute barrier to accessing treatment for their children. These financial constraints stem from unemployment and lack of skills to generate income which is a common challenge in low resource communities. The caregivers mentioned that they are willing to obtain quality health care services for their children however they are limited by finances. A caregiver mentioned that she had to delay health seeking due to financial constraints:

For us unemployed mothers in rural areas it happens that sometimes you don't even have the money to take the child to the clinic. But we are trying. I could not take her on the first date of her arrival with the letter due to financial challenges, the financial situation was very bad on that day, and I had to wait. She also came home

with a second letter, and then I took her because the situation was better then (caregiver L -Primary school D).

Another caregiver who is yet to access health care services for her children also mentioned that they are facing financial constraints as a result of unemployment:

I plan taking both of them to the hospital when I get money, their father and I are out of jobs at the moment but I will take them as soon as we get money....., transport fare cost about R30 for each person, it means R90 for the 3 of us...money is the problem.

We are waiting to have money to take him to the hospital (caregiver A - Primary school B).

Acceptability

The interaction between the health professionals and the patient is important in evaluating access to health care services. Some caregivers described the health professionals' attitudes, especially the nurses as rude, negligent and unfriendly. They also mentioned that they do not provide adequate amount of information about the child's health condition. A caregiver whose child is asthmatic narrated her experience at a PHC, she seemed irritated by the staff's attitudes and it was evident in the way she narrated her experience.

The service at this clinic is very poor, it's very poor. You can wait for 30 minutes while you have someone who is having an asthma attack. You wait 30 minutes while they are walking up and down. They don't prioritise. Some of the staffs are rude but there are some warm ones. They do not provide adequate information. I once asked them what to do when my daughter has an attack when we are at home, they responded by saying that there is nothing that you can do when you are at home. They are impatient and sometimes give inconsistent information on how to help the child, one will tell you that you need to pump the inhaler three times immediately and let her inhale at the count of 1 to 10 and at night do the same thing, another will tell you three times a day (caregiver K - Primary school D).

Caregiver's perceptions of the school health programme

Results in this section have been categorised into caregivers' perceptions of the ISHP, communication between the school and the caregivers, referral system and follow-up. The ISHP was perceived by the caregivers as helpful. The children are screened by the school

health nurses for different health conditions and they are able to identify health conditions the caregivers were either not aware of or did not pay attention to. As earlier mentioned, the caregivers' accounts show that the children's health conditions would have received little or no attention if they weren't identified at school.

The nurses also educate them on the children's health conditions and give them instructions on how to manage these health conditions. According to the caregivers, the mobile clinic initiative helps them in saving on cost of hospital or clinic visits which includes transportation as well as payment for medications and treatments. According to the caregivers, the school health programme does not only give the children medication but also other needed items such as sanitary pads, tooth pastes and tooth brushes. They also acknowledge the positive impacts of the treatment provided on the children's learning abilities.

The school programme is very helpful. They tell us about the illness and even refer the children to the hospital for more comprehensive treatments. The mobile clinic comes to examine the students, they also treat them and see the illnesses that we take for granted, and those that we parents wouldn't have noticed. The treatments are very helpful. They even provide them with pads and other items. I don't have to buy pads, they also give them Colgate and tooth brushes (caregiver I - Primary school A).

The programme is helpful for people like us who do not have the financial means to help the children. They care about the children health. They even give them medication and take them for check-up. We don't have a problem after they have been given treatment; the children return to school and get good grades. It is really helpful I must say (caregiver M - Primary school D).

The caregivers further explained that school health nurses and the clinic staff work together and this sometimes reduces the stress they go through in accessing health care services. Some caregivers mentioned that they were able to avoid the long queues and reduce waiting time because they had referral letters from the school. The caregivers also said that the services provided in school motivate them to be actively involved in their children's treatment process. The caregivers were happy that the school health nurses were concerned about their children's welfare and they expressed their sincere gratitude.

The programme makes life easier especially for we mothers, it saves time, because we skip the long queues at the clinic. I think it's good because it means that the children are obtaining adequate care. The school nurses are so curious and concerned about the children's well-being. The children are attended to medically when the mobile clinics visit. When the children arrive home with medication, even if the mother is lazy to go to the clinic but because the medication is there, they now assist their children (caregiver L - Primary school D).

Health education forms part of the school health programme package. The health education given to the children at school helps the children understand their health conditions especially those living with HIV. Reports from the caregivers indicated that majority of them do not have the patience and courage to educate the children about their health conditions especially those living with HIV. Majority of the caregivers are sometimes scared of how the children will react to the information but the education provided in school makes talking to the children about their health challenges easy. A caregiver narrates a situation she witnessed:

There was this woman who was afraid to talk to her child about HIV. The child kept asking why she uses the antiretroviral medications. She said they were told in school that one can only be infected by HIV through sexual intercourse and she has never had sex. How come I am living with HIV? The mother could not tell her that she was born with it. It's really not easy, but she eventually got help from one of the school nurses. They both spoke to the child and explained to her that not all HIV positive people got infected through sexual intercourse; some are infected from birth (caregiver N- Primary school D).

Communication between the schools and caregivers

Communication is a crucial component of health care services. It can be described as the starting point of the health care process (DoH & DBE, 2012). Most of the caregivers mentioned that the schools send letters to inform them about the screening and to obtain their consent for their children to be screened and treated. Another letter is then sent to inform them about their children's health condition and the treatments provided. Some of the caregivers were sent letter to refer the children for further treatment. A few caregivers mentioned that they were informed about the screening, results and referrals through phone calls. The school health nurses and teachers also visit the children and caregivers at their

homes in some cases, especially when they need to inform and educate the caregivers about the children's health conditions as well as to monitor the child's improvement.

The principal called me and explained that there are people coming to screen all the learners. So if you agree that your child can be screened, then you need to sign an informed consent form which I signed. So after they screened him, they discovered a problem they then referred him for further treatment. They wrote me a letter after doing the assessments. They also wrote me a referral letter for the child. I could understand the content of the letter, I then followed the instructions they gave in the referral letter (caregiver L - Primary school D).

Majority of the caregivers are however not satisfied with the way the school communicates with them. Letters are the most common means of information dissemination. These letters are sent through the children but some caregivers complained that the children do not deliver the letters to them. This therefore results in delays in seeking health care services for the children.

A letter was sent to inform us about the child's condition, we were told to take him to the clinic, but the letter stayed for so long in the child's school bag, the child forgot to deliver the letter. We could not take him to the clinic because we didn't receive the letter until another letter was sent (caregiver A - Primary school B).

Another shortcoming of using letters as the main means of communication is that majority of the caregivers does not have any formal education. Caregivers mentioned that they find reading and understanding the information in the letters challenging. This communication challenge contributes greatly to delay in seeking help for the child.

The school sent me letters but I usually see them late, sometimes when I check his school bag, I think he even throw the letters away because he is so playful. But I'm not educated its difficult reading those letters (caregiver O - Primary school D).

However, some caregivers indicated that they received phone calls from the school to inform them about the child's health condition and invite them to school. The school health nurses in some of the schools visit the children at home to check if the health condition is improving and if they are adhering to the treatment regimen. Nevertheless, the home visits (follow-up services) are not frequent.

The school nurse calls me and she comes here often to check on the child, she tries to monitor the treatment process and if the child is taking the medications correctly. She asks if I'm noticing any improvement (caregiver H - Primary school C).

Referral system

As earlier mentioned, children with major ailments and are in need of a more comprehensive assessment and treatment are often referred to the nearest clinics or hospitals. The health facilities where the children are referred to depend on the nature of treatment and management needed by the child. The more severe conditions are referred to the hospitals, where comprehensive treatments can be accessed. Caregivers' accounts however suggest that the referral system is still not well structured as the monitoring, follow-up and feedback components are not adequately carried out.

They said I must take him to the hospital because the knee tumour can only be managed at the hospital, so they referred him to St Mary's hospital. I took him to the hospital and he had a surgery but I have not seen the school nurses since then (caregiver E - Primary school A).

The child was taken to the hospital by the mobile clinic but I was told how the treatment went, I didn't hear from them after the child was taken to the hospital (caregiver A - Primary school B).

Perceptions of quality of care (screening and treatment)

On-site (school health services)

The on-site assessment is the first contact of most school-going children with the health care system. When caregivers were asked to describe the quality of health care services provided on-site, their responses suggest that they are satisfied with the health care services the children obtain in school. They further mentioned that the services are of good quality and effective and reported observing improvements in the children's health condition after receiving onsite treatment.

The cream he was given from school was very effective. The skin problem started healing after a few days (caregiver J - Primary school B).

The child had stomach ache in school. She was given medications in school and by the time she got back home she had stopped vomiting and she was fine (caregiver K - Primary school D).

One of the children was suffering from an infection, they treated her in school and she no longer complains of stomach pains (caregiver M - Primary school D).

The caregivers also mentioned that teachers and school health nurses assume parental roles in school and care for the children. They were impressed by their act of kindness to the children.

I am happy with the way the teachers and the nurses treat the children in school, they become their parents when they are in school and are so concerned about the children's health and entire well-being, only nurses like this that loves children should be sent to schools (caregiver K - Primary school D).

Referral sites

The referral sites are the hospitals and primary health centres the school-going children were referred to. Some of the caregivers stated their dissatisfaction with the reception at some of the referral sites which they associated with the health professionals' attitudes and the long waiting time. Majority of the caregivers were satisfied with the quality of the healthcare services their children obtained from the referral sites.

They rendered high quality services. Series of tests were conducted at the clinic and in the hospital. The treatment helped my child; I'm happy (caregiver B - Primary school B).

I would say I'm happy about the care and treatment they provided to the child when he was sick, the surgery helped a lot (caregiver E - Primary school A).

The fits stopped for a long time when he started taking the medications they gave him at the hospital (caregiver I - Primary school B).

They took out the tooth that was aching the child and also gave her medications for the eyes, we are so happy about the treatment they gave her (caregiver F - Primary school A).

However, some caregivers of children that were taken to the hospital by the mobile clinic stated that they didn't get detailed feedback from the school on the treatment and other health care services accessed by the children. However, some of the caregivers mentioned that:

My child told me that they were welcomed and well taken care of. He said that his eyes were tested to know if he was able to see things that are far or near (caregiver C-Primary school B).

We didn't get feedback about the child's treatment, but he said everything went well and they were treated very well" (caregiver G - Primary school C).

Perceived effectiveness of care services assessed.

The perceived effectiveness of the health care services received by the school-going children was described based on the improvements that the caregivers observed in the children's health conditions. Majority of the caregivers indicated that the children's health improved greatly after they were treated, both on-site and at the different health facilities (referral sites). A caregiver whose stepdaughter had amenorrhea stated that:

The treatment was very effective. When we came back from the hospital i started seeing differences because everything went back to normal. The pills they gave her worked perfectly and everything has been going well (caregiver B - Primary school B).

According to the caregivers, the children's improved health resulted in improved academic performance. A mother whose son had an eye defect said that:

I ask my son about his eyes after he was taken to the hospital, he told me they are no longer painful and he can clearly see now. This time he is trying to do well in school as he is now in grade 5(caregiver C - Primary school B).

Discussion

The study drew on Aday and Andersen's (1974) framework on access to health care to illuminate specific factors that could influence caregivers' access to health care service for their school-going children. By doing this, the study hoped to facilitate an in-depth understanding of factors that influence caregivers' experiences in accessing health care

services for their school-going children in low resources communities, bringing the integrated school health initiative into perspective.

Based on the findings of this study, majority of the caregivers were between 27 and 32 years. Although previous studies have revealed a high prevalence of teenage pregnancy and childbearing as well as teenage parenting among females between the ages of 15 and 19 in South Africa (Kaufman, de Wet, & Stadler, 2001; Christofides et al., 2014), nevertheless none of the participants are teenagers. This could be because children of teenage parents are often taken care of by their grandmothers. It could also be because children of caregivers in this category were not ill and haven't been treated or referred for further treatment from school. Furthermore the findings revealed that, mothers and grandmothers are the most active caregivers of school-going children among participants. In most cases, the weight of the burden of caring for a sick child falls more on the mothers and grandmothers in these communities. Caring for a sick child results in new responsibilities, as well as financial, physical and psychological distress. This provides support for previous studies carried out in some low- and middle- income and high income nations. These studies revealed that mothers are the most active participant in the child health care process and the various responsibilities that accompany caring for a sick child falls on them (Young, Dixon-Woods, Findlay, & Heney, 2002; Gibson, 1995; Smith, Cheater, & Bekker, 2015; Rafferty & Sullivan, 2016; Alsem et al., 2016).

Furthermore, previous studies conducted in West-Africa, United Kingdom and America shows that grandmothers are actively involved in seeking and accessing health care services for their grandchildren as well as taking up the responsibility to take care of their sick grandchildren (Sands & Goldberg-Glen, 1998; Fuller-Thomson, Minkler, & Driver, 1997; Pearson, Hunter, Cook, Ialongo, & Kellam, 1997). Although, no South Africa study have explored the characteristics of caregivers in low resource communities especially within the context of the school health initiative, a study conducted in South Africa by Chazan, (2008) revealed that the responsibility of care for children shifts to the grandmothers especially children orphaned by HIV/AIDS. However, a major concern with referring to Chazan's (2008) study is that it drew on ethnographic and survey data which may not have provided representative information on who is responsible for the care of school-going children. Moreover, the historical context of South Africa health system provided by Coovadia et al., (2009) also revealed that majority of the men migrate from rural to urban communities in search of employment leaving the women, elderly and children back home.

The care of the children therefore falls on the mothers and grandmothers. These findings therefore imply that there is a need to empower caregivers of school-going children who are mainly mothers and grandmothers.

This study shows that school-based health care services (SBHCs) have the potential to effectively provide for the health needs of school-going children. The findings revealed that children are screened for different health conditions that can impact on their learning capabilities. These health conditions were grouped into major and minor ailments. Major ailments are the most critical health conditions that require comprehensive care. These conditions are usually referred to health care centres (hospitals/clinics) when detected on site. They include eye problem, oral health conditions, skin infections, ear problems, mental health conditions etc. Conversely, minor ailments are health conditions that can be easily identified and do not require intensive treatment procedures. These health conditions are usually detected and treated on site by the school health nurses. The health conditions include cold/flu, fever, malnutrition, HIV etc. These health conditions are detected and treated by the school health nurses. This early detection of the health conditions improves the children's learning capabilities and their quality of life.

Majority of the caregivers perceive the school health initiative as one that effectively addresses the health needs of their school-going children. This provides support for a study carried out in Atlanta Georgia to evaluate school-based health care services (SBHCs), the findings of the study revealed that SBHCs are effective in addressing the health needs of school-going children (Keeton, Soleimanpour, & Brindis, 2012). Majority of the caregivers in this present study acknowledged the significance of the school health initiative. They perceived the health care services provided onsite and at the referral sites as cost effective, educative, helpful in detecting and treating the children's health problems effectively. According to the caregivers, they observed considerable improvements in the children's health after receiving treatment. Following the Aday and Andersen's (1974) framework, the ISHP can be described as a major enabling component to accessing health care services for school-going children in low resources communities as it describes different means of making quality health care services available to children.

According to the findings of this study, the school health programme enhances access to quality health care services for school-going children in low resource communities. Access is enhanced by the provision of school-based health services such as: i) screening the children for various health conditions ii) immunization and treatment for minor ailments iii)

referral of children in need of more comprehensive care services to the appropriate sites and transportation to the sites of referral in some cases. According to some of the caregivers of children that were referred for further treatment, the referral letters they were given made access to health care services in the facilities easy. This provides support for the findings of a study conducted in Michigan by McNall, Lichty, and Mavis, (2010) to determine the impact of SBHCs on school-going children. The study revealed that SBHCs provided in low- and middle- income communities increases access to primary health care services for the school-going children as well as their chances to utilize the services. Unfortunately, there is a scant literature on the impact of the South Africa school health initiative on access to quality health care services for school-going children. However, a study conducted before the development of the first school health policy in South Africa by Edwards-miller and Taylor (1998) to evaluate the school health service provided in KwaZulu-Natal, revealed that school health services enhance access to quality health care services for school-going children. Based on the findings of this study, one could infer that the SBHCs foster easy access to health care services for school-going children.

Despite the fact that majority of the caregivers attest to the fact that the school-based screening, treatment and referral services enhance access to health care for school-going children, the study reveals that certain barriers such as low health literacy, financial constraints, distance and transportation to the referral sites, still impedes access. Aday and Andersen categorised these factors under the characteristics of the population at risk and group them into predisposing and enabling factors. The caregivers' predisposing factors include the community and their level of health literacy while family incomes, transportation among others are the enabling factors. Moreover, the findings of a study conducted in New York by Yin and et al. (2012), explain the relationship between these barriers. The authors argue that caregivers with low health literacy are likely to report financial and transportation barriers as their reasons for not accessing quality health care services.

Based on the finding of this study, school-based health care services influence caregivers' health seeking behaviour. This study revealed that only few caregivers would have sought health care services for their children if they were not screened, treated and or referred for further treatment by the school health nurses. Prior to accessing school health care services, most of the caregivers did not realise the need to seek quality health care services for their school-going children. This is partly due to the limited knowledge and information they

have about their children's health challenges. The school health programme increases the caregivers' level of health literacy thereby motivating them to seek quality health care services for their school - going children.

Globally, previous studies among different populations have revealed that low health literacy is related to poor use of health care resources, poor ability to interpret health messages and poor health outcomes (Berkman, Sheridan, Donahue, Halpern, & Crotty, 2011; Yin et al., 2012). Furthermore, a study conducted in South Africa shows that low health literacy is associated with the disparities in health outcomes especially in low resource communities (Hugo et al., 2003) According to the findings of this study, the school health programme is an effective medium to educate caregivers about their children's health. The information provided by the school health nurses about the children's health condition, motivates the caregivers to access quality health care services for their school-going children. According to the caregivers, the children's health condition improves after accessing health care thereby resulting in improvement in the children's academic performances and their quality of life. The school health nurses and the school management can therefore maximize this opportunity to educate caregivers about their children's health conditions. Providing the caregivers with adequate information on how to effectively manage the children's health conditions, the symptoms to look out for in order to identify the different health conditions as well as when and where to seek health care services for the children will further enhance the children's wellbeing.

A systematic review carried out to understand caregivers' health seeking behaviour in sub-Saharan Africa revealed that despite the biomedical explanations of the causes and treatment for childhood illnesses given by medical professionals, caregivers still attribute the causes of some childhood illnesses to supernatural forces and traditional beliefs (Colvin et al., 2013). Furthermore, findings from a previous study conducted in South Africa on causal attribution of illnesses revealed that people living in low- and middle- income settings are likely to attribute illnesses to traditional and religious beliefs which include witchcraft, ancestors' punishment, breaking taboos, heredity etc. (Burns, Jhazbhay, & Emsley, 2011).

However, majority of the caregivers that participated in this present study did not attribute the causes of their school-going children's health challenges to traditional beliefs and supernatural forces. They also did not perceive traditional treatment to be better than medical treatment. Nevertheless, some of the caregivers visited traditional healers and used traditional treatments. This contrast could be because the study was carried out after the

school health intervention which might have influenced the caregivers' current health seeking behaviours and their perception of the children's illnesses. Other direct and indirect means of health promotion and education in the communities could also account for this contradiction.

Based on the findings of the study, unemployment accounts for the financial barrier to accessing quality health care services for school-going children. Majority of the caregivers are unemployed and the few employed ones earn very low income. This lack of steady sources of income was found to influence access to health care services. Before the intervention of the school health programme, caregivers utilized cheap and easily accessible alternatives such as the traditional medicines (*Muthi*), home-made remedies and other natural means of treatments. SBHCs therefore relieve the financial burden of taking the children to health facilities for screening and treatments. Yet, most of the caregivers could not afford the cost of transportation to the referral sites and it was found to be the most common barrier to access. Majority of the caregivers delayed health seeking due to the cost of transportation to the referral sites.

This supports previous studies in South Africa and Afghanistan that posit that people living in rural communities are more likely to delay accessing health care due to financial constraints (Vergunst, Swartz, Mji, MacLachlan, & Mannan, 2015; Trani, Bakhshi, Noor, Lopez, & Mashkoo, 2010). Edwards-miller and Taylor (1998)'s study also revealed that caregivers experience financial problems and majority of the caregivers are unable to afford the cost of medication and transportation to the referral facilities. Although this study was not conducted within the context of a school health policy, however it is the only study I found that explored the challenges caregivers encounter in accessing health care services for their school-going children in South Africa. Despite the fact that this finding was published 17 years ago, financial and transport problems remain major barriers to accessing health care services for school-going children.

Moreover, the delay in seeking health care services for school-going children due to financial problems could result in the deterioration of the children's health conditions thereby affecting school attendance and learning capability. Furthermore, this will undermine the effort of school health initiative in achieving complete well-being for school-going children. This finding indicates that there is a need for policy makers to develop possible strategies to address this transportation barrier to access. This could be in form of providing financial assistance towards the cost of transportation or providing vehicles to

transport the children to the health facilities. It is important to revisit the section of the ISHP that states that the Department of Social Development (DSD) will be responsible for ensuring that school-going children gain access to health care services, which includes providing financial support for transportation to the health facilities they are referred to (DoH & DBE, 2012).

As the findings of this study show, caregivers experienced long waiting time at the hospitals and the primary health centres the children were referred to, which were mostly government health facilities. The findings therefore provide support for previous studies conducted to evaluate the public health sector performances in South Africa which show that long waiting time, noisy and crowded waiting area and also the disrespectful behaviour of health professionals are factors that constitute major barriers to accessing-health care services at government owned health care facilities (Young, 2016; Wadee, Gilson, Thiede, Okorafor, & McIntyre, 2003; Harrison, 2009). According to the findings of this present study, long waiting time together with the unwelcoming attitudes of some of the health professionals constitutes major barriers to access.

These barriers relate to the characteristics of the health care delivery system described by the theoretical framework, which argues that, the structure and organization of the health system influences access. Together these two factors serve to discourage caregivers from seeking health care services for their school-going children. To address the barriers of long waiting hours due to long queues at the government health facilities, there is a need for the policy makers and the CBOs they partner with to consider expanding the range of services provided on-site (in school) in low resource communities. By so doing, the rate of referral and hospital visits will be reduced thereby preventing delay in accessing health care service for the school-going children. Furthermore, increasing the number of mobile clinic visits and the provision of more sophisticated screening and treatments by the mobile clinic could also reduce referral rates especially for the less severe cases.

The findings of a systematic review conducted by Mannava, Durrant, Fisher, Chersich, and Luchters, (2015), revealed that health professionals' attitudes to patients influences health seeking behaviour and quality of care. The health professionals' attitudes and behaviour in this study could however be as a result of the overburdened health system as well as the shortage of human and other resources which is common in low resource communities. However, this barrier results in delaying access to adequate health care services for school-going children. These findings reveal some of the short comings of the public health sector

in South Africa. However, the aim of the PHC re-engineering policy is to address these inadequacies which it hopes to achieve through the three main streams (DoH, 2011). The school health programme being one of the streams is designed to provide comprehensive health services and facilitate access to the health services required by school-going children (DoH & DBE, 2012). It is therefore important to address the factors that influence the health professionals' attitudes and behaviours. As earlier stated, one of the ways to address this is to provide more comprehensive health services in schools. Moreover, organising workshops to educate the health professionals on how to manage stress in the workplace and patiently attend to the patients can also assist in addressing this challenge. A failure to address these challenges will prevent both the PHC reengineering policy and the ISHP from achieving their goals.

The findings of this study reveals that majority of the caregivers are unable to discuss issues around reproductive health, sexually transmitted diseases especially HIV/AIDs with their children. This is because some of the caregivers are hesitant to disclose their status to the children due to the emotional and social effect they perceive it could have on the children. These consequences may include: i) children's anger towards their caregivers ii) children revealing their status to their friends which may result in discrimination (Wiener, Mellins, Marhefka, & Battles, 2007; Mandalazi, Bandawe, & Umar, 2014). The school-based health education therefore fills the void as it increases children's awareness about their health and gives them better understanding of their health condition. This finding provides support for previous studies that shows that school health education has the potential to influence and produce consequential change in school-going children's behaviour and attitude towards HIV prevention, management and stigmatization against people living with HIV/AIDS (Cáceres, Rosasco, Mandel, & Hearst, 1994; Cheng et al., 2008).

According to Bernhardt (2004), communication is a vital component of health care and can potentially influence health seeking behaviour as well as health outcomes. Furthermore, Street, Makoul, Arora and Epstein (2009), emphasized the importance of quality patient/caregivers-clinician communication. According to these authors, quality communication between the health professionals and patients will improve the patients' understanding of the health condition which could empower them to make decisions to access appropriate health care services. The findings of this study equally show that the quality of communication between caregivers and the school health nurses affects the caregivers' level of understanding of their children's health condition as well as caregivers'

ability to make decision to seek quality health care services and adhere to the treatment plans for their school-going children. Therefore, inadequate communication is a serious challenge that could undermine the efforts of the school health nurses and the school health initiative. Based on these findings, one could argue that quality communication between caregivers and the school health nurses is crucial to achieving successful health outcomes for school-going children (Bevan & Pecchioni, 2008). Quality communication between the caregivers and the school health nurses could equally improve caregivers' health literacy which will positively influence their decision to seek health care services for school-going children. The findings also reveal that effective communication between the caregivers and the school health nurses will further strengthen the referral system.

Therefore, in order to overcome the challenges of communication, different information dissemination strategies should be explored by the school health nurses in reaching out to the caregivers. Increasing the number of home visits (follow-up services) could also help in achieving effective communication. This will equally assist in monitoring the children's health condition and also provide opportunities to listen to the challenges caregivers encounter in accessing health care services for their children. Consistent follow-up could enhance the relationship between the caregivers and nurses, and also address the challenges some of the caregivers encounter with understanding the letters. Increasing home visits will also provide the nurses the opportunity to obtain feedback about the services the children accessed both on-site and at the referral sites which can also inform improvements in the quality and range of services provided for school-going children. The caregivers could also reach out to the school health nurses from time to time to inquire about their school-going children's health.

The limitations of this study should be put into consideration when interpreting the findings of this study. Firstly, although the study sought to explore the experiences of caregivers in accessing quality health care services for their school-going children within the school health initiative context, extending the study to other stakeholders of the school health initiative may provide different views on the factors that constitute barriers to access to health care services. Secondly, only few caregivers that met the inclusion criteria were available to participate in the study. An equal number of participants could not be achieved for all the categories of participants. Majority of the participants were caregivers whose school-going children were referred for further treatment by the school health nurses. However, this challenge was addressed by including caregivers of children from different

schools and community settings across all the categories in order to obtain different perspectives from caregivers. Thirdly, the fact that the study was conducted in only three low resource communities in KwaZulu-Natal might affect transferability of the study to other contexts. However different contextual factors may affect the transferability of the findings of this study.

Conclusion

Although ISHP has improved greatly in the area of health assessment, this study however revealed some lapses in the areas of communication between caregivers and the school health nurses. Information dissemination and transportation to the referral sites were the major issues of concern. Given that majority of the caregivers living in low resource communities are mostly unemployed and uneducated policy-makers should pay attention to these factors as they influence caregivers' health seeking behaviour for their school-going children. Furthermore, policy makers should develop interventions that will accommodate caregivers with limited resources so as to address barriers to accessing adequate health care services for all school-going children. Although, various interventions to improve access were stated in the policy, they have however remained on paper. Effort should be made to implement these interventions especially in the areas of communicating with caregivers, providing financial support for transportation and providing follow-up services for children that are referred for further screening and treatment from school. This could help improve the effectiveness of the ISHP and also help in achieving its goal which is to improve the general health of school-going children and address barriers to learning in order to improve educational outcomes.

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Appendix A

INFORMED CONSENT LETTER

My name is Gbotemi Bukola Aloro. I am a Health Promotion and Communication Masters student, studying at the University of Kwa-Zulu Natal, Durban, South Africa. I am interested in Caregivers' experiences in accessing health care services for their school-going children in the scarce resourced peri-urban communities of KwaZulu-Natal, South-Africa. To gather the information, I will ask you some questions only if you agree to speak to me.

Please note that:

- Your confidentiality is guaranteed as your inputs will not be attributed to you in person, but reported only as a population member opinion.
- The interview may last for about 40 to 60 minutes and may be split depending on your preference.
- Any information given by you cannot be used against you, and the collected data will be used for purposes of this research only.
- Data will be stored in secure storage and destroyed after 5 years. Only my supervisor will have access to the data.
- You have a choice to participate, not participate or stop participating in the research. You will not be penalized for taking such an action.
- The research aims at: investigating the prevalence and patterns of health conditions among primary school learners, exploring stakeholder's perceptions regarding the implementation of the ISHP, conducting an audit of the screening and referral process and patterns and assessing referral wait times and referral outcomes at primary and secondary referral points (clinics).
- Your involvement is purely for academic purposes only, and there are no financial benefits involved.
- If you are willing to be interviewed, please indicate (by ticking as applicable) whether or not you are willing to allow the interview to be recorded by the following equipment:

	willing	Not willing
Audio recording		

I can be contacted at:

Cell Phone: +27 62 0921081

Email: gbotemialoro@gmail.com

My supervisor is Dr Olagoke Akintola who is located at the School of Applied Human Science, Durban at the University of KwaZulu Natal.

Contact Details:

Phone number: +27 31 260 7426

Email: akintolao@ukzn.ac.za

You may also contact the Research Office through:

HSSREC Research Office

P. Mohun

Contact Details:

Phone number: +27 31 260 4557

Email: mohunp@ukzn.ac.za

INFORMED CONSENT FORM

I..... (full names of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project. I understand that I am at liberty to withdraw from the project at any time, should I so desire without any negative consequences.

Signature_____

Date_____

Zulu Version

INCWADI YEMVUME

Mina, _____Sengfundile mayelana nokuqukethwe inhlolovo. Ngियाqonda izincazelo zenhlolovo njengoba ngazisiwe futhi ngachazelwa ngazo ngomlomo. Isiphenduliwe imibuzo yami ngalenhlolovo, ngakho ngियाqonda ukuthi yini ebhekeke kimina uma ngiba yingxeny yalenhlolovo.

Signature_____

Usuku:

Appendix B

Interview guide

A Demographics/ characteristics of caregivers

- Age
- Gender
- Race
- Employment status / Occupation
- Marital status
- Relationship with the child

B Child's demographics

- Age
- Gender
- Grade

Experiences of caregivers in accessing health services/ help seeking behaviour

- Health condition/ problems/ challenges of the child
- When was the problem noticed/when it started
- How was the health problem identified
- Who identified the health problem
- When did they start seeking help for the child
- Where did they seek help from
- What are their experiences of accessing health care services for their children
- What challenges did they encounter in accessing care services in accessing care for their children

Barriers to accessing health care services

- What are the cultural beliefs associated with the child's health condition
- Did they experience any form of financial barrier to accessing care
- How will they describe their entry into the health care system
- How will they describe the referral system (if referred from school)
- How will they describe their travel and waiting time
- How will they describe the type (quality) of treatment their children received and the care team involved in the care services

Caregivers' perception of the school health program

- The quality of care given to the children
- The effectiveness of the school health programs
- The degree of communication/information they received about their children health

Experiences in utilizing available health care services

- How will they describe the type of care services provided in the schools?
- Will they describe the health care services provided in the clinic / hospital as satisfactory?

Appendix C

Ethical Clearance