An exploration of the learners' perceptions, awareness and satisfaction regarding the implementation of Integrated School Health Programme (ISHP) in selected secondary schools in uMgungundlovu district, in Kwazulu-Natal, South Africa

A dissertation submitted in partial fulfilment of the academic requirements for the degree of Master of Nursing (Community Health Nursing), in the School of Nursing and Public Health, College of Health Sciences, University of KwaZulu-Natal

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DECLARATION

I, Thabisile, Rebecca Khoza, declare that this dissertation entitled "An exploration of the learners perceptions, awareness and satisfaction regarding the implementation of integrated school health program (ISHP) in selected secondary schools in uMgungundlovu District in Kwazulu-Natal, South Africa" is my own work. It is being submitted for the degree of Masters in Nursing Community at the University of KwaZulu –Natal, Durban. It has not been submitted for any other purpose. All resources have been acknowledged by means of referencing.

Students Signature: …………………………   Date: …………………...

Supervisor's Signature: …………………………...   Date: ……………………

DEDICATION

This dissertation is dedicated to my Beloved mother, Bettina Sibisi, my siblings and my son Sizwe Khoza, my friends and Professor G.G. Mchunu for their love and encouragement.

ACKNOWLEDGEMENT

ABSTRACT

When learners are subject to adverse health risks, school attendance and academic performance are correspondingly affected. This phenomenon is a nationally and internationally recognized problem considering healthy youth productive to members of the society. The Department of Health (DoH) has introduced a re-engineering program for primary health care of which school health programs are one of three main areas of the primary health care services focusing on, but not limited to immunization, teenage pregnancy education about Human Immune Deficiency Virus /Acquired Immune Deficiency Virus (HIV/AIDs), and screening for health problem such as poor eyesight and hearing impairment. In 2012, the new Integrated School Health Program (ISHP) was piloted in very poor schools in the provinces of KwaZulu-Natal, Gauteng and Limpopo.

This study examines the learners' perceptions, awareness and satisfactions regarding the implementation of the ISHP services in uMgungundlovu, District, in KwaZulu-Natal, South Africa. A quantitative, non-experimental, descriptive design was used in this study to collect data from the four selected secondary schools to reach the following objectives: To determine the extent to which the ISHP is reaching people it is intended to effect; to describe learners' perception regarding the implementation of ISHP; and to determine the learners' level of satisfaction with the implementation of ISHP.

The total population of the study was expected to be 300 respondents from age 13-16 years which was calculated using a sample size calculator. The sample was 75 learners according to the percentages of the population in secondary schools and the grades of the study of the respondents. However, only 269 learners agreed to participate which left the response rate at 80.4 percent. Data was collected using a self-administered questionnaire after obtaining ethical clearance from the University and were analysed descriptively.

The findings revealed that participants perceived that school health nurses who are coming to visit the school once in 6 months only 20.1 percent had never seen school health nurses in the schools, 16.4 percent were learners and 4.1 percent were learners saying school health nurses visit weekly. According to the ISHP, oral health 35.3 percent were offered in their schools ,vision 27.1 percent ,immunization 19.7 percent, TB screen 17.1 percent and anaemia 4.1percent. This indicated that learners in rural areas were likely to receive oral care, hearing care, speech care and TB screening. Awareness about ISHP services offered in their schools as "know your body" revealed 48.7 percent of learners showed that they know about these

services. HIV/AIDs 26.0 percent, medical male circumcision 22.3 percent, sexual reproductive 30.5 percent, and learner referral 14.9 percent. Learners were not sure about learners' health problems, physically and emotional challenges educators are not equipped to deal with or do not have sufficient time to manage. It was found that 61 percent had a high perception, 31.5 percent, had a medium perception and 7.4 percent had a low perception about ISHP implementation in the school.

It was concluded that the implementation of the programme is not consistent with the objectives of the School Health Policy (ISHP, 2012). Due to lack of infrastructure and shortages of nurses, the ISHP did not cover all schools. These findings were not expected and they came as a surprise to the researcher. Conclusion made from the research findings, contributed to recommendation for nursing practice, nursing education and nursing research to enhance the quality of life of learners of ages between 13 to 16 years through comprehensive school health services.

Key Words: ISHP, *Learner, secondary schools, perception.*

LIST OF ABBREVIATIONS

- CBE: Community based Education
- CBD: Community based development
- CISHP: Comprehensive Integrated School Health Programme
- CBD: Community Based Organisation
- DoBE: Department of Basic Education
- DOE: Department of Education
- DoH: Department of Health
- ENHPS: European Network of Health Promoting Schools
- Freq: Frequency
- HPSI: Health Program School Initiative.
- ISHP: Integrated School Health Programme
- ISHP: Integrated School Health Policy
- KZN: KwaZulu –Natal
- NGOs: Non–Governmental Organisation /s
- NSDA: Negotiated Service Delivery Agreement
- NASN: National Association of School Nurses
- N: Population
- PHC: Primary Health Care
- n: sample size
- SGB: School Governing Body
- SPSS: Statistical Program for Social Science
- YRBS: Youth Risk Behaviour Survey
- UNICEF: United Nations International Children
- UNESCO: United Nations Educational Scientific and Cultural Organisation
- WHO: World Health Organisation
- WWW: World Wide Web
- X2: chi square

OPERATIONAL DEFINITIONS

The following operational definitions are used in the study:

- Health Promoting School (HPS): In the current study, the HPS is taken as an effective way to improve learner's health and their ability to learn as it is recognised globally and consequently as endorsed and supported by the World Health Organisation (WHO) and the National Department of Health (NDOH, 2014).

- Implementation: The interventionist fidelity to the various elements of an intervention's protocol, including consistency of delivery as intended and the time and cost of the intervention (RE-AIM, 2017).

- ISHP: For the current study, ISHP is taken as outlining health departments' responsibilities at national, provincial, district, primary health care facility and school levels. It thus recognises that strong partnerships between schools, communities and service providers are critical. In this regard, the policy describes how school health teams were based in primary health care clinics (PHC) and led by a professional healthcare staff (in this case a nurse), who may also be assisted by an enrolled nurse or nursing auxiliary. The health care staff will coordinate the delivery of school health services, do learner assessments and provide services on the sites, while health education were delivered by the key health promoters/stakeholders or community health workers (Department of Health and Basic Education, 2013).

- Program participants: In this study, these are the program key stakeholders; school teachers & the health staff that are meant to implement the ISHP and the learners that are participating in the ISHP.

- Secondary School: The federally designated, graduation separated classification of grades 8-12, regardless of whether, or not they're compiled together in one school or separate from the other grades.

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CHAPTER ONE

INTRODUCTION AND BACKGROUND OF THE STUDY

1.1. Introduction

The dissertation examines the learners' perceptions, awareness, and satisfaction regarding the implementation of the Integrated School Health Programme (ISHP) in selected secondary schools in uMgungundlovu District, KwaZulu-Natal in South Africa. Therefore, this chapter introduces the study by presenting the general background of the research; the research problem; purpose of the study; the research objectives; the research questions; significance of the study; preliminary literature review; research methodology; the structure of the research; definition of key terms used in the study; the theoretical framework; the application of the study; and the study outline.

1.2. Background of the study

In 2011, the South African National School Health Policy was revised by the Department of Health (DoH) in collaboration with the Department of Basic Education (DoE). The revised policy made way for the launching of the Comprehensive Integrated School Health Programme (CISHP) which was published in 2012. It caters for all learners in grade R to 12. This ISHP incorporated the principle of equity and human rights for learners, with specific consideration to the availability of resources required to cover all learners (Berry, Busch, De Leeuw, & Schrivers, 2013). The ISHP is a programme which has been developed over the last decade to address school health in a more comprehensive way. It represents a settings approach where different aspects of schools are considered to improve the health opportunities for learners (Lee, 2009 ;2014). In most cases, the Integrated School Health Programme is meant to incorporate school health services and school health education, and the school health environment as components (Murray, Low, Hollis, Cross, & Davis, 2007). With regards to the aforementioned components, quite a number of education and health stakeholders are increasingly becoming interested in ISHP hence, they are involved in partnering with education institutions to protect and improve the health of learners and school personnel (Allensworth and Kolbe 1987; Allensworth 1995). This has necessitated the introduction of the PHC re-engineering strategy to further strengthen the implementation of ISHP.

1.2.1. PHC Engineering

PHC re-engineering is the strategy based on the Negotiated Service Delivery Agreement (NSDA) signed by the Minister of Health and numerous other Cabinet Ministers and Provincial Members of the Executive Council (Naledi, et al., 2011). According to Naledi et al. (2011), PHC re-engineering is the key to the success of the NSDA implementation process and seeks to shift the PHC system from a largely passive, curative, vertically and individual oriented system to one with more proactive, integrated and population based. The main focus of PHC re-engineering is to strengthen the district health system and do the basic better Health and Welfare Sector Education and Training Authority, 2011). The National Council has adopted the three streams to be implemented in the PHC re-engineering, they are: (a) the deployment of ward based PHC outreach teams; (b) strengthening of school health services; and (c) deployment of district clinical specialist teams aimed at improving maternal and child health (NDOH, 2011). Naledi et al. (2011) state that one of the PHC streams envisaged is the effective implementation of national school-based PHC system led by nurses. One of the priority areas in the PHC re-engineering strategy is school health services, starting with the schools in the lowest socio-economic areas and crèches (Naledi, et al., 2011). Naledi et al. (2011) conclude that the effective implementation of PHC re-engineering requires the mobilisation of strategic partners, including health workers, academic institutions, professional bodies, unions, the private sector, other government departments, civil society, and communities.

1.3. Problem statement

There are varying perceptions on how the school teachers are meant to be implementing ISHP programmes, and understand the revised school health promotion initiatives such as the ISHP. It is still not clear if schools in the KwaZulu-Natal Province are implementing the ISHP as stipulated in the DoH policy. Notwithstanding, the fact that ISHP has existed in SA schools since 2012, documented literature shows that there are only a few evaluation studies conducted to follow up on the progress of the implementation of such programmes in schools. Relevant literature has mainly revealed a lack of proper infrastructure and inequity in the distribution of resources in schools, revealing many disparities between urban and rural schools (Swart & Reddy, 1999). In this regard, the evaluation would be critical to monitor and document programme implementation and can subsequently, aid in understanding the

relationship between specific programme elements as well as improving the programme outcomes. This is made possible since the process evaluation data is used to fine-tune the programme, and hence, help to keep the programme on track. Thus, the evaluation may be used to confirm whether the intervention was indeed implemented before using resources to assess its effectiveness. (Scheirer, et.al., 2013; Bartholomew, et. al., 2011).

1.4. Study Purpose and Objectives

This study aims to determine the perception, awareness and satisfaction of the learners in the implementation of the Integrated School Health Programme (ISHP) in selected secondary schools in uMgungundlovu District of KwaZulu-Natal Province.

1.4.1. Study objectives

To reach the above aim, the study had the following objectives.

1. To determine the extent to which the ISHP is reaching the people it is intended to reach.
2. To describe learners' perception regarding the implementation of ISHP in selected secondary schools in uMgungundlovu District.
3. To determine the learner's awareness regarding the implementation of ISHP
4. To determine the learners level of satisfaction with the implementation of ISHP in the selected secondary schools in uMgungundlovu District.

1.5. Research questions

The following research questions motivated the study.

1. What is the extent to which the ISHP is reaching the people it is intended to affect?
2. What are the learners' perceptions regarding the implementation of ISHP in selected Secondary Schools in uMgungundlovu District?
3. What are the learners awareness of the implementation of ISHP?
4. What is the learners' level of satisfaction with the implementation of ISHP in the selected secondary schools in uMgungundlovu District?

1.6. Significance of the study

It is normally a noble idea that after any programme has been initiated; it will need to be evaluated after some time in order to assess the successes and limitations of the initiative, and in order to determine whether the programme should continue (Polit & Beck, 2012). The proposed study is thus expected to provide answers that would have critical policy implications by enhancing or assisting with the improvement of the outcomes of the Integrated School Health Programme, and influence school health promotion policy training through the nursing curriculum and hence, recommend for future research. Consequently, the outcome would in the long run, be used to successfully convince policy makers to fund school health programmes. Therefore, a comprehensive system is needed to evaluate the value of these programmes to add value to the decision-making process by assisting decision makers through the clarification of various ways in which a given policy could influence health by making sure that health considerations are never overlooked (Thacker, et al., 1994; Kemm, 2001). Furthermore, the majority of the policy makers and funders have become progressively concerned with allocating scarce resources to those programmes that are effective and efficient (Pluye, Potvin & Denis, 2004; Hall-Beyer, 2012).

Policy: The proposed study is thus expected to provide answers that would have critical policy implications by enhancing or assisting the Integrated School Health Programme, training, and future research. Consequently, the outcome would, in the long run, be used to successfully convince policy makers to fund school health programmes. It will benefit the country and it will influence the government of national unity to change policies in schools, which will promote health and well-being of the learners, thus improving, the health status of learners and decreasing morbidity rate.

Nursing Education: The study has the potential to help nursing educators to improve their teaching skills in school health nursing, thus bridging the gap between theory and practice. The study may benefit educators and learners in identifying health problems affecting learners and ways to overcome them.

Nursing Research: The study has the potential to motivate other researchers to conduct more studies in mixed methods, thus gaining more knowledge and information on ISHP.

Nursing Curriculum: The curriculum needs to be revised to be in line with the Integrated School Health Policy to identify and meet the needs of the learners in disadvantaged communities.

Further Research: The researcher may benefit by gaining knowledge; the majority of the policy makers and funders have become progressively concerned with allocation of scarce resources to those programmes that are effective and efficient.

1.7. Operational Definitions

The following operational definitions are used in the study:

- Health Promoting School (HPS): In the current study, the HPS is taken as an effective way to improve learner's health and their ability to learn as it is recognised globally and consequently as endorsed and supported by the World Health Organisation (WHO) and the National Department of Health (NDOH, 2014).
- Implementation: The interventionist fidelity to the various elements of an intervention's protocol, including consistency of delivery as intended and the time and cost of the intervention (RE-AIM, 2017).
- ISHP: For the current study, ISHP is taken as outlining health departments' responsibilities at national, provincial, district, primary health care facility and school levels. It thus recognises that strong partnerships between schools, communities and service providers are critical. In this regard, the policy describes how school health teams were based in primary health care clinics (PHC) and led by a professional healthcare staff (in this case a nurse), who may also be assisted by an enrolled nurse or nursing auxiliary. The health care staff will coordinate the delivery of school health services, do learner assessments and provide services on the sites, while health education were delivered by the key health promoters/stakeholders or community health workers (Department of Health and Basic Education, 2013).
- Program participants: In this study, these are the program key stakeholders; school teachers & the health staff that are meant to implement the ISHP and the learners that are participating in the ISHP.
- Secondary School: The federally designated, graduation separated classification of grades 8-12, regardless of whether, or not they're compiled together in one school or separate from the other grades.

1.8. Conceptual frameworks of the study

A conceptual framework helps to guide the methods and interventions to be used in a process evaluation appropriately (Polit & Beck 2012). This study was guided by two conceptual frameworks which are; Reach, Effectiveness, Adoption, Implementation and Maintenance (RE-AIM) and Logic Models. An extensive description of each model follows below.

1.8.1. RE-AIM model

The RE–Aim model is used for evaluating public health interventions that assess five dimensions; reach, efficacy, adoption, implementation, and maintenance. Therefore, since the current study assesses and evaluates the school health programme, it was useful to apply the RE-AIM framework in assessing school health services and health-promotion programmes at schools. The model was successful in assessing the health promotion intervention of school children in America, and thus, is valuable as it had positive results (Glasgow et al., 1999). Moreover, using this model allows for a comprehensive assessment of school children's health needs (DOH, 2011).

RE-AIM was developed to enhance the impact of health promotion interventions by evaluating the dimensions such as capacity to be considered. The most relevant to real world implementation reach underserved population and to be adopted within. A conceptual framework helps to guide the methods and interventions to be used in a process evaluation (Polit & Beck, 2012).This study will be guided by two conceptual frameworks that is RE-AIM and the Logic models. According to Glasgow, Vogt, and Boles (1999), the RE-AIM model helps in reminding us of the key purposes of public health and community interventions whereas the Logic Model is a set of parts which are coordinated in order to accomplish a set of goals (Churchman, 2002). Figure 1.1. Below shows the five (5) dimensions of the RE-AIM model. These elements can be used in assessing and evaluating the school health programme. Since the current study will be assessing and evaluating the Integrated School Health Programme, it will be useful to apply RE-AIM framework in assessing the ISHP.

The model was successful in assessing the school health programme intervention of school children in America and is valuable as it had positive results the (Glasgow et.al., 1999). Moreover, using this model will be allowing for a comprehensive assessment of school children needs (DoH,2011).

Figure 1.1 shows the five (5) elements of the RE-AIM model. These elements can be used in assessing and evaluating the school health programme.

1.8.1.1. Elements of the Re-Aim Model

- Reach: The absolute number, proportion, and presentation of individuals who are willing to participate in each initiative, intervention, or programme.

- Effectiveness: Is the impact of an intervention on important outcomes, including potential negative effects, quality of life, and economic outcomes.

- Adoption: The absolute number, proportion, and representativeness of settings (e.g., health departments) and interventionists (e.g. nurses, educators) who deliver a programme.

- Implementation: The interventionist' fidelity" to the various elements of an intervention's protocol, including consistency of delivery as intended and the time and cost of the intervention.

- Maintenance: The extent to which a programme becomes institutionalized or part of the routine organizational practices and policies.

- A theoretical framework helps to guide the methods and interventions to be used in a process evaluation appropriately (Polit & Beck, 2012). In most cases, health promotion and education programs normally seek to made meaningful improvements in population health with limited resources. It is therefore a complex, multilevel challenge (Brown et.al; 2012; Green, 2005).

In this regard, currently there is little agreement on the criteria necessary to make concrete conclusion that a program has produced a significant public health impact (Glasgow, 2003; Des Jaris, 2004, Dzewaltowski, 2004). Hence, standard metrics that accurately summarize complex and multidimensional outcomes would be critical. In America for example, a current model used is the RE-AIM framework which offers a comprehensive approach to considering five dimensions important for evaluating any potential public health impact of an intervention (Glasgow ,1999,2003). The Re-Aim model is used for the evaluating any potential public health interventions that assesses 5 Dimensions: Reach, Efficacy, Adoption, Implementation and Maintenance. Therefore, since the current study will be assessing and evaluating the Integrated School Health Programme, it will be useful to apply the RE-AIM model in assessing the school health

services and health promotion in schools. The model was successful in assessing of health promotion intervention of school children in America and thus is valuable as it had positive results then (Glasgow et al. 1999). Moreover, using this model will be allowing for a comprehensive assessment of school children's health needs (DoH,2011).
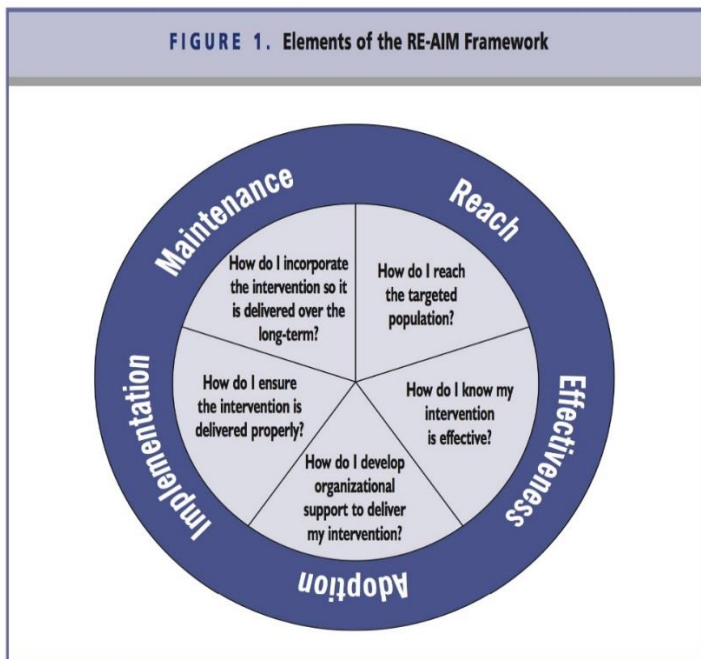
Figure 1. 1Represents RE- AIM Evaluation Model

1.8.2. Logic Model

Churchman (2002), describes a Logic Model as a set of parts which are coordinated in order to accomplish a set of goals. The Logic Model is complete when it covers all the processes, inputs, and outputs for example activities and participants' outcomes impact of the implementation of the programme. The model, therefore, depicts the evaluation of the programme as three tiered.

Figure.1.2. below shows the three (3) elements of the Logic model. These elements can be used to monitor programme evaluation.

1.8.2.1. Elements of a logic model

Inputs: Are the resources that are made available for the planning, implementation, and evaluation of projects, for example, inputs are human resources, funding, facilitators, equipment, curricula, teachers and key informants.

Process: Process evaluation involves documentation and description of specific programme activities such as how much of what, for whom, when, and by whom. It includes monitoring the reach and participation by the target population. Process evaluation assesses if the programme reached the intended population.

Outputs: Are divided into activity outputs and are educational programme components e.g., classes, newsletters, demonstrations, and participant outputs are the demographics of the individuals, families, and communities who are reached.

Outcomes: Describe the changes that occurred because of the programme outputs. In this study, only short-term outcomes, namely, awareness and satisfaction with the programme will be explored.

The Logic model
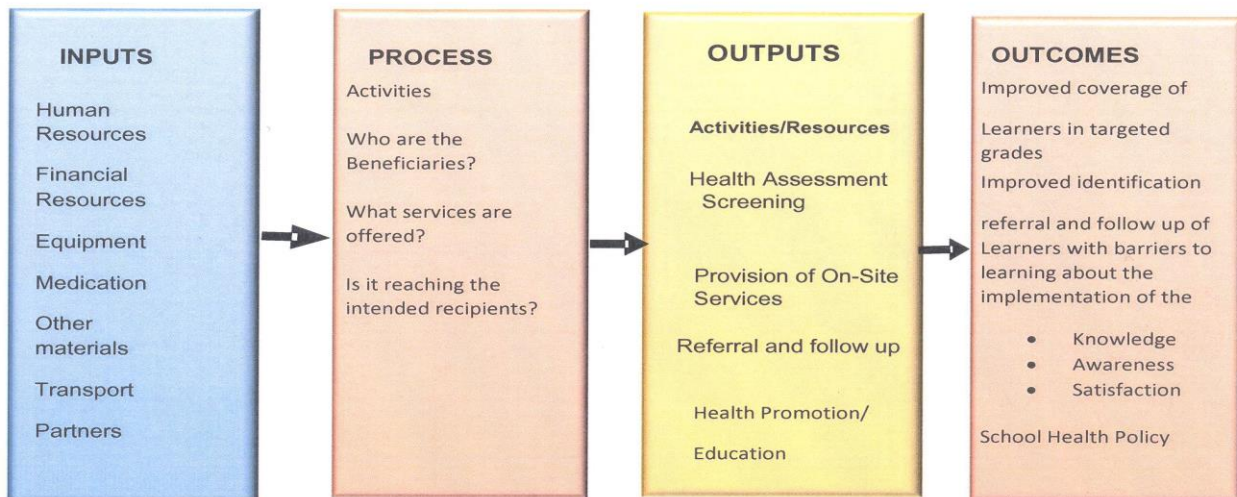
Figure 1.2. shows three elements of the Logic model

The programme will be guided by study objectives in conjunction with the conceptual framework.

- To determine the extent to which the ISHP is reaching intended people
- To describe learners' perception regarding the implementation of ISHP in selected secondary schools.
- To explore the learners' awareness regarding the implementation of ISHP.
- To determine the learners level of satisfaction with the implementation of ISHP in the selected secondary schools in uMgungundlovu District.

  An evaluation progress in the implementation of school health programmes will include Inputs, Processes, and Outputs and Outcomes in conjunction with study objectives to explain the evaluation of the progress towards the implementation of the programme.

  Objective no1 will be aligned with the inputs which explains the resources that will be utilized in the programme. For example, policy support, evaluation programme sustainability, and people that will be dedicated to or influenced by this programme, laws and regulations, partnership, people and nurses.

Process/activities looking at:

Who are the beneficiaries of this programme?

What will the programme do?

Develop policies

Outputs are those things that we do (providing products, goods, services to programme customers), and the people we reach (informed consumers), knowledge, decision makers, what we do, who we reach. The output will refer to this programme reaching the people, clients, decision makers, and nurses. Describing our outputs allows us to establish linkages between the problem (situation) and the (intended outcomes). The people who the researcher will reach also are outputs of the programme and will be the centre of our model. They constitute a bridge between the problem and the outcome. Are the participants satisfied regarding the programme/activities that are implemented? How was it implemented? It is aligned with objectives 3 and 4?

- **Outcomes** are short term and answer the questions. They are aligned with 4 objectives the programme intended to meet. What is the current situation that we intend to reach?

Evaluation Objectives	Evaluation Question	Research Question	Data Collection Methods	Data Collection/Tools	Respondents	Responsible	Time
What specific area does the evaluation specifically targeted?	What do we want to know about this program?	What are the questions addresses this evaluation questions?	What data collection method will be used to measure the indicator?	What specific tool will be used?	Who will provide the information needed?	Researcher	
To describe learners' perception regarding the implementation of ISHP	What are the learners' perceptions towards ISHP	What are the learners' perceptions regarding the program?	Self-Administered questionnaire	Self-Administered questionnaire	Learners/Participants	Researcher	
To explore the learners' awareness regarding the implementation of ISHP.	What are the benefits towards learners' awareness regarding the activities that are implemented in the ISHP?	What are the learners' exploration regarding the implementation of ISHP	Self – Administered Questionnaire	Self – Administered Questionnaire	Learners /Participation	Researcher	

To determine the level of satisfaction with the implementation of ISHP	What are the learners' satisfaction regarding the implementation of ISHP	Learners provide feedback on the program	Self-Administered Questionnaire	Self-Administered Questionnaire	Learners /Participants	Researcher	
To determine the extent which the ISHP reaching the people it is intended to affect.	Is the programme reaching the intended recipient? What are the demographics characteristics of the learners?	What is the extent to which the ISHP reach the people? How is the program being implemented? What are the activities being involved in the implementation?	Self – Administered Questionnaire	Self – Administered Questionnaire	Learner/Participants	Researcher	

Table 1.2. Illustration of the evaluation of Logic model

Knowledge on how to be involved in these services/knowledge of customers to understand the cause of problems and potential solutions.

- Awareness of the programme
- Satisfaction about the implementation of the services.
- Intention
- Skills and competence are in place/customers possess the skills needed to resolve the situation
- Improved policies of a sustainable workforce
- Motivation of the customers to have the desire to effect change.
- Attitudes of the customers who believe their actions can make a difference.

An evaluation of progress in the implementation of the school health programme will include implementing School Health and Educational policies that include multidisciplinary teams and stakeholders; the education sector including schools and teachers, the health sector and health promotion service providers, the students and health promotion researchers, parents and even the community at large in the programme (Parsons et al. 1996; Barnekow et al. 2006).

Whatever the misdistribution of policies and learning environments, not including the community to look after the school during school holidays, no meetings to include the community, no participation of the parents in the upkeep of the gardens, and no proper toilets which can lead to spread of diseases (DoH, 2012).Infrastructure improvement led themselves to HPS activities in parallel for an example is the "tippy tap" which facilitates hand washing as an avenue to hygiene education (Zanget et al., 2012).Novel sanitation in the form of environmentally friendly toilets links with clean water and environmental education and the prevention of diarrheal diseases. School based garden projects (Beery et al., 2014) foster a range of skill development in participating with children as evidenced by evaluation of the programs in the UK (Royal Horticultural Society, 2012).

 Moreover, it shares some characteristics of evaluating the programme and implementation. Intersectoral collaboration, multidisciplinary action and partnerships are important requirement of public health"(Sambo,2012,p.3).The necessity for such collaboration across sectors" in the context of HPS has been recognised previously (Verganin et al.,1998),development of HPS network identified as a way to encourage greater intersect oral cooperation (Swart & Reddy, 1999; Dharamsi et al., 2014; Lee et al., 2014),and experience of

this occurring in a university – driven South African HPS program reported (Preiser et al.,2014).

The focus would, therefore, be on key stakeholders involved in selected secondary schools as possible participants. The prospective secondary schools to be selected would have at least 700 or more learners; Grade 8 to 10 learners should be represented in the school; the secondary schools should represent learners between 13 and 16 years; and these schools should represent the socio-economic and cultural diversity of the uMgungundlovu District in the context of the research both in the rural and urban areas.

These evaluation models are aligned with the Logic Model that is used as the conceptual framework. The Logic Model looks at inputs, outputs, and outcomes. This study was shaped and guided by the conceptual framework as adapted from the logic model for programme planning and evaluation which was prepared by Karen Horsch, an evaluation consultant in October, (2002).

1.8.2.3. Application to the study

The evaluation framework was developed from the Logic model described here and is based on a health and education framework covering appropriate short indicators. The tool for evaluating the implementation of School Health promotion can identify methods by which the schools can be more effective as health promoting institutions and factors that influence this process. The Logic Model evaluates and assesses what was gathered from the schools using their own resources. (Churchman, 2002)

1.9. Preliminary literature review

In the early 1960s, several conferences and meetings took place between the World Health Organization (WHO) and the United Nations Education, Scientific and Cultural Organization (UNESCO) to determine how school health could be improved (Bradshaw et al., 1964; Ayila et al., 2014). A publication was released in 1966 which was one of the first international documents to pragmatically address the planning and implementation of school health programmes (Sibandze et al., 2014; Sinthumunye & Munyati, 2014). Gibbes et al. (2010) claim that many similar principles and recommendations that can be seen running through these documents. The building blocks of the Health Promoting School (HPS) and Comprehensive School Health Education (CSHE) frameworks which emerged in the 1980s

and 1990s had clearly been articulated many years earlier. Another influential stimulus for school health was to be found in the Declaration of Alma-Ata World Health Organization (Clay, 1988). This statement came out of a major International Conference on Primary Health Care held in Alma-Ata, which called on all governments "to formulate national policies, strategies and plans of action, to develop a multi-sectorial approach to involve citizens in forecasting, organization, operation and control of Primary Health Care, and to focus on education as a means of preventing and controlling health problems" (St. Leger, 1999; Wardell et al., 2003; Strand et al., 2008; Oloukoi et al., 2014). Furthermore, the WHO reported:

> The Declaration of Alma-Ata was the first international attempt at this high level to pinpoint the myriad of factors influencing health and thus provides emphasis for developing strategies by the member states of the WHO. The focus of the Declaration of Alma-Ata was that it brought in the idea of Health for all needs to be realized come the year 2000 (Ayila et al., 2014). This prompted a closer examination by governments and Health Authorities about how this could be achieved. The Ottawa Charter for Health Promotion was another major milestone in influencing the direction of Health Promoting Schools (WHO, 1986). Its core objectives were to: (i) build health public policy, (ii) create a supportive environment, (iii) strengthen community action, (iv) develop personal skills and (v) reorient health services (WHO, 2013).

1.10. School Health in Africa

Within sub-Saharan Africa, health promotion initiatives have recently been facing several challenges. The health challenges facing children in African countries are recognised to be considerable while the resources available for both health and to provide for their education are in contrast limited. The gross inequities in health within and between countries present a challenge to the World to address the social determinants of Health (Marmot, 2005). For this reason, the World Health Organization (WHO) health promoting schools (HPS) model is a relevant concept for Africa as potential means of driving improvement (WHO REGIONAL OFFICE for Africa;2013), yet a 2004 review found no evaluations of HPS initiatives from Africa (Mukoma & Flisher,2004). However, potential of health promotion in the school health setting is flexible, inexpensive and effective intervention in sub-Saharan Africa, and low and middle-income countries elsewhere is evident. The activities of the WHO regional Office of Africa(WHO/AFRO) are driving change ,the Stellenbosch consensus statement on HPS provides a benchmark on HPS relevant to Africa (Macnab,2013,as are some reports of other global evidence on the effectiveness of HPS (Macnab et al., 2014), Health benefits can

be achieved in parallel with the recognized advantages of motivating girls and boys to pursue and value educational opportunities .The WHO/AFRO health promotion cluster provides leadership ,guidance and technical support in the formulation ,implementation, monitoring and evaluation of health promotion policies ,plans strategies and programs in order to accelerate the response to the determinants of health and address priority public health issues in the African Region(WHO Regional Office for Africa,2013).The focus is on priority public health issues include :maternal and child health ; HIV/AIDS,TB and Malaria ,diabetes hypertension, cancer ,violence, injuries and other non-communicable conditions; environmental degradation; water sanitation and hygiene ;polio, leprosy and other neglected tropical diseases; and new threats to health(e.g. climate change ,pandemic influenza rapid urbanization),WHO,2013).In addition guidelines for interventions were generated, and training workshops held to promote use of tools to address prevention and control of non-communicable disease. Conference activities have resulted in declarations calling for and outlining priorities to improve health of several specific populations and the World Health Assembly has adopted a series of far reaching resolutions (WHO Regional Office FOR Africa ,2013) However the potential for applications of the WHO model to contribute to progress in sub-Saharan Africa has still as yet to be widely recognized in mainly countries ,and severe problems with health and development are occurring especially regarding educationally driven elements of development policy (Sippel et al., 2011) Challenges recognized to exist include variation in motivation and leadership from ministries in the context of promoting HPS initiatives (WHO,2012),and limited institutional relationships and partnerships in the community (Fawcett et al.,2010) In many countries in Africa the "health systems are subject to powerful social and economic influences that often pull them from their intended goals" (Sambo,2012,p.3), and education systems faces challenges due to recognized deficiencies in terms of infrastructure and resources and lack of motivation among teachers in schools (Swart and Reddy,1999,2014)..In fact, Lundqvist (1961) points out that the state of health in a majority of these sub-Saharan states is worse than in any other region, thus, earlier studies have indicated that the region is not actually on track in achieving any of the United Nation's Millennium Development Goals since focus has shifted away from the ideals of the Ottawa Charter to different countries' individualistic behaviour change approach (Lundqvist, 1961; Breebaart et al., 2001). Such shifts are as a result of political choices of governments which normally come with consequences such as those that have favoured technocratic approaches over harnessing the popular mobilizations that have been known to accompany national struggles (Lundqvist, 1961; Breebaart et al., 2001).

Health and education are in themselves beneficial and can be viewed as investments in human capital which, will in future lead to a higher standard of living. It has been reported that the people of Africa experience lower levels of both health and education than those prevailing in other regions of the world (National Health Policy, 2016; Krueger & Lindahl, 2000; Wittmer et al., 2010; Yuan et al., 2014). This reflects the lower level of economic development in Africa, hence, helps to explain the low level of development, and suggests a set of policies for improving Africa's standard of living. Overall, Africa's life expectancies still remain at the bottom of the ladder, and the mounting epidemic of HIV/AIDS among others in most of sub-Saharan Africa and more so in central and southern Africa, threatens to reduce life expectancies in many of these countries in the future (; Still et al., 2003; Wittmer et al., 2010). This hence calls for a lot of emphasis on health promotion programmes. Thus, an evaluation of any existing health promoting initiatives becomes paramount.

1.11. School Health in South Africa

School health programmes have quite a long historical background in the Republic of South Africa (Bremner, 1965; Vergnani et al., 1998). The existence of school health services started way back in 1914 even well before there were marked inequities in the availability and provision of school health services during the unpopular racial isolation regime (Van Rooyen, 1983; Vergnani et al., 1998). As pointed out by Whittaker (1965) and Bazzaz (1975), there existed serious inequities in both the availability and provision of school health services. This was most evident in that school health services were provided effectively to all schools in white dominated areas several times a year, while schools in the disadvantaged, mainly former homeland areas dominated by the black majority, only received these services once every two to three years or not at all (Bazzaz, 1975). However, the new dispensations after the 1994 democratization have seen several initiatives focusing on developing networks of health promoting schools. Such initiatives are thus seen as a mechanism to address the historical inequities among children in South Africa (Swart & Reddy, 1999;2014).

The ANC government's response to rapidly increasing health challenges due to lifestyle changes which are linked to urbanization including changes in diet, socio-economic, cultural and environmental factors have involved population-based approaches for prevention, such as campaigning for public health plus policy legislation related to substance (tobacco and alcohol) abuse, and identification of individual risk factors in high-risk persons (Witkowski

& O'Connor, 2012; Vorster, 2002; Mayosi, et al., 2009). Despite efforts at improving management and prevention of non-communicable diseases, such awareness campaigns often do not actually reach the intended audience, more so in rural areas and/or former black homelands. Similarly, lack of skills and training among health workers contribute to the aforementioned. In this regard, the Department of Health (DoH) has made health promotion as a priority area in its strategic plan, advocating the development of cost-effective and evidence-based measures in order to reduce the projected burden of disease (O'Connor & Crow, 1999, 2012; Sekhwela, 2003, 2007; Crow, 2007). In fact, these days, several D0H and the Department of Education (DOE) policies which are aimed at addressing children's health needs among others have been put in place. These include policies such as the Health Promoting School Initiative (HPSI), formally a WHO initiative (Balayan et al., 1995; WHO, 2008; WHO, 2013). The is also the South African National Policy on HIV/AIDS for Learners in public schools, and learners and educators in further education and/or training institutions (Bredenkamp & Theron, 2013; Coombe, 2000), Youth and Adolescent Health Policy (DoH, 2012) and more recently, the South African National School Health Policy,2013 (Van Rooyen, 2012) are also some of those initiatives in place.

Breebaart et al. (2001) point out that South Africa has recently progressed from a triple burden of disease to four times the burden of disease consisting of poverty-related diseases, emerging chronic diseases, injuries and the impact of HIV/AIDS (Balayan et al., 1995; United Nations Development Programme, 2013; Campbell & Mzaidume, 2001). Thus, such a burden places a high demand on existing health services that are already struggling to cope with limited resources and structural developments due to national health reform and calls for priority setting at national health policy level (Balayan et al. 1995; Campbell & Mzaidume, 2001). In this regard, an evaluation of health promotion programmes at local/regional levels would be important.

1.12. School Health Policy

The Department of Health in collaboration with Department of Basic Education revised the National School Health Policy in 2011.The Policy is aligned to the Negotiated Services Delivery Agreement (NSDA) 2010-2014; the government has therefore developed a programme of action for the promotion of long and healthy lives for all South Africans, as well as the Millennium Development Goals). (MDGS) which were replaced by The Sustainable Development Goals. (United Nations .2015).

Moreover, the revised policy made away for the Comprehensive, Integrated School Health Programme (ISHP) for Grade 0 to 12 learners which are implemented at sub–district level. The ISHP implementation strategy incorporates the principle of inequity and human rights with specific consideration to the availability of resources required to cover all learners (DoH, 2014). The new ISHP which will replace the 2003 School Health Policy and implementation guidelines outline how school health services will be strengthened and expanded.

The new programme aims to ensure delivery of more services on-site and to ensure more systematic referrals and follow ups of learners. Furthermore, emphasises is placed on reaching full learner coverage beginning in the most disadvantaged schools (DoH, 2014). The school health policy consists of a vision, principles as well as objectives (Ramma, 2010). The policy will develop and address barriers to learning that will hinder the learners' maximum benefit from education. It has been identified that the major health barriers to learning for children in South Africa are: (a) poor nutrition (b) poverty (c) environmental factors such as unclean water and sanitation and disabilities including gross locomotor dysfunction and improved vision and hearing. These factors impact on attendance at school and the learner's ability to concentrate on school activities. It causes poor pass and retention rates for schools and impacts negatively on the development of children and youth (WHO, 2011; Klugman, 2011). Other important health factors impacting on the development of children and youth of school going age include issues related to sexuality, HIV /AIDS, reproductive health, trauma and violence, substance abuse and mental problems (WHO, 2002; Eaton et al., 2003; Novello et al., 1992; Morojele et al., 2006). Such factors should be addressed through Health Promotion and Health Education activities and need to be incorporated into the life orientation area of the South Africa school curriculum.

1.13. Research Methodology

A quantitative, non-experimental, descriptive design was used to describe the learners' perception, awareness, and satisfaction towards the implementation of the Integrated School Health Programme (ISHP) in selected secondary schools. The descriptive design was selected to obtain the characteristics of the items being researched (Burns, Grove and Gray, (2012), Polit and Beck (2012) state that the purpose of descriptive studies is to describe and document an aspect of a situation as it occurs. According to Burns, Grove and Gray (2012), the descriptive approach was useful in providing greater insight into characteristics within a particular field of study, and may be useful in evaluating or justifying the current practice. It can be used in this study to describe the relationship among variables, instead of assuming a cause and effect relationship. By using a descriptive design, more information could be gathered regarding the characteristics of the learners in selected secondary schools.

1.14. The Paradigm and the Approach

The researcher will adopt a positivist paradigm for this study. A positivist fundamental assumption is that there are affixes, orderly and unbiased reality that can be objectively studied and uncovered and is often associated with quantitative research, (Polit & Beck, 2012). The positivist paradigm, sometimes known as logic positivism, serves as a guide in this study. The positivists' scientific approach involves the use of orderly disciplined procedures with tight control over the research situation (Polit & Beck, 2012). Quantitative research is a formal, objective, systematic process for generating new information (Burns, Grove & Gray, 2012).

1.15. Research Setting

The data was collected at four selected secondary schools in uMgungundlovu district, KwaZulu-Natal, South Africa from grade 8, 9 and 10. The study was conducted to determine the implementation of the Integrated School Health Programme.

1.16. Research Population

Polit & Beck (2012) define a population as an entire aggregation of the case in which the researcher is interested in all the individuals with common, defining characteristics (Burns, et al., 2012). The population comprised of 500 learners in grades 8, 9 and 10 who enrolled in each of the four selected secondary schools. In KwaZulu-Natal, they were approximately 76 secondary schools with approximately 500 learners. In uMgungundlovu district the population of this study consisted of 300 learners at four selected secondary schools. The researcher was looking at 25 learners in each grade of four selected secondary schools that is grades 8, 9 and 10. To make up to 300 learners from different grades and schools to participate in the study. Each school consisted of 75 learners from three grades: learners in grade 8 there were 83, grade 9 were 92 and grade 10 were 94 out of 269 respondents.31 respondents some of them they refused to participate and some of the learners they did not return the assent and consent forms from their parents/guardians.

1.17. Sampling of Schools

The researcher selected four secondary schools in uMgungundlovu district, in KZN where data was collected. The four schools were selected using purposive sampling. The main goal of purposive sampling was to focus on the particular characteristics of a population that were of interest, which would best enable the researcher to answer the research questions. Sampling units were selected based on their similar characteristics and were of particular interest to the researcher. The sample size was 300 learners from selected secondary schools. Researcher was looking at 25 learners in each grade from 8,9 and 10 from four selected schools which make 300 learners, moreover some of the learners did not return the assent and consent forms from their parents which ends up with   However, only 269 agreed to participate in this study and the response rate was (90 percent). Respondents were distributed according to their schools and grades in the four selected secondary schools. The recruitment strategies for this study, the researcher made an appointment with each of the Principal of the four selected secondary schools. The researcher was providing a protocol together with a letter from Ethics (UKZN) permission letter who granted a researcher to conduct her study. The researcher had to explain every aspect about her study, the session will be taking only 10 to 25 minutes, and it will take place in the hall/classroom. The researcher will explain that the

study won't harm anyone if the participants wants to withdraw from the study they were free to do so.   . Confidentiality and anonymously will be maintained for the whole process. The researcher is looking for the learners from age 13 to 16 to participate from the study. In grades 8, 9 and 10. Consent forms were distributed to the learner to give their parents/guardians as they were minor below 18 years. As well as   assent forms were distributed to be filled in by the learner, if they agreed to participate to the study. The researcher explained everything regarding the study.

1.18. Data Collection Process

The researcher obtained permission from the Department of Education as well as from the Principals of the four selected secondary schools. Assent forms were given to the learners to sign. Informed consent forms were also given to the minor learners' parents or guardians to sign. Once all those who agreed to participate had been identified, a date for data collection was fixed with the Life Orientation teacher. Participants were approached in their classrooms, and the purpose of the study was explained detail. The questionnaires were distributed and the respondents completed the questionnaire on their own to ensure confidentiality and anonymity. The researcher took more than five to ten sessions in one school. Some of the learners they forgot to ask the forms from the parents/guardians. In other days you won't be able to get other learners because they are exchanging their classes. The educators they want to cover their syllabuses because the exams were around the corner. Each and every school you need to comeback more than five sessions. Sometimes the educators were in the meeting you should wait to be asked a permission before you seen the learners. There were some challenges sometimes other learners are writing exams, tests and you need to comeback on the other day. The data collection took about four weeks due to other constrains and there were no biased during this session. The researcher explained and clarified questions and to any respondents' queries. The respondents were asked to put the completed questionnaires into a box for security reasons. Codes and numbers were used instead of learners' names to ensure confidentiality. Out of 300 questionnaires distributed, 269 were collected after completion representing a response rate of 90%. Therefore, in the present study, a very good response rate of 90percent was obtained, providing the researcher with the opportunity to generalize about the total population.

1.19. Data Analysis

Data analysis was done with the assistance of the supervisor and the statistician from the Durban University of Technology. Data analysis was done using The Statistical Package for the Social Sciences (SPSS version 24.0). Descriptive statistics was used to describe the research phenomena. Table frequency, bar diagrams and pie charts and communication data (Polit & Beck, 2012) Cross tabulation was performed to determine the relationship between the variables.

1.20. Ethical Considerations

During this research study, permission and consent to conduct the study were duly obtained from the UKZN ethics committee and appropriate school authorities. Written and informed consent was obtained from respondents (Appendix D). Consents were granted by parents for learners, who were under the age of 18 years, however, if the parents did not respond, it would be treated as if they have consented. This included assent forms while the researcher was participated with minor learners. Respondents were well informed about their right to participate or to refuse to participate, and the right to opt out at any stage of the research process should they deem it necessary. Participants were also assured that any information gained from them was treated with the utmost confidentiality. Respondents were told not to write their names on questionnaires to ensure anonymity. Data will be kept under lock and key for 5 years and once the research process was completed questionnaires were disposed of by means of shredding. So, the UKZN ethical regulations and research practice were fully adhered to.

1.21. Management of research data and records

To further foster the commitment of the University of KwaZulu-Natal to openness in research, the data on which this dissertation is based will be made available for evaluation to the broader research community. Therefore, in conformation with the ethical code of the University, for confidentiality, and to protect the University's intellectual property rights, a safe storage has been arranged for all the data used for this research. These data are to be retained at the University for the next five years, after which they are expected to be destroyed if no publication based on the dataset appears within these years.

1.22. Outline of the Dissertation

This dissertation is organized into the following five chapters:

Chapter One presented an introduction and the background to the study, the research problem, the research objectives and research questions. It outlined the significance of the study, defined key terms and presented the conceptual frameworks, an overview of the study and the conclusion.

Chapter Two reviews the related literature, which involves identification, location, and analysis of documents containing information related to the research problem. These are organized into themes which are presented as subheadings.

Chapter Three focuses on the methodology, outlining the research method, the study population and the instruments used for data collection. This chapter describes the data collection and presents the methods used for data analysis.

Chapter Four presents the findings from this study.

Chapter Five discusses the findings from the previous chapter in relation to the relevant literature. This chapter also concludes the study and presents recommendations that explore the learners' perceptions and satisfaction regarding the implementation of school health programme in four selected secondary schools in uMgungundlovu District Pietermaritzburg in KwaZulu-Natal, South Africa.

1.23. Summary

In summary, this introductory chapter explained the background and motivation to the study; gave an overview of research methodology; outlined of the research problem; the research objectives; the research questions and the structure of the research. Chapter Two discusses the review of literature on the integrated school healthy programme in South Africa.

CHAPTER TWO

LITERATURE REVIEW

2.1. Introduction

In Chapter One, the background and motivation to the study was discussed; the research methodology, research problem, research objectives, research questions; and the structure of the research were equally outlined and explained. Therefore, this chapter presents the literature review which follows a sequence of events that incorporates findings, readings, understandings and forming conclusions about the published scholarly research and theory on the Integrated School Health Programme (ISHP) (Burns, Gray & Grove. 2012). The process underscores the viewpoints of various protagonists and presents what is already known about the topic, and it forms a basis of comparison that serves to support or inform the study (Burns et al., 2012). This technically engenders the research question and enables the researcher to identify the study gap. However, due to the narrow concentration of this study implementation, the review is not intended to be exhaustive. Therefore, the focus of this chapter is to review the existing literature on Integrated School Health Program (ISHP), as an offspring of the WHO's Global School Health Initiative (GSHI), such as the Health Promoting School (HPS) and Comprehensive School Health Program (CSHP).

2.2. School health programme

Over the last decade, some initiatives have been proposed by various international organizations with a view to achieving greater integration of youth-oriented health promotion activities, while at the same time influencing individual and social determinants of health (Kolbe, 1985; World Health Organization (WHO), 1991; Allensworth, 1993; English, 1994; WHO, 1997b; McBride *et al*., 1999)

WHO's Global School Health Initiative, launched in 1995, seeks to mobilize and strengthen health promotion and education activities at the local, national, regional and global levels. The Initiative is designed to improve the health of students, school personnel, families and other members of the community through schools,

According to Jones and Furner (1998), the goal of WHO's Global School Health Initiative is to increase the number of schools that can truly be called "Health-Promoting Schools":

characterized by continuous consolidation of its capacity and facility as a healthy setting for living, learning and working.

WHO's Global School Health Initiative consists of four broad strategies:
- Building capacity to advocate for improved school health programmes
- Creating Networks and Alliances for the development of Health-Promoting Schools
- Strengthening national capacities
- Research to improve school health programmes

The review establishes the fact that recently published studies have revealed that this comprehensive WHO's Global School Health Initiative approach to child-youth health promotion takes different forms, such as Health Promoting Schools (HPS) – a concept which is more prevalent in such countries as Australia (The Australian Health Promoting Schools Association, 1997). The Comprehensive School Health Program (CSHP) - a popular concept in both the US and Canada (Canadian Association for School Health, 1991; Allensworth *et al*., 1995). These are hereby delineated accordingly below.

2.2.1. Health Promoting Schools (HPS)

The Health Promoting Schools concept was proposed in the early 1980s by the WHO. In 1992, the European Health Promoting Schools Network was set up jointly by the European Regional Office of the WHO, the Council of Europe (CE) and the Commission of the European Communities (CEC) (WHO, 1993). Since then, the concept of HPS has been taken up by other networks throughout the world, such as the one in Australia (The Australian Health Promoting Schools Association, 1997). According to the European Network: The Health Promoting Schools aims at achieving healthy lifestyles for the total school population by developing supportive environments conducive to the promotion of health. It offers opportunities for, and requires commitments to, the provision of a safe and health-enhancing social and physical environment. (WHO, CEC and CE, 1995, Parsons et al., 1997)

The components of HPS are three in number, these are: (i) the formal health curriculum that gives school-aged children the essential knowledge and social skills that will allow them to make enlightened choices affecting their physical and psycho-social health; (ii) the school environment, which refers to the quality of the physical environment and the school climate,

the health services and policies of the school; and finally (iii) the school/community interactions (Parsons *et al*., 1996; Booth and Samdal, 1997).

Therefore, a Health-Promoting School (Jones and Furner, 1998; WHO, 2003):

- Strives to improve the health of school personnel, families and community members as well as students

- Fosters health and learning with all the measures at its disposal

- Engages health and education officials, teachers and their representative organizations, students, parents and community leaders in efforts to make the school a healthy place

- Strives to provide a healthy environment, school health education and school health services along with school/community projects and outreach, health promotion programmes for staff, nutrition and food safety programmes, opportunities for physical education and recreation and programmes for counselling, social support and mental health promotion

- Implements policies and practices that respect an individual's self-esteem, provide multiple opportunities for success and acknowledge good efforts and intentions as well as personal achievements. (Jones and Furner, 1998; WHO, 2003).

- A study examined five (5) themes were extracted as a major barriers and challenges:

- Intra and Inter-sectoral collaboration

- Policy and rule formulation

- Infrastructure and capacity

- Human resources

- Community involvement according to Macnab et al., 2013 verbalises that lack of motivation to collaborate in implementation of the program among existing work force of the ministries of Education and Health and Medical Education reflects absence of the most required commitment among top and middle authorities.

Human resources refers to the individuals whose actions are meant primarily to protect and improve health.

- Challenges in this category are include availability of the health work force considering that health workers should be available where and when needed, Effective health worker should be competent and waste the technical knowledge and skills required to provide care of high quality, and possess the interpersonal skills needed to engage in patient-centred and professional care, including lack of commitment of excessive load. Adequate funds to ensure that can be used service when needed. Infrastructure and supplies to be efficient and support proper care delivery, infrastructure should accessible by potential users, well-equipped, well maintained and adapted to population needs. Challenges may entail poor availability of drugs reliable supply system for technologies, quality, unaffordability and procurement and storage users.

- Knowledge of information: A variety Health information systems may contribute to the production, analysis, dissemination and use of reliable and timely health information by decision makers and practitioners, at different levels of the Health Systems (HSs), both on regular basis and in emergencies.

- Leadership and Governance: Healthy policy and its relationship with actors whose activities impact population health, challenges overseeing and steering the whole HSs i.e. private/public entities, while protecting the public interest, limited resources need to be reconciled and health policy makers, develop strategic policy frameworks which may entail effective oversight.

- Service delivery: Such as various packages of care and services delivered for the prevention, promotion and treatment of acute and chronic conditions:

- Challenges include access to services (Affordability, Accessibility, and Geographically accessibility (e.g. from rehabilitation to palliative care). The vertical integration and co-ordination of health services and referral systems, community of care, quality and efficiency of services. This category thus refers to the immediate outputs of the resources inputs.

- Context Population: Affected by contextual and demographic factors, which all for responsiveness and adaptation to social, economic, technological, cultural, political, regulatory and environmental changes and transitions over time. Stigma maybe attached to certain conditions, impending proper care to be sought and delivered. Challenge in this category including long standing trends such as ageing, migration and particular mixes of chronic and infectious diseases as well as sporadic events such as epidemics, conflicts and wars (Bartholomew,2011 and Cane et al.,2012).

2.2.2. On-site services

According to Health Education, both the DoE and DoH need to train school teachers, especially Life Orientation teachers so that they can work together with the Department of Health to revise this school health programme through the PHC, in order to prevent illnesses and diseases and promote health in totality (ISHP Resource Manual for SHN, 2012). Moreover, they presented all service programmes that must be provided in each school in order to reach the standard of each learner, physically, emotionally psychologically etc. The plan should indicate:

- The annual target regarding the learners in each school in 9 provinces.

- The number of schools to be reached.

- The number of targeted learners in that school

- The number of equipment/medication needed (e.g. gloves and services that will be needed which services will be provided at each school by whom. (All services outlined in SHS package must be provided

But there will be some variation in terms of how and whom the services will be provided. (ISHPRM, 2012). These services will be provided by policies and acts from DoE and DoH together with other multidisciplinary teams, related to the implementation of Integrated School Health Programme according to the stipulations of these services/programme. In this study, the respondents show that three-quarters of the 269 respondents lacked information about these services when all of them are important (ISHP, 2012).

2.2.3. Comprehensive School Health Program (CSHP)

According to Allensworth *et al*. (2003): A Comprehensive School Health Program (CSHP) is an integrated set of planned, sequential, school affiliated strategies, activities, and services designed to promote optimal, physical, emotional, social, and educational development of students. The Program involves and is supportive of families and is determined by the local community based on community needs, resources, standards, and requirements. It is coordinated by a multidisciplinary team and accountable to the community for program quality and effectiveness (Allensworth *et al*., 1995:2).

The components of CSHP are eight in number, these are: (i) planned, sequential health education across the whole curriculum, from grade 1 to grade 12; (ii) school-based health services; (iii) the school environment; (iv) physical education at school; (v) food services; (vi) counselling services; (vii) health promotion among school staff; and (viii) school/community integration of health promotion efforts (Allensworth & Kolbe, 1987).

Both the Health Promoting School (HPS) and the Comprehensive School Health Program (CSHP) initiatives have been promoted as a possibility of exceeding some of the restrictions related to school health initiatives, especially those that focuses on school-aged children. This consist of going further than sheer practices which is largely dependent on health education curricular, to a more comprehensive, integrated approach of health promotion which emphasizes both child attitudes and behaviours, and their environment.

2.4. School health globally

In the early 1960s, several conferences and meetings took place between the World Health Organization (WHO) and the United Nations Education, Scientific and Cultural Organization (UNESCO) to determine how school health could be improved (Bradshaw et al., 1964; Ayila et al., 2014). A publication was released in 1966 which was one of the first international documents to address pragmatically the planning and implementation of school health programmes (Sibandze et al., 2014; Sinthumule & Munyati, 2014). Gibbes et al. (2010) claim that several similar principles and recommendations that can be seen running through these documents. The building blocks of the Health Promoting School (HPS) and Comprehensive School Health Education (CSHE) frameworks which emerged in the 1980s and 1990s had clearly been articulated several years earlier. Another influential stimulus for school health

was to be found in the Declaration of Alma-Ata World Health Organization (Clay, 1988). This statement came out of a major International Conference on Primary Health Care held in Alma-Ata, which called on all governments "to formulate national policies, strategies and plans of action, to develop a multi-sectorial approach to involve citizens in forecasting, organization, operation and control of Primary Health Care and to focus on education as a means of preventing and controlling health problems" (St. Leger, 1999; Wardell et al., 2003; Strand et al., 2008; Oloukoi et al., 2014).

2.4.1. Some Major International Conference Declarations

The Declaration of Alma-Ata was the first international attempt at this high level to pinpoint the myriad of factors influencing health and thus, provides an emphasis for developing strategies by the member states of the WHO. The focus of the Declaration of Alma-Ata was that it brought the idea of health for all needs to be realized come the year 2000 (Ayila et al., 2014). This prompted a closer examination by governments and health authorities about how this could be achieved. The Ottawa Charter for Health Promotion and the Jakarta Declaration were other major milestones in influencing the direction of Health Promoting Schools (WHO, 2012). The Ottawa Charter focuses on creating: 1) healthy public policy; 2) supportive environments; 3) community action; 4) personal skills; and 5) a reorientation of health services. It also focuses the Initiative on creating health as well as preventing health problems by calling for actions that enable individuals to: care for themselves and others, make decisions and have control over their life (WHO, 1986). Complementarily, 'the Jakarta Declaration emphasizes on creating *sustainable* health promotion programmes. Thus, the WHO Initiative calls for international, national, district and local actions to promote social responsibility, increase investments in schooling, consolidate and expand partnerships, build community capacity, empower individuals and secure an infrastructure for health promotion through schools. Such actions help to unlock the potential for health promotion that is inherent in all schools' (Jones and Furner, 1998).

2.4.2. Challenges facing School Health Programmes

WHO's Expert Committee on Comprehensive School Health Education and Promotion reviewed challenges to the development of school health programmes as identified by national, district and local education and health workers. Five broad problems are commonly identified at each organizational level, they are as follows:

1. Inadequate vision and strategic planning.
2. Inadequate understanding and acceptance of programmes.
3. Lack of responsibility and accountability.
4. Inadequate collaboration and coordination among persons addressing health in schools.
5. Lack of Programme infrastructure, including financial, human and material resources as well as organising mechanisms.

Despite the barriers, WHO's Expert Committee found major reasons why school health programmes should be further developed. Therefore, the Committee concluded that there is a rich base of knowledge on which to act to develop and improve school health programmes. Furthermore, it concluded that research in both developing and developed countries demonstrates that school health programmes can simultaneously reduce common health problems, increase the efficiency of the education system and advance public health, education and social and economic development in each nation (Department of Health & Department of Basic Education,2012) DoH &DoBE, 2012)

2.4.3. Expert recommendations for School Health Programme (DoH&DoBE,2012)

To strengthen each nation's capacity *to improve health as well as education,* the WHO Expert Committee recommended two broad actions that must be supported at the local, national and international levels, they are:

•   expanding investments in schooling
•   expanding the educational participation of girls,

To promote health through schools, the WHO Expert Committee made three recommendations about what schools must do:

•   provide a safe learning and working environment for students and staff
•   serve as an entry point for health promotion and a location for health intervention
•   enable children and adolescents to learn critical health and life skills,

The WHO Expert Committee also recognized that schools clearly need to support health promotion; thus, they made the following five recommendations:

- policies, legislation and guidelines must be developed to ensure the identification, mobilization and coordination of resources at the local, national and international levels
- teachers and school staff must be valued and provided with the necessary support to enable them to promote health
- communities and schools must work together to support health and education

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1. Policies, legislation and guidelines must be developed to ensure the identification, mobilization and coordination of resources at the local, national and international levels
2. Teachers and school staff must be valued and provided with the necessary support to enable them to promote health
3. Communities and schools must work together to support health and education (DoH & DoBE, 2012).

2.5. School health in Africa

According to the Population Reference Bureau (PRB) (2006), about one third (33percent) of the sub-Saharan Africa's (SSA) population comprises of young persons between the ages of 10 to 24 years. Garcia and Fares (2008) in an article titled 'Why is it important for Africa to invest in its youth', argue that 'while countries in the developed world will experience a decline in the proportion of their population that comprises youth, sub-Saharan Africa (SSA,) will continue to experience an increase. However, the youth in SSA exist in a context of unescapable poverty, scarce educational opportunities, high HIV/AIDS prevalence, widespread conflict, weakening social controls and breakdown of traditional norms (Blum, 2007; Blum et al., 2012). The implications of these outcomes on the health and wellbeing of youth and for the potential contributions of youthful populations to the economies of African nations is momentous. Vila (2000) and Garcia et al., (2008) opine that education has been positively linked to good health, economic growth, and fewer social conflicts. Youth in Africa face substantial barriers in accessing health services. Youth-friendly health initiatives have potential to ensure that services reach young people and that their unique health needs are met (Tylee et al., 2007). However, according to the World Health Organization (WHO) (2010), most SSA countries have a dearth of youth-friendly health services and inadequate policies to address adolescent health needs. For example, in South Africa, one of the better-endowed countries in the region, young people aged 13 and above are typically attended to in the adult health care system by health professionals who lack specialized training to handle the needs of young people (Stefan and Van der Merwe, 2008).

Within sub-Saharan Africa, the Health Promotion initiative which is supposed to be an interventional measure has also been facing many challenges. In fact, UN (2013) points out that the state of health in a majority of these sub-Saharan states is worse than in any other region. Thus, earlier studies have indicated that the region is not actually on track in achieving any of the United Nation's Millennium Development Goals since focus has shifted away from the ideals of the Ottawa Charter to different countries' individualistic behaviour change approach (United Nations, 2013; Breebaart et al., 2001). Such shifts are a result of political choices of governments which normally come with consequences such as those that have favoured technocratic approaches over harnessing the popular mobilizations that have been known to accompany national struggles United Nations,2013); Breebaart et al., 2001).

Health and education are in themselves beneficial and can be viewed as investments in human capital which will in future lead to a higher standard of living. It has been reported that the people of Africa experience lower levels of both health and education than those prevailing in other regions of the world (WHO Regional Office, 2013); Krueger & Lindahl, 2000; Wittmer et al., 2010; Yuan et al., 2014). This reflects the lower level of economic development in Africa, and hence helps to explain the low level of development, and suggests a set of policies for improving Africa's standard of living. Overall, Africa's life expectancies still remain at the bottom of the ladder, and the mounting epidemic of HIV/AIDS among others in most of sub-Saharan Africa and in central and southern Africa threatens to reduce life expectancies in many of these countries in the future (Calvin, 1976; Still et al., 2003; Wittmer et al., 2010). Hence, this calls for a lot of emphasis on Health Promotion programmes. Thus, an evaluation of any existing health promotion initiatives becomes paramount.

2.6. School Health in South Africa

School health programmes have quite a long historical background in the Republic of South Africa (Bremner, 1965; Vergnani et al., 1998). The existence of school health services started way back in 1914, even well before there were marked inequities in the availability and provision of school health services during the unpopular racial isolation regime (Van Rooyen, 1983; Vergnani et al., 1998). As pointed out by Whittaker (1965) and Bazzaz (1975), there existed serious inequities in both the availability and provision of school health services. This was the most evident in that school health services were provided effectively to all schools in white dominated areas several times a year, while schools in the disadvantaged, mainly former homeland areas dominated by the black majority, only received these services once every two to three years or not at all (Bazzaz, 1975). However, the new dispensations after the 1994 democratization have seen several initiatives focusing on developing networks of health promoting schools. Such initiatives are thus seen as a mechanism to address the historical inequities among children in South Africa (Swart & Reddy, 1999; Dharamsi et al.; 2014; Lee et al.; 2014) experience of this occurring in South African HPS program reported (Preiser et al.,2014).

The ANC government's response to rapidly increasing health challenges due to lifestyle changes which are linked to urbanization including changes in diet, socio-economic, cultural and environmental factors have been to implement population-based approaches for prevention, such as campaigning for public health plus policy legislation related to substance (tobacco and alcohol) abuse, and identification of individual risk factors in high-risk persons (Witkowski & O'Connor, 2012; Vorster, 2002; Mayosi, et al., 2009). Despite efforts at improving management and prevention of non-communicable diseases, such awareness campaigns often do not actually reach the intended audience in rural areas and/or former black homelands. Similarly, a lack of skills and training among health workers contributes to the aforementioned. In this regard, the Department of Health (DOH) has made health promotion a priority area in its strategic plan, advocating for the development of cost-effective and evidence-based measures to reduce the projected burden of disease (O'Connor & Crow, 1999, 2012; Sekhwela, 2003;2010; Crow, 2007). In fact, these days several DoH and the Department of Education (DoE) policies which are aimed at addressing children's health needs, among others, have been put in place. These include policies such as the Health Promoting School Initiative (HPSI), formally a WHO initiative (Balayan et al., 1995; WHO, 2012; WHO, 2008). The South African National Policy on HIV/AIDS for Learners in public schools, and learners and educators in further education and/or training institutions (Bredenkamp & Theron, 2013; Coombe, 2000), the Youth and Adolescent Health Policy (DOH, 2012), and more recently, the South African National School Health Policy,2013; (Van Rooyen, 1983) are also some of those initiatives in place.

According to YAHP,2012 youth and adolescents have a right to be provided with appropriate and accurate knowledge on how to protect themselves against illness and injury, including the consequences of drugs ,sexual abuse ,exploitation, and how to prevent pregnancy, STIs and HIV infection. Adolescents also need to be educated on attitudes and behaviours that will enable them to develop respect of women's self–determination in matters of sexuality and reproduction. Youth and Adolescents Policy, (DoH June 2014).

Breebaart et al. (2001) point out that South Africa has recently progressed from a triple burden of disease to four times the burden of disease consisting of poverty-related diseases, emerging chronic diseases, injuries and the impact of HIV/AIDS (Balayan et al., 1995;, Youth and adolescent Health Policy,2012; Campbell & Mzaidume, 2001). Thus, such a burden places a high demand on existing health services that are already struggling to cope

with limited resources and structural developments due to national health reform, and calls for priority setting at national health policy level (Balayan et al. 1995; Campbell & Mzaidume, 2001). In this regard, an evaluation of health promotion programmes at local/regional levels would be important.

2.6.1. PHC Re-Engineering

The recently introduced re-engineering of the PHC model in South Africa has school health services as one of its focus area. In 2003, the DOH adopted a national policy on school health services, however, the reality is that school health services are poorly resourced and therefore unevenly provided within and between provinces (Pillay & Baron 2013). These authors further argue that whilst it is desirable to have a school health nurse in every school, the reality is that with 29 000 schools in the country, this is not possible in the short to medium term. Where the initiative has been implemented, it is therefore imperative to assess the progress and identify any bottlenecks related to its implementation.

In the South African context, the goal of the ISHP is to "improve the general health of school-going children as well as the environmental conditions in schools, and address health barriers to learning" (Shung-King, 2013; Kwan, Petersen, Pine & Boratta, 2005). In this regard, the National Department of Health (NDOH, 2013) has outlined the following objectives for the ISHP: (a) to provide preventive and promotive services that address the health needs of school-going children; (b) to facilitate referral to health and other services where required; (c) to support the school community in promoting healthy schools; (d) to ensure the sustainable coordination and multi-sectoral partnership and (e) to mobilize resources for the implementation of the school health policy.

Given that the earlier implementation of the 2003 policy focused mostly on screening for visual and hearing impairments of Grade R and Grade 1 learners, the ISHP now aims to introduce a comprehensive package of health care services for all learners from grade R to grade 12 (Berry, 2013). The concept of school health is embedded in the early WHO programmes from the 1960s, when several symposiums and seminars were organized by the World Health Organization (WHO) and United Nations Education, Scientific and Cultural Organization (UNESCO) to decide how school health could be improved (World Health Organization, 2012). As a result of these international events, several WHO programmes and

projects relating to health promotion have been developed and implemented. Health promotion addresses the determinants of health, aims to enable change and to empower people to acquire the capacity to improve their own health as well as the health of their community (Kickbusch, 2003; Polit, & Beck, 2012). It links the individual with the environment and attends to how the environment affects health (Gallivan, Greenberg and Brown, 2008; Estabrook, Zapka, & Lemon, 2012; Estabrook, Harden, & Allen, 2013)

School health programmes, therefore, are educational, political, economic, environmental, and medical programmes which are designed to reduce disease and promote health in schools among individuals (Swart, & Reddy, 1999, 2014; Mũkoma & Flisher, 2004). Such programmes are further defined as an integrated set of planned, sequential, school-affiliated strategies, activities and services which are designed to promote the optimal physical, emotional, social and educational development of learners (Barnekow, Brewer, Buis, Clift, Jensen, Paulus, Rivett & Young, 2006). The concept of health promotion was developed to encompass the fostering of lifestyles and other socio-economic, environmental and personal factors that include capacity building of different stakeholders by raising their awareness in health matters which are beneficial to health (Mahler 1981). The goals of ISHP therefore, is to improve the health status of children and in turn, to improve the development of quality education (Green & Raeburn, 1988; Mũkoma & Flisher, 2004). In South Africa, the concept of school health is implemented through the revised ISHP in 2011.

The concept of health promotion in schools was initially proposed by the WHO in the early 1980's. It has since been taken up by other networks in different parts of the world which include among others, three European Network of Health Promoting Schools (ENHPS) - the European Commission, the Council of Europe and the WHO Regional Office for Europe, 2013; Barnekow et al., 2006). Although this network started with only seven countries, the ENHPS has expanded over the years and by the late 90s, it already had forty-three countries as members (Nutbeam, 1998).The Australian Health Promoting Schools Programme among others, aims at achieving a healthy lifestyle for the total school population by developing supportive environments conducive to the promotion of health (Deschesnes, Martin & Jomphe Hill, 2003; 2013; Busch, Leeuw & Schrijvers, 2013; WHO & Expert Committee on Diabetes Mellitus, 2013).

Health Promotion refers to educational, political, economic, environmental, and medical strategies designed to reduce disease and promote health in schools (Swart and Reddy 1999, 2014). In most instances, these projects seek to translate health promotion concepts into practice (Nutbeam, 1998). One such initiative was that of health promoting schools. The WHO's Comprehensive School Health Education and Promotion Initiative which was launched in 1995, aimed to foster health-promoting schools (HPSs). These are schools that constantly reinforce their capacity as a healthy setting for living, learning and working (Kwan et al., 2005; Lee 2009; Lee 2014; WHO & PAHO, 2011).

Consequently, the health promoting schools' initiative seeks to mobilize and strengthen health promotion and education activities through schools to improve the health of learners, school staff, families and the community in general (Lister-Sharp et. al., 1999; Swart and Reddy 1999; Kwan et al. 2005; Lee, 2005; WHO & PAHO, 2011).

Moreover, this initiative is established on the following critical principles of health promotion according to the Ottawa Charter: a) building a healthy public policy; b) creating supportive environments; c) strengthening community action; d) developing personal skills and e) re-orientating health care services towards prevention of illness and promotion of health (World Health Organization, 1997; Swart & Reddy, 1999; Clift & Jensen, 2005; Rasmussen 2005; Busch et al., 2013). The initiative of health promoting schools is critical in promoting an active boundary between education and health to have more operative, bearable and achievable health promotion initiatives which target children and adolescents. It thus emphasizes the importance of concrete and effective community action in setting priorities for health, decision making, and strategic planning and above all, implementing the above mentioned for the realization of better health (Nutbeam, 1998). Several studies by McNeely, Nonemaker, & Blumy, 2002; Bandura, 2004) among others have looked at the effects of schooling programme outcomes. Generally, the health of school going children and adults is critical to those outcomes because health, like schooling, is a form of human capital; hence, it is expected to be related to labour market success (Strauss & Thomas, 1998; Schultz, 2005; Ashraf, Lester, & Weel, 2008)

For a long time, schools have offered important settings for health education (Mũkoma & Flisher, 2004). The World Health Organization (2012), argued that most of the schools in sub-Saharan Africa don't have a multidisciplinary team which leads to the infrastructure of learning environment that is not improved. An all-inclusive school health programme can

therefore, endow learners not only with the understanding, approaches, and abilities necessary to make constructive health choices, but also the setting, impetus, amenities, and backing required to improve and uphold healthy behaviours (Resnicow, 1993; Resnicow & Allensworth, 1996). Such a programme comprises of health education; a healthy environment; health services; counselling, psychological, and social services; integrated school and community efforts; physical education; nutrition services; and a school-based health programme for faculty and staff (Allensworth & Kolbe, 1987; Allensworth, 1995).

The recent introduction of the revised PHC model has school health services as one of its focus areas. In 2003, the DoH adopted a national policy on school health services, however, the reality is that school health services are poorly resourced and are therefore unevenly provided within and between provinces (Pillay & Baron, 2013). Pillay and Baron (2013) further argue that whilst it is desirable to have a school health nurse in every school, the reality is that with 29 000 schools in the country, this is not possible in the short to medium term. Where this initiative has been implemented, it is therefore imperative to assess progress and identify any bottlenecks related to its implementation.

In many cases, especially in the sub-Saharan countries, school health services and health education practitioners experience many hurdles reflecting the inequities of years of discriminatory practices such as the previous provision of services along racially segregated lines, disproportionate personnel-to-student ratios, financial constraints, and inadequate training of staff (Swart & Reddy, 1999; Reddy, 2003; Reddy et.al.,2014; James et al., 2004; Mũkoma & Flisher, 2004). Consequently, issues of health of individuals in schools did not receive the high priority it deserved.

There are several studies that have been undertaken both in South Africa and other countries that evaluated school health programmes, and the findings of these studies have not been consistent. For example, they have shown that school health programmes, if implemented well, do have a significant positive impact on the health outcomes of learners (Durlak & Wells, 1998; Manios & Kafatos, 1999; Schultz, 2005; Brown & Summerbell, 2009).

On the contrary, other evaluation studies have reported only a modest impact made by health programmes related to the health outcomes (Schultz, 2005; Warwick, et. al., 2005) Furthermore, other studies were inconclusive regarding the impact of these programmes on learners' health (Braverman, 1989). An example is the European Network of Health

Promoting Schools (ENHPS) and HPSI evaluation which showed that both these programmes have the potential to, but do not necessarily contribute to health-related outcomes among learners and staff (Garwood & Sinclair, 1979; Mũkoma & Flisher, 2004; Saha et al., 2004; Clift & Jensen, 2005).

A systematic review conducted by Mũkoma and Flisher (2004) where nine studies were reviewed to identify assessments of school health promoting interventions, found out a positive development of health-promoting school programmes. The study similarly reported that at times, changes were made to school policies and organizational structures to aid the health promoting initiatives while in other projects, the health promotion was seamlessly incorporated into the school curriculum. Additionally, the study pointed out that a number of stakeholders that included parents and local communities were also involved in the planning and implementation of these interventions.

2.6.2. School Health Policy in South Africa

The Department of Health in collaboration with Department of Basic Education revised the National School Health Policy in 2011.The Policy is aligned to the Negotiated Services Delivery Agreement (NSDA) 2010-2014, the government has therefore developed a programme of action for the promotion of long and healthy lives for all South Africans, as well as the Millennium Development Goals (MDGs) and it was replaced by The Sustainable Development Goals. United Nations (2015).

Moreover, the revised policy made way for the Comprehensive, Integrated School Health Programme (ISHP) for Grade 0 to 12 learners which is implemented at sub–district level. The ISHP implementation strategy incorporates the principle of inequity and human rights with specific consideration to the availability of resources required to cover all learners (DoH, 2014). The new ISHP which will replace the 2003 School Health Policy and implementation guidelines, outline how school health services will be strengthened and expanded.

The new programme aims to ensure delivery of more services on-site and to ensure more systematic referrals and follow ups of learners. Furthermore, emphasises is placed on reaching full learner coverage beginning in the most disadvantaged schools (DoH, 2014). The school health policy consists of Vision, Principles as well as Objectives (Ramma, 2010). The

policy will develop and address barriers to learning that will hinder the learner's maximum benefit from education. It has been identified that the major health barriers to learning for children in South Africa are: (a) poor nutrition (b) poverty (c) environmental factors such as unclean water and sanitation and (d) disabilities including gross locomotor dysfunction as well as improved vision and hearing. These factors impact on attendance at school and the learner's ability to concentrate on school activities. It influences poor pass and retention rates for schools and impacts negatively on the development of children and youth (WHO, 2012; Klugman, 2011). Other important health factors that impact on the development of children and youth of school going age, include issues related to sexuality, HIV /AIDS and reproductive health, trauma and violence, substance abuse and mental problems (WHO, 2012; Eaton et al., 2003; Novello et al., 1992; Morojele et al., 2006). Such factors should be addressed through Health Promotion and Health Education activities and need to be incorporated into the Life Orientation area of the South Africa school curriculum. This study was aiming to evaluate this programme by using two framework: Logic Model and RE-AIM model in order to guide this study as well as the Comparison of the old NSHP and the new ISHP to identify the gaps.

Table 2: Comparison of the old NSHP and the new ISHP

HEALTH PROMOTION	Implementation of the 2003 policy, focused primarily on screening for visual and hearing impairment of grade R to grade 1 learner. Across all grades, but primarily in primary schools.	The new policy aims to introduce a comprehensive package of health care services for all learners for grade R to grade 12. Across all grades, new focus on sexual and reproductive health, and risk behaviour in secondary schools.
	Focused on screening in foundation phase, In1983 Child care act which enable children to consent to medical treatment from the age of 14, however this act were repealed on April 2010 and replaced by new act to reduce the age consent to medical treatment to 12, provided the child is mature enough to understand the risk benefit and other implications of treatment	Focused on screening in foundation phase, In1983 Child care act which enable children to consent to medical treatment from the age of 14, However this act were repealed on April 2010 and replaced by new act to reduce the age consent to medical treatment to 12, provided the child is mature enough to understand the risk benefit and other implications of treatment
PREVENTION AND CLINICAL CARE.	Deworming TD vaccine introduced 6 years into the implementation period.	Deworming and TD vaccination for 6 and 12 years old. Contestation on the provision of contraception in schools. Possibility of introducing the HPV Vaccine for young girls.
PSYCHOSOCIAL AND MENTAL HEALTH	Assessments to be introduced only if provinces had the necessary capacity.	Assessments now is requirement.
CHRONIC ILLNESSES	Mentioned, but no specific implementation direction.	Identification and support of children with chronic diseases a required part of the service.
INTERACTION WITH SCHOOL COMMUNITY, EDUCATORS, PARENTS, CAREGIVERS. **KEY SOURCES STAFF**	Left to individual nurses and school health teams to negotiate with schools, with mostly poor co-ordination. Multiple-partner teams to be established at district level for co-ordinated planning of school-based interventions. Districts to fund school health posts entirely out of existing budgets. Staff support and training left to districts.	More structured between health and education. Community based implementation teams in health and school-based teams required to work together. Multi-partner teams to be established at district level for co-ordinated planning of school-based interventions. National grants made available to support the recruitment of additional nurses for school health. Standardized training manual for nurses and educators, developed, initial training supported from the national level.

TRANSPORT	Mostly shared with other outreach services and often unavailable for school health.	Mobile vehicles equipped for eye, dental and general primary level care provided to 10 NHI Pilot sites, specifically for school health services Providing transport incumbent on other districts.
MONITORING AND EVALUATION	Poor –inappropriately aggregated indicators.	Indicators still under construction.
POLITICAL SUPPORT	Weak –low level of support from the MoH and none from the MoBE.	Strong –school health featured consistently in the State of Nation address since 2010; strongly supported by MoH and MoBE who co-signed the policy. In principle support from various national education bodies at the launch of the 2012 Policy. Much media publicity, especially regarding sexual and reproductive health aspects. President MoH and MoBE attended the launch.
CONTEXT	One of many child health Polices developed in post-apartheid period, and relatively low priority and other child health issues. Pledging district health system with many challenges.	Renewal health system reform efforts, with school health as one of several priority streams of district level PHC reforms.
RELATIONSHIPS BETWEEN SECTORS.	Tri –sectoral policy task team, with health the only active member.	Tri –sector policy task team, with NDoH and DoBE active partners, social development significantly less involved.
VARIOUS PROGRAMMES IN HEALTH	Inadequate co-ordination, between school health and health Promoting School.	Co-ordination between various health programmes not yet optimal.
LEADERSHIP CAPACITY	National and Provincial school health co-ordinator positions largely vacant for first years of implementation.	Designated national, provincial, and district school health role players in health and education largely in place.
HEALTH SERVICE PACKAGE HEALTH ASSESSMENT	Mainly for grades 1 and R, roughly 1 million learners per year. Disadvantaged school should be prioritised, but not done in a structured way.	Expanded to 1 year in each educational phase, grader/1, 4, 8 and 10, close to 4 million learners per year. Quintile 1 and 2 schools purposively prioritised.

2.6.3. The gaps identified in the reviewed literature

In general, the literature reviewed revealed that in developed countries and under developed world the implementation of school health programme is more productive than in Africa. The review also revealed that there has been academic debate regarding the initiative but from policy and implementation perspective, but with less attention on monitoring and evaluation from the beneficiary (learners) perspective. Moreover, there is a need to regularly track the effectiveness of the program from the recipient's point of view for evaluation purposes. The review further showed that, in sub-Saharan Africa, the population of young people is high and on the increase. And that they are prone to several health risks. This could be attributed to different socio-economic challenges in Africa and the environment. Therefore, results on studies that have been determined by the developed countries on this subject cannot be generalized to African nations in making policy and in implementing practical interventions.

From the review of literature on South Africa, it shows that, most of the studies on school health initiatives have been conducted within the urban and suburban areas. It was also obvious that, little progress has been made in understanding the challenges of getting through to rural communities with the programme and how they benefit from the programme. Moreover, very limited research has been carried out concerning the learners' awareness, perception and satisfaction about the implementation of ISHP in South Africa in general. To date, there is still a dearth in the evaluation of research that focuses on the progress in implementing this essential health programme. This research study, therefore, focuses on evaluating progress in terms of implementation of ISHP in selected secondary schools in uMgungundlovu District of KwaZulu-Natal Province. It is expected to create awareness among policy makers about the need for evaluation mechanisms of the implementation strategies especially those involving the young people in both urban and rural areas alike.

2.7. Summary of the Chapter

This chapter reviewed related literature in books, book chapters, journal articles, conference proceedings and technical reports based on research questions, key variables of the theory that underpinned the research and broader issues around the research questions. Focus in reviewing the literature was based on the following themes: ISHP implementation and effectiveness, learners' awareness, perception and satisfaction about the implementation. The literature on each of these themes was reviewed covering first the global context followed by the regional and local context.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1. Introduction

In the previous chapter, a preliminary review of the literature determined which features the viewpoints of various protagonists and presents what is already known about the topic. This was done with a view to set the basis of comparison that serves as a foundation for this study, and to establish the study gap for the research. However, in this chapter, the research methodology, the research design, the research instrument, and the validity and reliability of the research instrument are the main focus. Furthermore, the chapter explains how data were collected, the methods used for data analysis and the ethical consideration involved in this study.

3.2. Research Methodology

The research methodology is the overall procedure that guides a researcher when conducting a study (Leedy & Omrod, 2005). According to Schensul (2012), the research methodology is normally considered a research design. In fact, methodologies comprise of the designs and frameworks adopted for a research project (Lapan, et al., 2012). (Paltridge &Starfield 2007) opine that the choice of research methods predicates largely on the methodology. This is the case because the research methods are basically constructed on the preferred approach adopted for collecting and analysing data (Blaikie, 2010). Therefore, research methods are fundamental systems employed for a research study (Marshall, & Rossman, 2006; Walliman, 2011), which could generally be interpreted as data collection tools or techniques (Lapan, et al, 2012; Silverman, 2013).

3.3. Research Paradigm

A paradigm is a "worldview" or a set of assumptions about how things work. According to Rossman, & Rallis (2003,2016), a paradigm is "shared understandings of reality". Quantitative and qualitative research approaches entail diverse assumptions about how a research study should be done and the part the researcher plays. For this study, the researcher adopts a positivist paradigm. Positivist fundamental assumption is that there are affixes, orderly and unbiased reality that can be objectively studied and uncovered and is often associated with quantitative research, (Polit & Beck, 2012). A positivist approach involves

the use of orderly disciplined procedures with tight control over the research situation (Polit & Beck, 2012). According to this worldview, knowledge is objective and quantifiable. Positivistic thinkers adopt scientific methods and systematize the knowledge generation process with the help of quantification to enhance precision in the description of parameters and the relationship among them. Positivism is concerned with uncovering truth and presenting it by empirical means (Henning, Van Rensburg and Smit, 2004:17). Therefore, positivist paradigm, sometimes known as logic positivism, serves as a guide in this study.

3.4. Research Approach

The research design is the comprehensive approach adopted to incorporate the sundry components of the research in an articulate and rational manner, to guarantee that the research problem successfully addressed (De Vaus & De Vaus, 2001; Trochim & Donnelly, 2001). Therefore, based on the research problem presented in chapter one (section 1.3) of this study, a quantitative, non-experimental methodology is adopted as the blueprint for the collection, measurement, and analysis of data. This is basically because the research problem focuses on evaluating implementation of Integrated School Health Programme (ISHP), from the learners (beneficiaries) perspective. According to (Burns, Gray & Grove 2012), a quantitative research is a formal, objective, systematic process for generating new information. Quantitative methods underscore objective measurements and statistical examination of data collected through polls, questionnaires, and surveys (Babbie, 2010; Muijs, 2010). Therefore, this study uses a quantitative research approach to collect statistical data and to generalise them across target groups of learners in order to explain their experience (awareness, perception, and satisfaction) regarding the implementation of the ISHP in their various schools.

Most quantitative research, however, could be into two categories: researches which describe issues and that which aimed at ascertaining extrapolations or fundamental relationships. For this study, descriptive studies are employed as a research design.

3.5. Research Design

A descriptive design was used to determine the learners' perceptions, awareness, and satisfaction towards the implementation of the Integrated School Health Programme (ISHP) in the selected secondary schools. The descriptive design was selected to obtain the characteristics of the items being research Burns, Grove and Gray,2012). Descriptive research could be used to determine an update account of activities without a control over variable. According to Borg & Gall (1989), descriptive studies are aimed at finding out "what is," so observational and survey methods are frequently used to collect descriptive data. It deviates from the analytical research design which seeks to answer 'why' questions. Ethridge (2004) argues that descriptive research could be considered as basically an effort to discover and describe what is, while analytical research seeks to determine why it is, or how it came to be that way. Fox & Bayat (2008) affirm that descriptive research is "aimed at casting light on current issues or problems through a process of data collection that enables them to describe the situation more completely than was possible without employing this method" (Polit & Beck 2012) state that the purpose of the descriptive studies are to describe and document an aspect of a situation as it occurs. According to Burns, Gray & Grove, (2012), a descriptive approach is useful in providing greater insight into characteristics within a particular field of study and may be useful in evaluating or justifying the current practice. It is therefore used in this study to report the percentage summary on a single variable, instead of assuming a cause and effect relationship. By using a descriptive design, reliable information was gathered regarding the experience of the learners in selected secondary schools touching ISHP.

3.6. Research Setting

The research setting refers to the place where the data are collected. It worth mentioning because the environment within which a research is carried out has significant impact on its experimental design, the type of data that can be collected and the interpretation of results. In this study, data were collected at four selected secondary schools in uMgungundlovu district, KwaZulu-Natal, South Africa from grade 8, 9 and 10. The study was conducted to explore

the leaners' awareness, perception and their satisfaction regarding the implementation of the Integrated School Health Programme in their respective schools.

3.7. Research Population

Polit & Beck (2012) define a population as an entire aggregation of the case in which the researcher is interested in all the individuals with common, defining characteristics (Burns & Grove, 2012). The population comprised of 500 learners in grades 8, 9 and 10 who enrolled in the four selected secondary schools. In KwaZulu-Natal, they were approximately 76 secondary schools with approximately 500 learners.

The population of this study was expected to be 300 learners: 75 learners from the four selected secondary schools. Each school was expected to produce 25 students from the three targeted grades: grade 8, 9, and 10. However, only 269 learners eventually responded thus: grade 8 was represented by 83 learners, grade 9, 92 learners and grade 10, 94 learners. This 90 percent turnout was good enough for the study because it falls within the expectation of the researcher. So, it was not a surprise because it was well planned for during the process of determining the number of participant required for the research.

3.7.1. Inclusion criteria

Heavy (2011), Polit & Beck (2012) posit that the inclusion criteria make up the list of characteristics that a subject must have to be eligible to participate in the study. In this study the following inclusion criteria were used:

- Those learners willing to participate from ages between 13-16 years old.
- The exclusion criteria are characterised that eliminate a subject from being eligible to participate in a study (Heavy, 2011; Polit & Beck, 2012)

3.7.2. Exclusion criteria

In the study, the exclusion criteria consisted of:

- Those learners unwilling to participate in the research study.

Learners who are below or above the prospective age that is needed in the study.

3.7.3. Sampling of Schools

According to Polit & Beck (2012), sampling is the process whereby a portion of the population as an entire population are selected. They define sample as a subset of a population selected to participate in the study. The researcher selected four schools in the uMgungundlovu district in KZN where data was collected. Those four schools were conveniently selected on their proximity to where the researcher works. The four schools were selected using purposive sampling. The main goal of purposive sampling was to focus on particular characteristics of a population that were of interest, which would best enable the researcher to answer the research questions. Sampling units were selected based on their similar characteristics as they were of particular interest to the researcher.

- A sample was a part or fraction of the whole selected by the researcher to participate in a research study (Brink, 2010). The use of the largest sample size is highly recommended as they were more representative of the population than smaller samples (Polit & Beck, 2012). The researcher used a stratified random sample and within each stratum, simple random sampling was carried out. Stratified random sampling was used to group elements of the population so that elements belong to one group only. A sample was drawn from a list of learners registered for grades 8, 9 and 10 from four designated secondary schools at uMgungundlovu District. Learners would be grouped firstly according to their schools, then their grades. Using a table of random numbers 15 learners were selected from each stratum of the four schools' settings and each of the three schools eventually had a sample size of 45 from the three grades. The targeted sample size was, therefore, 180 students. It was believed that this sample size would be adequate to ensure a representative sample regarding in the study.

3.8.1. Respondents

The participants were 269 learners from grade 8, 9 and 10 in four selected secondary schools in uMgungundlovu district in KwaZulu-Natal.

3.8.2. Pilot Study

A pilot study is a small version of the main study (Burns, Gray & Grove, 2012). It is administered to a limited number of subjects from the same population. The aim of the pilot study is to ascertain the feasibility of the proposed study and early detection of flaws. The pilot study was conducted to grade 8, 9 and 10 learners who are between the ages of 13 – 16yrs and the participants did not take part in the main study.

3.9. The data collection process

The researcher selected four secondary schools in uMgungundlovu district, in KZN where data were collected. The four schools were selected using purposive sampling. The main goal of purposive sampling was to focus on the particular characteristics of a population that were of interest, which would best enable the researcher to answer the research questions. Sampling units were selected based on their similar characteristics and were of particular interest to the researcher.

The researcher obtained permission from the Department of Education (Appendices C) as well as from the Principals of the four selected secondary schools (Appendices F), and the assent forms to sign by the learners (Appendices 'A), informed consent forms where the learner was a minor parents or guardians signed. (Appendices B) Once all those who agreed to participate, an identified data collection date was identified with the LO teacher. Learners who had obtained consent from their parents or guardians were approached in their classrooms and the purpose of the study was fully explained. Classrooms in their schools were used as the venues of data collection during break and lunch times. Respondents were provided with a study information sheet (Appendices A) and the consent form (Appendices 'A). Respondents were informed about their anonymity and that no identifiable information should be entered on the questionnaire.

The researcher distributed the questionnaires. Respondents completed the questionnaire on their own to ensure confidentiality and anonymity. The researcher explained and clarified any questions to answer respondents' queries as suggested by Polit and Hungler (2012). The respondents were asked to put completed questionnaires into the secured box for security reasons. Codes and numbers were used instead of learners' names to ensure confidentiality (Burns, Gray & Grove, 2012). Out of 300 questionnaires distributed, 269 were collected after completion representing a response rate of 90percent. Saunders, Lewis, and Thornhill (2000) argued that response rates in surveys can be as low as 40percent and that a response rate of approximately 30percent is reasonable. In contrast, Babbie and Mouton (2001) argued that a response rate of 50 percent is fairly good, while that of 60 percent and 70 percent is very good. Therefore, in the present study, a very good response rate of 90percent was obtained, providing the researcher with the opportunity to generalize about the total population.

3.10. Data Analysis

Data was analysed together with the assistance of the researcher's supervisor and a statistician from Durban University of Technology. The analysis was analysed with the Statistical Package for the Social Sciences (SPSS VERSION 24.0). Descriptive statistics was used to describe the research phenomena. Table frequencies, bar diagrams, pie charts and communication data was included (Polit & Beck, 2012). Cross tabulations were performed to determine the relationship between the variables.

3.11. Ethical Considerations

Ethics is defined by Bankowski (1995) as a "branch of philosophy that deals with the distinction between right and wrong, and the moral consequences of our actions". In health research, respondents are human beings and their rights shall be considered. Beauchamp and Childress (cited in Smith, 1995) cite that within the framework of ethics, there are four major principles, namely, respect for the autonomy of individuals, non-maleficence, beneficence, and justice. Punch (in Morse, 1991) points out that there are issues that need to be addressed in research such as consent, deception, privacy, and confidentiality which shall be dealt with either before, during and even after fieldwork

During this study, ethical clearance was duly obtained from the Ethics Committee of the University of KwaZulu-Natal. Also, permission to conduct the study was obtained from the Department of Education and from the principals of the four designated schools. Written and informed consent was obtained from respondents (Appendix D). Consent were granted by parents for learners who were under the age of 18 years. Furthermore, assent forms were filled in by the learners if the parents/guardians agreed. Respondents were informed that they have the right to participate or to refuse to participate, and could opt out at any stage of the research process should they deem it necessary. Participants were assured that any information gained from them would be treated with strict confidentiality. Respondents were instructed not to write their names on questionnaires to ensure anonymity. Data is kept under lock and key for 5 years and once the research process was completed, questionnaires were disposed of by means of shredding.

As prescribed by Brink, Van Der Walt and Van Rensburg (2012), and the World Medical Association Declaration of Helsinki (2004), the research study adhered to the ethical principles, and the following were considered.

- A two-page participation information letter was provided to each learner explaining the purpose of the research and the nature of the questionnaire (Appendices). They were also provided with a consent form to participate in the study which they sent to their parent/s or guardian/s for minor learners. The parent/s or guardian/s signed before the learner answered any questions. Every learner was given a copy of what (Appendices).

- The principle of justice was adhered to ensuring the participants confidentiality. During the data collection process, the researcher informed participants not to write their names on the questionnaires. It was explained to them that the completion of the questionnaire required signing a consent form from the parents. The respondents were assured that no sensitive information would be divulged during the publication of the study results.

- All prospective participants were informed of the purpose of the study and of the fact that the research would be made available to all respondents.

- The respondents had the right to decide voluntarily whether or not to participate in the study without any risk of penalty or prejudicial treatment. The principle of Respect was thus adhered to.

- The principle of beneficence rules that well-being of the respondents was maintained. The Researcher ensured that no discomfort or inconvenience occurred during the data collection.

3.12. Data Management

To further foster the commitment of the University of KwaZulu-Natal to openness in research, the data on which this dissertation is based has been made available for evaluation to the broader research community. Therefore, in conformation with the ethical code of the University, for confidentiality, and in order to protect the University's intellectual property rights, a safe storage has been arranged for all the data used for this research. These data are to be retained at the University for the next five years, after which they are expected to be destroyed if no publication based on the dataset appears within these years.

3.13. Data Dissemination

The final results were communicated to the supervisor and Head of Department of Education in KZN at the end of the study. The report of the findings was submitted to the principals of the four selected secondary schools in uMgungundlovu District, KZN. A date was arranged for feedback to the respondents at which results would be presented. Findings would be published in accredited academic journals. Furthermore, the research findings emanating from the study will be presented to the Department of Education. A paper based on the study will be presented at a conference.

3.14. Summary

This chapter discussed the research design, the research instrument, and the validity and reliability of the research instrument. It described how data were collected, the methods used for data analysis and the ethical considerations involved in this study. The data management and the dissemination of the results were also explained. The next chapter presents the results of the study.

PRESENTATION OF THE FINDINGS

4.1. Introduction

This chapter presents the results of the study. To reiterate, the research objectives of this study were: (1) to determine the extent to which the ISHP is reaching the people it is intended to affect; (2) to describe learners' perception regarding the implementation of ISHP in selected secondary schools in uMgungundlovu District; and (3) to determine the learners level of satisfaction with the implementation of ISHP in the selected secondary schools in uMgungundlovu District.

The self-administered questionnaire was the primary tool used to collect data and then distributed to learners in KwaZulu-Natal. The data collected was analysed with The Statistical Package for the Social Sciences (SPSS) version 24.0. The results were presented descriptively using frequencies and percentages in the form of graphs, tables, cross-tabulations and other figures emanating from the quantitative data that was collected

Regarding the sample size realization, a total of 300 questionnaires were despatched and 269 were completed and returned to the researcher, which gave a 90percent response rate.

4.2. Respondents' Demographic Profile

4.2.1. Gender of the respondents

The findings from this study indicate that the majority of the respondents, 63.8 percent (n=170) were female while 36.8 percent (n =99) were males (Figure 4. 1).
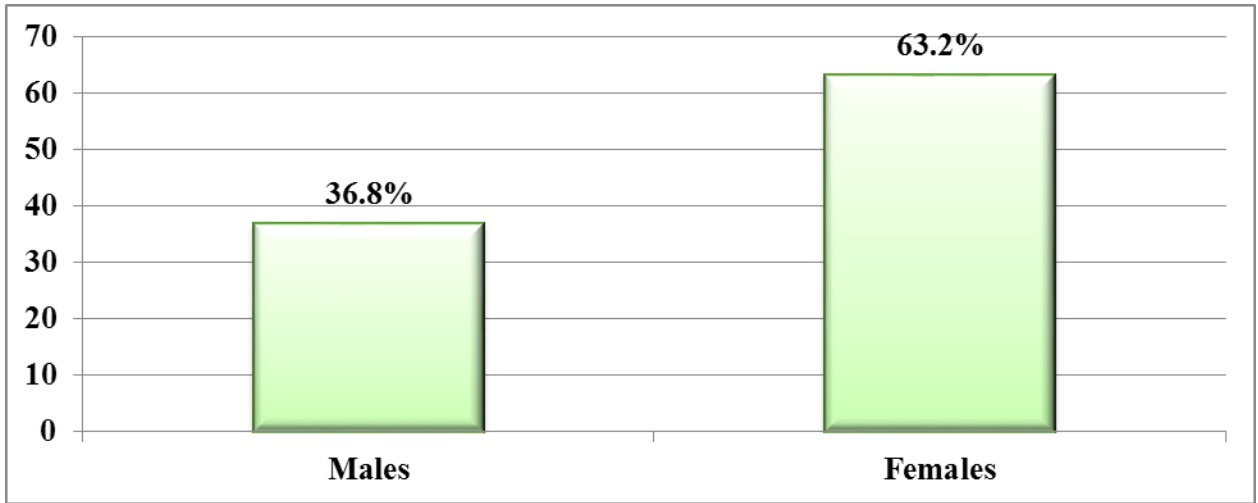
Figure 4. 1: Gender of the participants **(**n=269)

4.2.2. Age group of the respondents

Of the 269 respondents who participated in this study, 81.4 percent (n=219) were between the age group of 13 and 16 years while 17.1percent (n=46) were below 13 years and 1.5 percent (n=4) were above 16 years of age (Figure 4. 2)
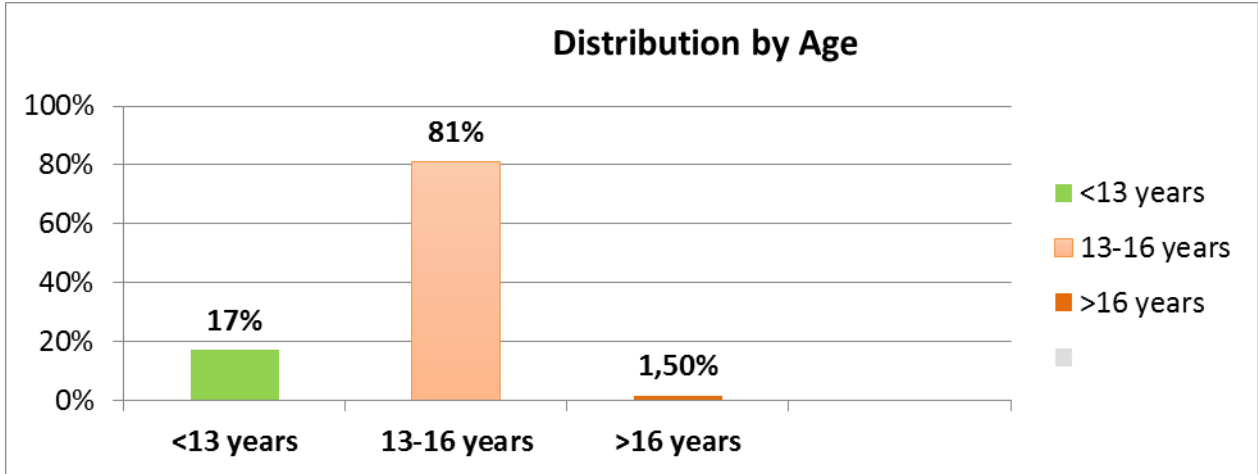
Figure 4.2. Age distribution of the respondents (n=269)

4.2.3. Race of the respondents

This study found that the majority of the respondents, 86 percent (n=232) were African while 7 percent (n=19) were Coloureds and 7percent (n=18) were Indian (Figure 4. 3).
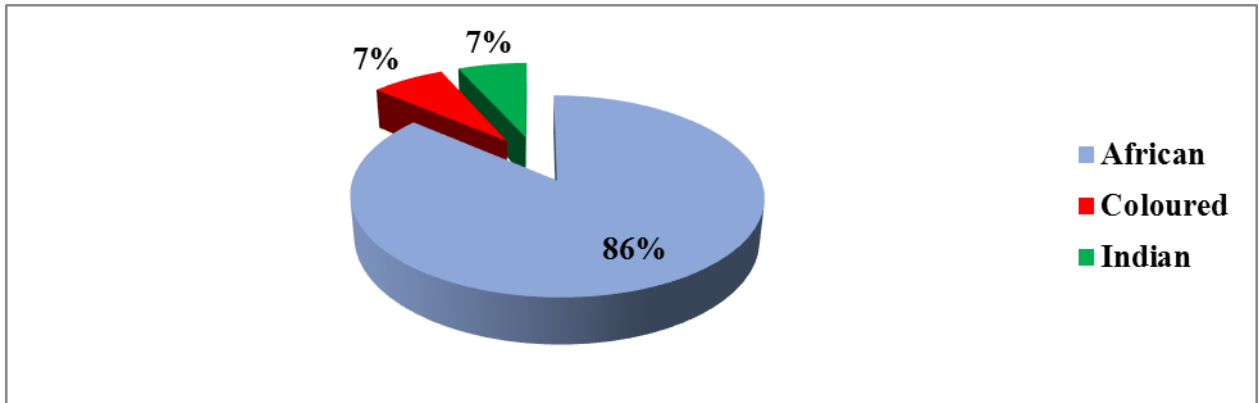
Figure 4.3 Race of the respondents

4.2.4. School participation

Out of 269 respondents from the 4 schools that participated in this study, 27.9 percent (n=75) were School B while 24.5 percent (n=66) were School D, School A and School C were both 23.8 percent (n=64) (Figure 4. 4).
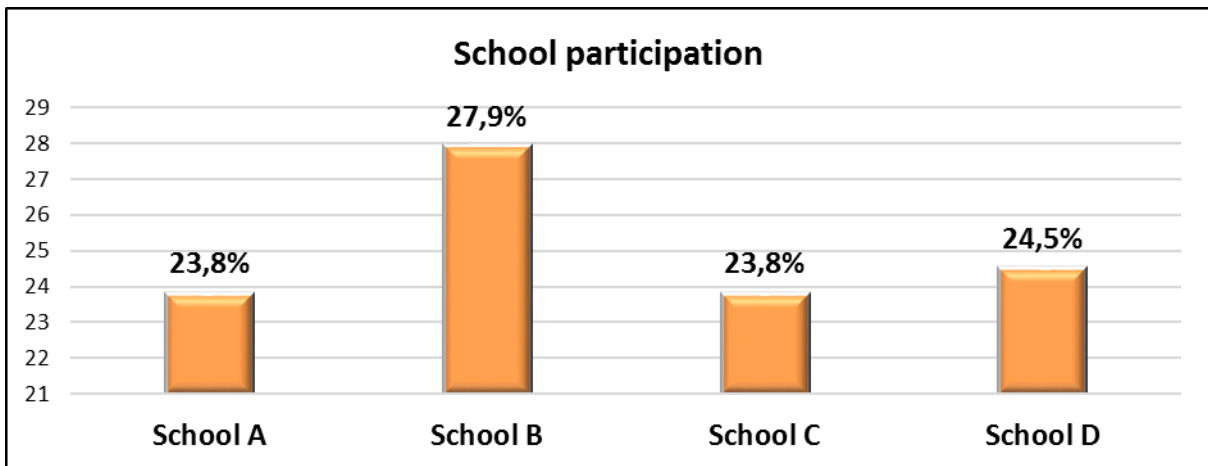
Figure 4.4 School participation

4.2.5. School grades

It was found that of the 269 respondents, 94 (34.9 percent) were in grade 10, followed by 92 (34.2percent) in grade 9 and lastly, 83 (30.9 percent) were in grade 8 (Figure 4. 5).
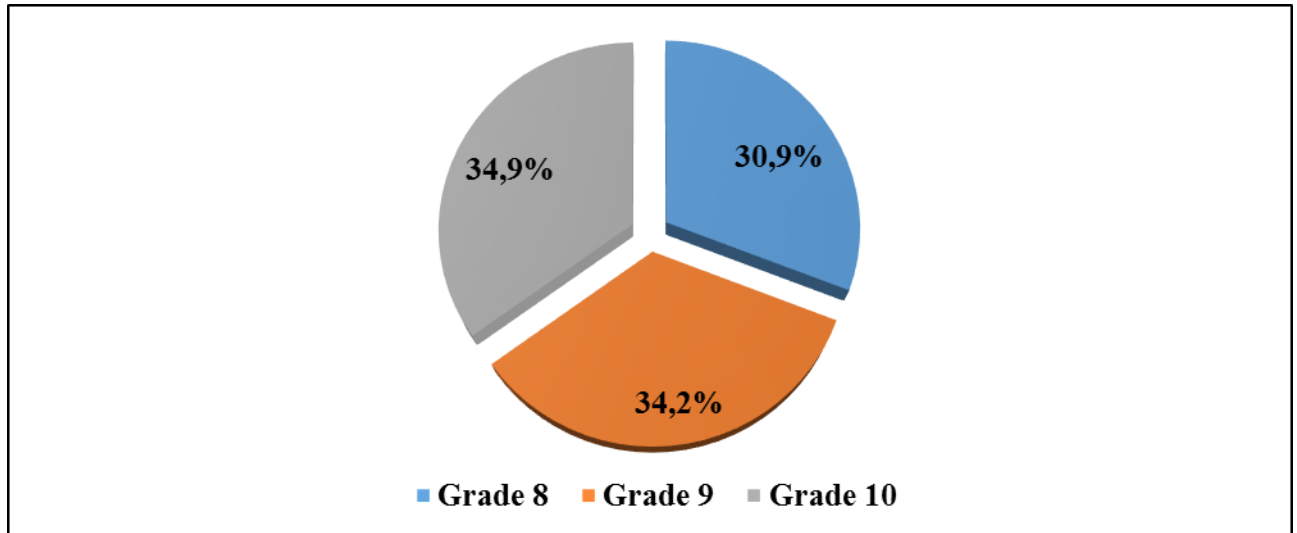
Figure 4.5 Respondents school grade profile.

4.3. Extent to Which the ISHP is Reaching the People it is Intended to Reach

4.3.1. Frequency of visits to schools by school health nurses

The findings from this study indicated that the frequency of school visits by school health nurses varied. Of the 269 respondents who participated in this study, 37.2 percent (n=100) said school health nurses come once in 6 months, while 20.1 percent (n=54) have never seen school health nurses in their schools, 16.4 percent (n=44) of learners said nurses come to school once every three months, 15.6 percent (n=42) said school health nurses comes monthly, and 6.7 percent (n=18) of the learners said nurses come daily, and finally, 4.1 percent (n=11), of learners saying school health nurses come weekly (Figure 4. 6).
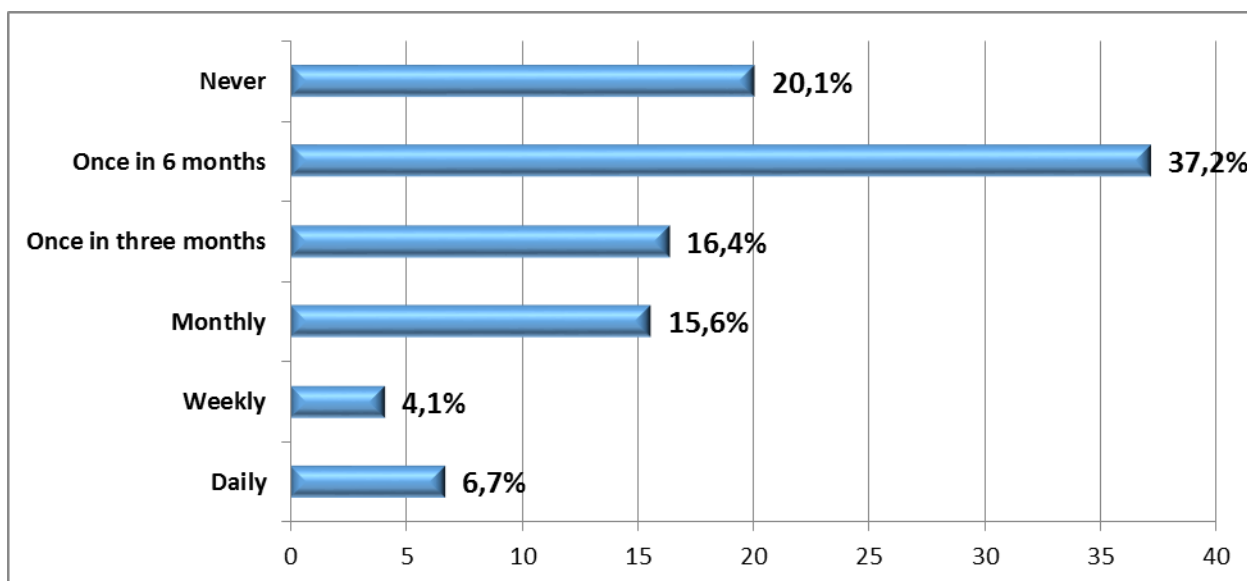
Figure 4.6 Frequency of visits to schools by school health nurses

4.3.2 Services offered to the schools

The findings from this study indicated that varied percentages of respondents reported that ISHP services were offered in their schools. The services offered included nutritional assessment (18 percent; n=49); visual assessments (27.1 percent; n =73); oral health (35.3 percent; n=95); ear examinations (10.4 percent, n=28); hearing assessments (11.5 percent; n=31); speech assessments (19.3 percent; n=52); chronic illnesses (8.6 percent; n=23); immunization (19.7 percent; n=53); minor ailments (5.9 percent; n=16); T.B screening (17.1 percent; n=46); anaemia (4.1 percent; n=11) and psychological support (25.3 percent; n=68) (Table 4. 1).

Table 4.1 Services offered in the Integrated School Health Programme (ISHP)

Services	Yes		No	
	Freq.	%	Freq.	%
Nutritional assessment	49	18.2	220	81.8
Visual assessments	73	27.1	196	72.9

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Oral health	95	35.3	174	64.7
Ear examinations	28	10.4	241	89.6
Hearing assessments	31	11.5	238	88.5
Speech assessments	52	19.3	217	80.7
Chronic illnesses	23	8.6	246	91.4
Immunization	53	19.7	216	80.3
Minor ailments	16	5.9	253	94.1
T.B screenings	46	17.1	223	82.9
Anaemia	11	4.1	258	95.9
Psychological support	68	25.3	200	74.3

However, Table 4.1. indicates that significant percentages from various schools did not receive the following the health services: Nutritional assessments (81.8 percent; n=220); visual assessments (72.9 percent; n=196); oral health (64.7 percent; n=174); ear examinations (89.6 percent; n =241); hearing services (88.5 percent; n=238); speech services (80.7 percent; n=217); chronic illnesses (91.4 percent; n=246); immunisation (80.3 percent; n=216); minor ailments (94.1 percent; n=253); TB screening (82.9 percent; n=232); anaemia (95.9 percent; n=258) and psychological support (74.3 percent; n=200).

Cross tabulation of the rural school versus urban school location and services offered. A chi-square test was run in order to establish the association between the provision of ISHP services and the school location (urban versus rural). There was a significant association between the school location and oral health care (X_2=6.401, d. f=1, p=0.011), hearing care

(X_2=11.777; d. f=1, p=0.001); speech care (X_2=4.855; d. f=1; p=0.028), and TB screening (X_2=21.265; d. f=1; p=0.000). This indicated that students from the rural area were likely to receive oral care, hearing care, speech care, and T.B screening.

Table 4.2 Cross tabulation of the rural school versus urban school location and services offered

Services	Yes (%)		No (%)	
	Rural	Urban	Rural	Urban
Nutritional assessment	10.0%	8.2%	41.6%	40.1%
Visual assessments	11.5%	15.6%	40.1%	32.7%
Oral health	21.9%	13.4%	29.7%	34.9%
Ear examinations	7.1%	3.3%	44.6%	45.0%
Hearing assessments	9.3%	2.2%	42.4%	46.1%
Speech assessments	12.6%	6.7%	39.0%	41.6%
Chronic illnesses	5.6%	3.0%	46.1%	45.4%
Immunization	10.4%	9.3%	41.3%	39.0%
Minor ailments	4.1%	1.9%	47.6%	46.5%
T.B screen	14.1%	3.0%	37.5%	45.4%
Anaemia	2.6%	1.5%	49.1%	46.8%
Psychological support	14.2%	11.2%	37.7%	36.9%

4.4. Awareness of ISHP Services Offered at Schools

It was found that of 269 respondents, 48.7 percent (n=131) reported that "know your body" health services was offered in their schools, 42.4 percent(n=114) reported that lifestyle information and drugs, alcohol, smoking, and diet advice were provided, 34.6 percent (n=93) reported that school feeding programmes was offered in their schools; 34.2 percent (n=92) reported that sexual reproductive and rights were offered in their schools, 30.5 percent (n=82) reported HIV counselling, 26.0 percent (n=70) reported that personal and environmental hygiene advice was offered in their schools, 22.3 percent (n=60) reported that medical male circumcision was offered in their schools, and 14.9 percent (n=40) reported that learners referred for further assessment was offered in their schools (Figure 4. 7).
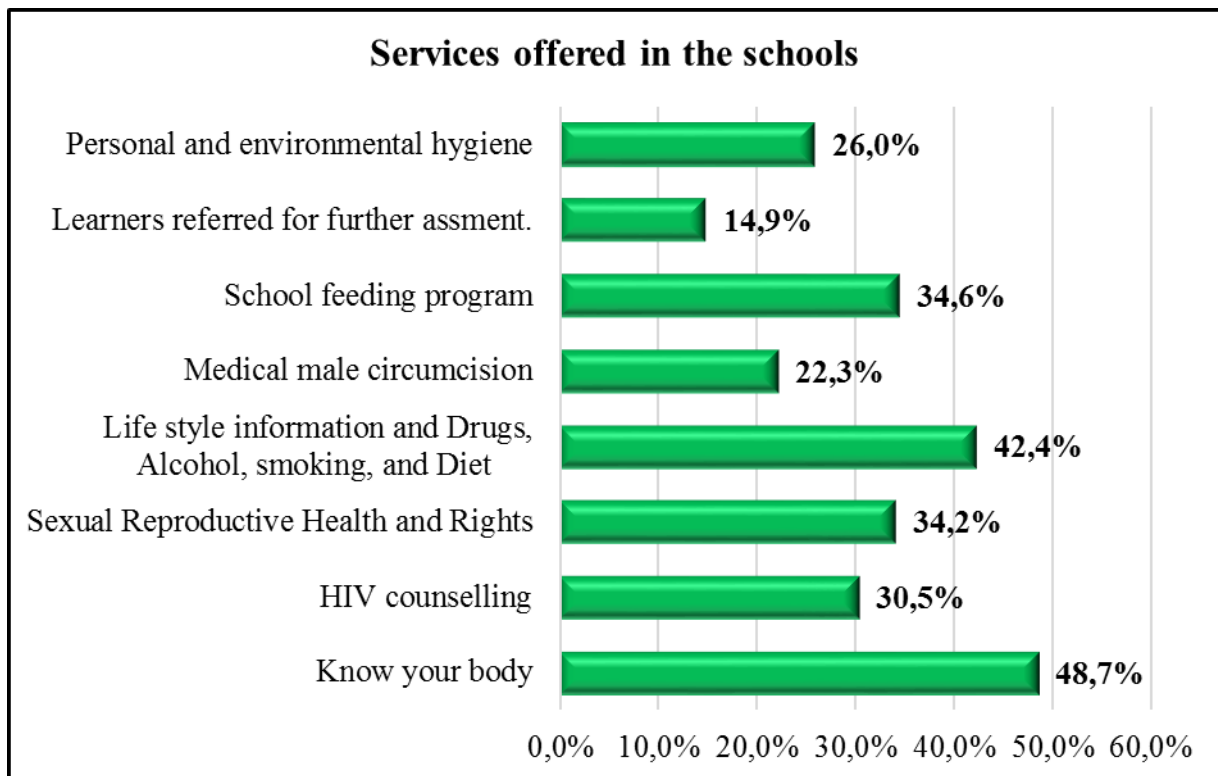
Figure 4.7 Services offered in the school

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4.5. Level of Satisfaction With the Services Offered

The findings from this study indicated that of 269 respondents, 44.6 percent (n=120) were very satisfied, 20.1 percent (n=54) were neither satisfied nor dissatisfied, 17.5 percent (n=47) were somewhat satisfied, 11.9 percent (n=32) were very dissatisfied, and 5.9 percent (n=16) were somewhat dissatisfied.
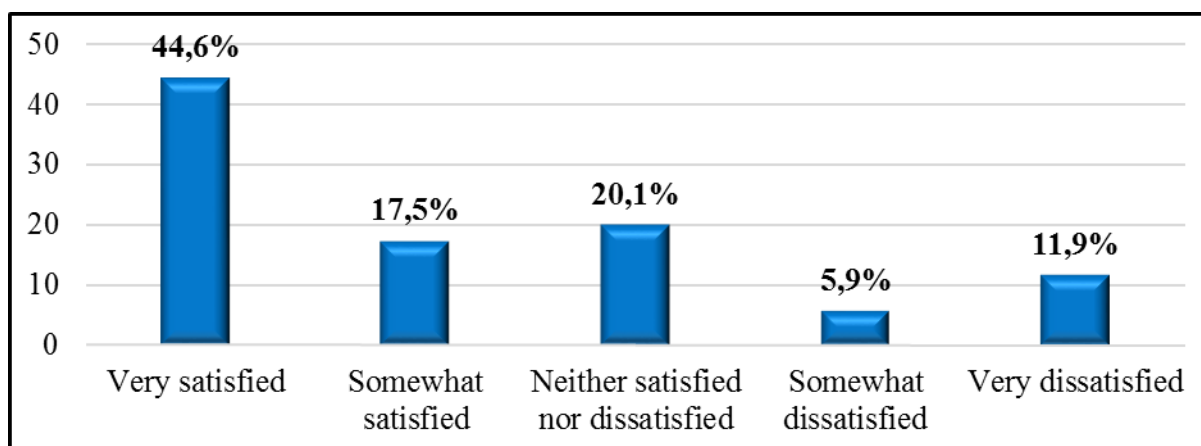
Figure 4.8 Level of satisfaction with the services offered

A chi square test was performed in order to establish a relationship between socio demographic characteristics and the level of satisfaction about services offered. There was a significant association between gender (X^2=11.080; d. f=4; p=0.026); age (X^2=22.289; d. f=8; p=0.004); school name (X^2=39.267; d. f=12; p<.000) and grade (X^2=34.464; d. f=8; p<.000).

4.6. Health Promotion Activities Needed at School

The findings from this study indicated that the information about health promotion activities were needed in ISHP services. This included contraception, male and female condoms, family planning (41.6 percent; n=112); bullying (41 percent; n=111); male medical circumcision, CTOP (38.3 percent; n=103); teenage pregnancy,; smoking dagga (37.9 percent; n=102); depression (24.2 percent; n=65); psychological support (39.8 percent; n=107); emotional support (39.4 percent; n=106); alcohol (30.9 percent; n=83); menstruation (26.8 percent; n=72); STIs and HIV (27.1 percent; n=74); sexual services (24.5 percent; n=66); physical abuse (23.0 percent; n=62); emotional abuse (22.7 percent ; n=61);

breastfeeding (22.3 percent; n=60); suicide (21.9 percent, n=59) and violence (16.4 percent; n=44).
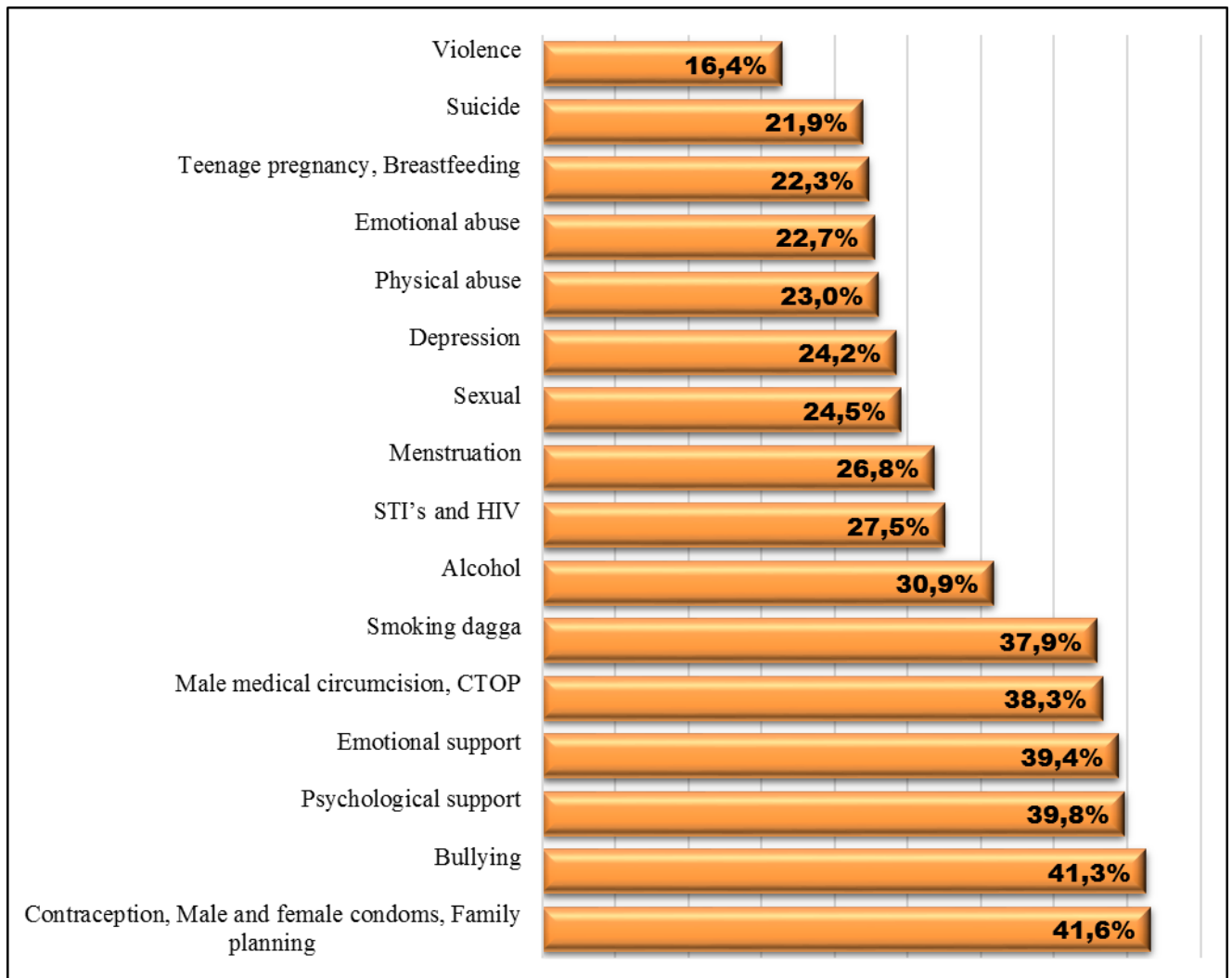
Figure 4.9 Health promotion activities needed at school

4.7. Learners Perceptions About ISHP Implementation

The findings from this study revealed that 36.8 percent (n=99) agreed, and 31.2 percent(n=84) strongly agreed that the school health nurses are good about explaining the reason for screening tests. However, 14.5 percent (n=39) were uncertain, 9.7 percent (n=26) disagreed, and 7.8 percent (n=21) strongly disagreed that the school health nurses are good about explaining the reason for screening tests.

It was observed that 32 .0 percent (n=86) agreed, and 15.6 percent (n=42) strongly agreed and they thought that their school health nurses' office has everything needed to provide

complete health information assessments. However, 21.6 percent (n=58) were uncertain, 15.6 percent (n=42) disagreed, and 15.2 percent (n=41) strongly disagreed they thought that their school health nurses' office has everything needed to provide complete health information assessment.

Out of 269 respondents, 28.6 percent (n=77) agreed, and 25.3 percent (n=68) strongly agreed that the health information care they have been receiving was just about perfect. However, 20.4 percent (n=55) were uncertain, 13.0 percent (n=35) disagreed, and 12.6 percent (n=34) strongly disagreed that the health information care they have been receiving was just about perfect.

The findings indicated that out of 269 respondents, 32.0 percent (n=86) agreed, and 17.5 percent (n=47) strongly agreed that they felt confident that they could get the screening care they needed without being set back. However, 23 percent (n=62) were uncertain, 14.1 percent (n=38) strongly disagreed, and 13.4 percent (n=36) disagreed that they felt confident that they could get the screening care they needed without being set back.

It was found that 24.9 percent (n=67) agreed, and 26.0 percent (n=70) strongly agreed that when they go for screening, the nurses are careful to check everything when treating and examining them, however 23.0 percent (n=62) were uncertain, 14.1 percent (n=38) strongly disagreed, and 11.9 percent (n=32) disagreed.

Of 269 respondents, 29.0 percent (n=78) agreed, and 21.2 percent (n=57) strongly agreed that sometimes school health nurses make them wonder if their findings/diagnosis are correct. However, 20.1 percent (n=54) were uncertain, 16.4 percent (n=44) disagreed 13.4 percent (n=36) strongly disagreed.

It was found that 19.3 percent (n=52) agreed, and 16.7 percent (n=45) strongly agreed that they must pay more attention to their screening assessment, 23.4 percent (n=63) strongly disagreed, 17.8 percent (n=48) disagreed 22.7 percent (n=61) were uncertain. The study findings demonstrated that 25.3 percent (n=68) agreed, and 11.2 percent (n=30) strongly agreed that they have easy access to the referrals to the specialists they need, however 24.5 percent (n=66) were uncertain, 20.8 percent (n=56) strongly disagreed, and 18.2 percent (n=49) disagreed.

Of the 269 respondents, 16.7 percent (n=45) agreed, and 17.8 percent (n=48) strongly agreed where they get assessment care, learners must wait too long for emergency treatment, however 25.3 percent (n=68) were uncertain, 23.4 percent (n=63) strongly disagreed, and 16.7 percent (n=45) disagreed. The findings show that 20.1 percent (n=54) agreed, and 11.5 percent (n=31) strongly agreed school health nurses act too busy and impersonal towards them, however 25.3 percent (n=68) were uncertain, 20.1 percent (n=54) strongly disagreed, and 23.0 percent (n=62) disagreed.

It was found that 23.0 percent (n=62) agreed, and 34.2 percent (n=92) strongly agreed that their school health nurses treat them in a very friendly and courteous manner, 17.5 percent (n=47) were uncertain, 14.1 percent (n=38) disagreed, and 11.2 percent (n=30) strongly disagreed. The results indicated that 23.0 percent (n=62) agreed, and 17.5 percent (n=47) strongly agreed that those who provide their health assessment/education sometimes hurry too much when they examine them, 21.9 percent (n=59) were uncertain, 21.2 percent (n=57) disagreed, and 16.4 percent (n=44) strongly disagreed.

Of 269 respondents, 16.0 percent (n=43) agreed, and 13.0 percent (n=35) strongly agreed that school health nurses sometimes ignore what they tell them, 23.0 percent (n=62) strongly disagreed, 30.1 percent (n=81) disagreed, and 17.8 percent (n=48) were uncertain. The results show that 19.0 percent (n=51) agreed, and 18.6 percent (n=50) strongly agreed that they have some doubts about the ability of the school health nurses who treat them, 23.4 percent (n=63) were uncertain, 20.8 percent (n=56) disagreed, and 18.2 percent (n=49) strongly disagreed. Of 269 respondents, 24.9 percent (n=67) strongly agreed, and 21.2 percent (n=57) agreed school health nurses usually spend plenty of time with them, 20.8 percent (n=56) were uncertain, 20.8 percent (n=56) strongly disagreed, and 12.3 percent (n=33) disagreed. It was also found that 25.3 percent (n=68) agreed, and 15.6 percent (n=42) strongly agreed they find it hard to get an appointment for referral right away, 21.2 percent (n=57) were uncertain, 20.4 percent (n=55) disagreed and 17.5 percent (n=47) strongly disagreed.

The study findings show that 23.0 percent (n=62) strongly agreed 18.6 percent (n=50) agreed, and they were dissatisfied with some things about the school health care that they received, 20.4 percent (n=55) strongly disagreed, 17.8 percent (n=48) disagreed and 20.1percent (n=54) uncertain. Furthermore, were 30.5 percent (n=82) strongly agreed, 16.4 percent (n=44) agreed they could get assessment care whenever they needed it, 23.8 percent (n=64)

strongly disagreed, 16.0 percent (n=43) disagreed and 13.4 percent (n=36) were uncertain.

Table 4.3 Perception about ISHP implementation

	Strongly disagree		Disagree		Uncertain		Agree		Strongly agree	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%
School health nurses are good about explaining the reason for screening tests.	21	7.8	26	9.7	39	14.5	99	36.8	84	31.2
I think my School health nurses' office has everything needed to provide a complete health information assessment	41	15.2	42	15.6	58	21.6	86	32.0	42	15.6
The health information care I have been receiving is just about perfect	34	12.6	35	13.0	55	20.4	77	28.6	68	25.3
I feel confident that I can get the screening care I need without being set back	38	14.1	36	13.4	62	23.0	86	32.0	47	17.5
When I go for screening, they are careful to check	38	14.1	32	11.9	62	23.0	67	24.9	70	26.0

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	Strongly disagree		Disagree		Uncertain		Agree		Strongly agree	
everything when treating and examining me										
Sometimes school health nurses make me wonder if their findings/diagnosis is correct	36	13.4	44	16.4	54	20.1	78	29.0	57	21.2
I have to pay more to my screening assessment	63	23.4	48	17.8	61	22.7	52	19.3	45	16.7
I have easy access to the referrals to the specialist I need	56	20.8	49	18.2	66	24.5	68	25.3	30	11.2
Where I get assessment care, learners have to wait too long for emergency treatment	63	23.4	45	16.7	68	25.3	45	16.7	48	17.8
School health nurses act too busy and impersonal towards me	54	20.1	62	23.0	68	25.3	54	20.1	31	11.5
My school health nurses treat me in a	30	11.2	38	14.1	47	17.5	62	23.0	92	34.2

	Strongly disagree		Disagree		Uncertain		Agree		Strongly agree	
very friendly and courteous manner										
Those who provide my health assessment/education sometimes hurry too much when they examine	44	16.4	57	21.2	59	21.9	62	23.0	47	17.5
School health nurses sometimes ignore what I tell them	62	23.0	81	30.1	48	17.8	43	16.0	35	13.0
I have some doubts about the ability of the school health nurses who treat me	49	18.2	56	20.8	63	23.4	51	19.0	50	18.6
School health nurses usually spend plenty of time with me	56	20.8	33	12.3	56	20.8	57	21.2	67	24.9
I find it hard to get appointment for referral right away	47	17.5	55	20.4	57	21.2	68	25.3	42	15.6
I am dissatisfied with some things about the school health care that I receive	55	20.4	48	17.8	54	20.1	50	18.6	62	23.0

	Strongly disagree		Disagree		Uncertain		Agree		Strongly agree	
I am able to get assessment care whenever I need it	64	23.8	43	16.0	36	13.4	44	16.4	82	30.5

An overall score of the perception about the ISHP implementation in the school was conducted, and 18 items mentioned above were considered. The responses ranged from 1= strongly disagree, 2=disagree, 3= uncertain, 4= agree, and 5=strongly agree. The higher the score is, the more the perception of the respondents towards ISHP implementation, and the lower score, the lower the perception towards the ISHP implementation in the school. It was found that the minimum score was 18, and the maximum score was 85. The mean score was 56.862, and the standard deviation was 12.3375. The median was 57 and mode was 56. It was found that 61percent had a high perception, 31.5 percent had a medium and 7.4 percent had a low perception about ISHP implantation in the school.
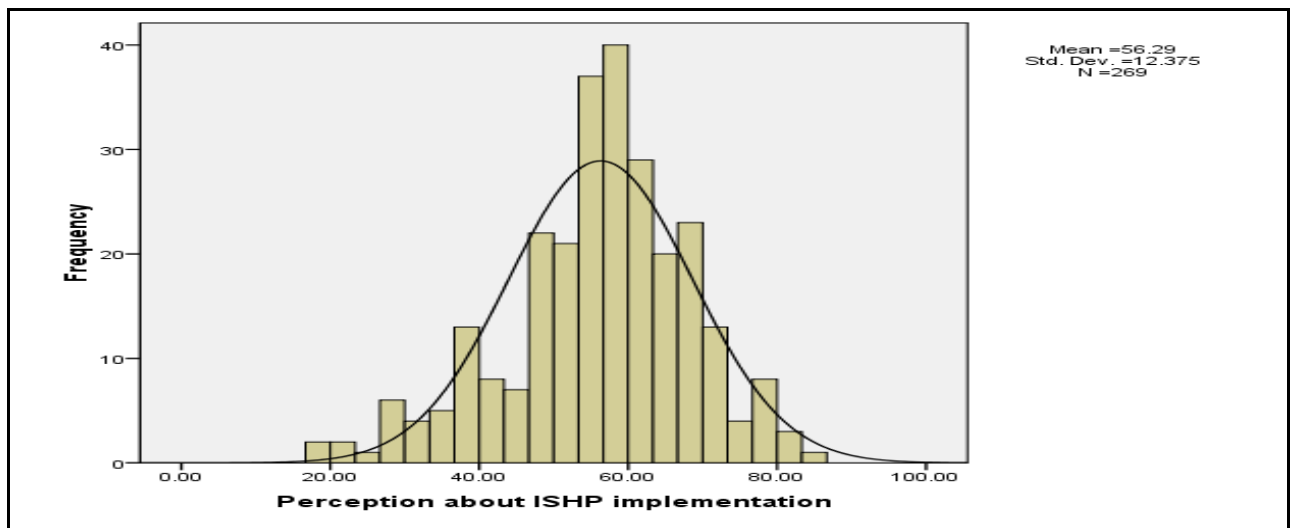
Figure 4.10 Histogram of perception about ISHP implementation

		Perception about ISHP implementation
A spearman correlation was done to establish the relationship between the socio demographic data and the overall score of ISHP implementation in the school. There was a significant relationship with the following: Age (r_s [269] = -.228; p < .000); School name (r_s [269] = -.223; p < .000); School location (r_s [269] = -.132; p < .030) and School grade (r_s [269] = -.216; p < .000).		
Gender	Correlation Coefficient	-.034
	Sig. (2-tailed)	.579
Age	Correlation Coefficient	-.228[**]
	Sig. (2-tailed)	.000
Race	Correlation Coefficient	-.086
	Sig. (2-tailed)	.161
School Name	Correlation Coefficient	-.223[**]
	Sig. (2-tailed)	.000

School location	Correlation Coefficient	-.132*
	Sig. (2-tailed)	.030
School Grade	Correlation Coefficient	-.216**
	Sig. (2-tailed)	.000
How often do the school health nurses come to your school?	Correlation Coefficient	-.269**
	Sig. (2-tailed)	.000
**. Correlation is significant at the 0.01 level (2-tailed).		
*. Correlation is significant at the 0.05 level (2-tailed).		

4.8. Summary

An account of the results from the analysed quantitative data has been given in this chapter. The results included the socio-demographic characteristics, the extent to which the ISHP is reaching the people it is intended to reach, health promotion activities and the perception of learners about the ISHP implementation in the schools. Chapter 5 presents the discussion of the findings, conclusion, and recommendations.

CHAPTER FIVE

CONCLUSION, RECOMMENDATIONS AND DISCUSSION

5.1. Introduction

The previous chapter presents the discussion of the study findings which is guided by the study objectives, questions and framework. It also provides a reflection on the findings based on learners' perceptions, their awareness and satisfaction regarding the implementation of ISHP in selected secondary schools. However, this chapter focuses on the summary, conclusion, and recommendations of this dissertation. It seeks to summarize the research findings with a view of highlighting the extent to which the ISHP attains. Is the ISHP consistent with what the programme document is saying? It also highlights the content of the programme, and how consistent it is with what is supposed to be offered. The chapter also discussed the learners' perceptions regarding the implementation of the programme, the learners' level of satisfaction with a view to unpack the interesting and the disappointing findings. The following study objectives and these terms for the framework are as follow:

- To determine the learners' perceptions regarding the implementation of ISHP in integrated school health programme.
- To explore their awareness of ISHP
- To describe the level of satisfaction towards the implementation of ISHP in the Integrated School Health Programme in uMgungundlovu District.

They are also guided by framework via:

- Inputs which are related to the resources that can be used to implement programme.
- Processes which are related to services that are offered in the ISHP.
- Outputs which are related to the activities, clients, customers.
- Outcomes Short-term: Increase learners' knowledge, satisfaction about the implementation of the services.

5.2. ISHP Delivery and Frequency of the Nurses to the Schools

From the learners, there were a few disappointing findings. Of the 269 learners interviewed, 54 of them indicated that they have never seen school health nurses in their schools. This negates the provision of the programme policies and guidelines, which stipulates that every

school should have a stationed school health nurse (SHN). On the other hand, 44 learners reported that nurses come to their schools once every three months, while 42 claimed that school health nurses come monthly. None of this is in line with the Integrated School Health Policy and guidelines (ISHP, 2012). However, it is quite interesting to note that, 18 learners were of the opinion that nurses come daily and 11 learners reported that school health nurses come weekly. That notwithstanding, it is of extreme concern for the researcher that 54 learners have reported having not seen school health nurses in their schools at all. Therefore, based on the study's findings, one could deduce that, although ISHP programmes have been initiated in most schools, many schools are still lacking these essentials services. It is uncertain though whether ISHP services or programmes are lacking in rural or urban schools or both.

It is disappointing to find out from this study that although school health nurses do visit some schools, the frequency of their visits is unpredictable. This also is inconsistent with the ISHP policy, which stipulates that the school health teams (as outlined in the National Health Insurance Green Paper) will be based in PHC clinics and led by a professional nurse, and possibly be assisted by the enrolled nurse, or nursing auxiliary. For every 2000 learners, the professional nurse will coordinate the delivery of school health services, do learner assessments and provide onsite services. While health education will be delivered by health promoters or community health workers. On the contrary, other evaluation studies have reported only a modest impact made by this programme in terms of the health outcomes (Schultz, 2005). Further studies were conclusive regarding the impact of these programmes on learners' health (Braven, 1989). An example was the European Network of Health Promoting Schools (ENHPS) and HPSI evaluation which showed that these programmes have the potential to but do not necessarily contribute to health-related outcomes among learners and staff (Garwood & Sinclair, 1979; Mukoma & Fisher, 2004; Saha, et al. 2004; Clift & Jensen, 2005). Furthermore, the study revealed that respondents were lacking knowledge towards awareness of school health nurses' visits. (ISHP, 2012).

5.3. Learners' Awareness About ISHP Services

According to Schram (2000) if learners in secondary schools were not made to understand their importance of school health programme, the utilization of school health service will not be achieved. The findings of the study indicated that there is no significant relationship between awareness and utilization of school health services among the learners from the

selected secondary schools. Of the 269 respondents, 155 reported that lifestyle information and education about drugs, alcohol, smoking, and diet are not offered in their schools, while 114 reported that lifestyle information and education about drugs, alcohol, smoking, and diet was offered in their schools. Meier et al., (2012) provides findings that long-term marijuana use started in teen years does have a negative effect on intellectual function. The more dependent the person becomes on marijuana the more significant the impairment. The study revealed a perfect positive relationship between the school health services of "know your body" among the respondents, 131 responded positively. The results are not surprising because most learners are taught during primary level about these services. It was surprising though, that the study findings showed that some essential services are not offered in the schools. More than half of the respondents (69.5percent) reported that HIV counselling is not of concern in the KZN Province where statistics shows that the percentage of young people between the ages of 15-24 years are the individuals that are infected with HIV and AIDS. The findings of this study are in line with the study that was conducted in U.K that reported that 6151 people are newly diagnosed with HIV and AID's.

According to the UN AIDS Report (2014), South Africa has the second highest rate of death from AIDS in the World with teenage girls and young women being most at risk of HIV infection. It stated that 13percent of all deaths from AID's took place in South Africa. The second highest number is in Nigeria where 14percent of AIDS's deaths in 2013 occurred. Rates of STIs among young teen woman, especially in the rural area, were the harder hits with HIV. Most studies into health-seeking behaviour in South Africa have focused (2012) on gender differences in health-seeking behaviour. In KwaZulu-Natal, Moodley (2013) noted that disclosure and stigma around partners and fear of abandonment and isolation from friends and family were also an issue among men. The study showed that it is only a minority of the learners that affirmed that they have been taught about anaemia, and this only constitutes 1.4percent of the study's respondents. The majority of the learners in the study were unsure of whether or not they have been taught about particular issues pertaining to their health. This suggests that they have not been taught adequately at their schools.

5.4. Learners' Level of Satisfaction with the Implementation of ISHP

In this study regarding the level of satisfaction of school health services, only 120 respondents reported that they were very satisfied with the implementation of the services that are offered in the school. It was surprising most of the learners were not sure about the services that are offered in their schools. This could result in poor utilisation of the service by learners

.. According to the Integrated School Health Programme Resource Manual for School Health Nurses (2012) they designed a package for ISHP which stipulates three components that must be followed by each school's learners in South Africa via screening as each and every learner must go for screening to detect early disease to prevent and promote health through school health nurses or any member of DoH in combination with the Department of Basic Education and other stakeholders e.g. Optometrist's about visionary which is the most important about reading purposes.

5.5. Learners' Perceptions About the Implementation of ISHP

Although some learners reported to have not seen the school health nurses, it is however pleasing that almost a quarter of the learners reported to have received most of the essential services as outlined in the ISHP (49 nutritional assessment, visual assessments 73; oral health 95; ear examinations 28; hearing assessments 31; speech assessments 52; chronic illnesses 23; immunizations 53; minor ailments 16; and TB 46). The study revealed that adolescents is a time of rapid transition, experience significant emotional, physical and psychological changes. These changes influence behaviour, in particularly, decisions to engage in in risky behaviour. Theses including sexual activity, alcohol consumption, smoking and substance abuse. 88percent of the 1.2 billion adolescents worldwide live in developing countries where access to sexual and reproductive health (SRH) services that could support them are often inadequate and fragmented (South African Medical Journal, 2014). Unplanned pregnancies can affect the health and wellbeing of adolescents, placing them at a risk for morbidity and mortality related to unsafe abortion and childbirth, as well as limiting their education and employment opportunities, and their eventual livelihood outcomes.

In a survey conducted in 2012, four of the nine South African Provinces showed that 19.2percent of female learners aged between 12-19 years had had at least one pregnancy, with the majority being unwanted pregnancies. 5.8percent of males in the same age group had impregnated a girl. In addition, condom used by 15 -24 years olds in their most recent sexual encounter dropped from 85.2percent to 67.5percent for males and from 66.5percent to 49.8percent for females according to two nationally representative surveys conducted in 2008 and 2012. 15percent of the sexually active female learners reportedly, did not usually use contraceptives and 67percent did not use condoms. According to this study, it was surprising that the majority of the learners' lack information about this services that are offered in their schools, such as sexual reproductive health, HIV counselling, male medical circumcision and learners referred for further assessment and so forth. In addition, 71percent of the sexually active male learners reportedly did not use condoms. And out of 4.4percent sexually active learners who had contracted a sexually transmitted infection (STI), only half have received treatment. South Africa has a statutory commitment to address these problems so the state of youth SRH is not ignored. Many government and non-governmental organisation (NGO) initiatives have been implemented since SA's transition to democracy, such as:

- Policies addressing youth SRH

- The National Policy on HIV and AIDs for learners and education in Public Schools and Students and Education in Further Education and Training Institutions (1999)

- The National HIV and AID's Life Skills Education Programme (2000)

- The National School Health Policy (2003)

- The South African Children's Act (2005)

- The Revised HIV and AIDs Life Skills Education Programme (2009)

- The Integrated School Health Policy (2012)

- The Department of Health Integrated Strategy on HIV, STIs, and TB, 2012-2016.

In grading the implementation of the ISHP using the learners' perception it was quite interesting to note that 67percent (more than half of the respondents) agreed that the school health nurses are good about explaining the reason for screening tests, while only 17.5percent disagreed and the remaining 14.5percent were uncertain. As to whether the school health nurses' office has everything needed to provide complete health information assessments, while 21.6percent were uncertain, and 30.8percent disagreed it was disappointing to find out that only 47.6percent (less than half of the respondents) agreed with this statement.

Again, it was observed that half of the learners mentioned that school health nurses' office has everything needed to provide complete information assessment which is a positive sign regarding the implementation of (ISHP) through school health nurses. It emphasized that school health nurses who visit schools do provide information. Furthermore, they felt confident that they could get the screening care they needed. This is in line with the study that was done in New York that reported providing complete information in a joint programme of the New York City Department of Education, Department of Health and Mental Hygiene (DOHMH), OHS provides health services and preventive services to DoE learners. The WHO criteria include the following: Screening should be done only for diseases with serious consequences, so that screening tests could potentially benefit people's health.

Surprisingly the majority of the learners showed that they lack information about referrals to specialists and they do not know if nurses act too busy and impersonal towards them. According to (ISHP, 2012), the aim of this programme is to improve children's health, reduce barriers to learning and assist learners to stay in school and perform to the best of their abilities (ISHP, 2013, By Health E-News).

5.6. Limitations of the Study

The researcher acknowledges several limitations in the study that:

- The study was only conducted in four schools. This has somehow limited generalization of the results.

- Reaching the participants was a bit of a challenge. Although data collection times were agreed upon with principals from different schools, data collection process encroached into tuition times as students were not keen to participate during their lunch or tea breaks. This led to some educators being impatient while waiting for students.

- Although the study incorporated both urban and rural schools, it would, however, be better if schools from deeply rural areas were engaged to assess if the ISHP programmes were implemented in those areas.

- A large percentage of the study's sample were females, and this could have altered perceptions. However, this could not be avoided as generally, females outnumber males.

5.7. Recommendations

Owing to the burden of diseases in South Africa, strengthening the primary health care (PHC) service delivery in the country is of necessity. However, the country needs a radical shift of focus from curative services to preventive approaches.

Based on the study findings that revealed that there was poor implementation of the essential services as stipulated by ISHP policy document, it is recommended that the educators team up and work together, especially in rural areas as promulgated by the ISHP (2012). Learners should be encouraged to voluntarily go for HIV counselling and testing during assessment services (ISHPM, 2012). Pre-and post–test counselling must also focus on HIV prevention education, counselling those who are positive must focus on both access to treatment care and support, and positive prevention. However, provision of SHR preventive services (namely contraception and condoms provision) in schools has been contested despite the most recent youth HIV/STI and pregnancy statistics 4-5 and the 2005 SA Children's Act (which enables youth aged >12 years to access SRH care services without parental consent and ensures confidentiality). Results of a study done for TB patients revealed that the delay to seek formal

health facilities is due to fear of the stigma that is associated with TB.81.4 percent of them sought informal remedies from private doctors and self-medicated, 50.9 percent bought drugs, 24.6 percent visited private doctors, 3.4 percent bought herbal medicine, 1.5 percent visited a witch doctor, 5.9 percent visited a government health facility and 0.6 percent did nothing (Mutinda, Kabiri & Mwaniki, 2014).

5.7.1. Recommendations for nursing practice

- According to the study, learners in the four selected secondary schools experienced poor school health services and poor communication with the Department of Education, which can improve through community-based collaboration and partnerships between the DoH, DoBE, other political structures, universities and community organisations like NGOs and FBOs.

- Schools should be informed about health campaigns. A year programme of topics could enable schools to prepare in advance.

- Information about opportunities for training in first aid should be provided by DoBE or DoH to schools well in advance in order to arrange a substitute for absent educators.

- Stakeholders should be updated on currently available school health services as well as the proposed PHC re-engineering programme and school health packages, and its significance by means of road shows or ward meetings lead by professional nurses.

This study indicated that secondary schools are currently not the main focus of school health services, and an allocated school health nurse could enhance such relationships with these schools' key stakeholders in his/her ward by inviting them to community meetings where information could be obtained, and challenges about rendered school health services to learners in secondary schools could be discussed.

5.7.2. Recommendations for nursing education

- Nursing Education Institutions (NELs) should revitalise school health nursing as part of the basic nursing education curriculum to introduce the Integrated School Health Programme and PHC re-engineering early during training.

- Knowledge and needed skills for rendering school health services could be enhanced by nursing students visiting schools as part of their clinical hours. Moreover, these nursing students are not allocated to all schools in uMgungundlovu.

- Nursing students would become more aware of school health services as much as the learner will benefit from regular visits.

- Parents need to be involved in school health services to equip their children, especially teenagers

- Informative campaigns to educate parents about their primary role in the physical, emotional, psychological and social well-being of their learners should be held by nursing education institutions as part of a community project.

5.7.3. Recommendations for nursing research

- The similar explorative research study could be conducted in more schools and results can be compared.

- A study on the collaborative partnership between the DoBE and DoH should supply valuable information about how to enhance the accessibility of comprehensive school health to learners.

- Research to evaluate the implementation process of the Integrated School Health Programme within PHC re-engineering could be valuable.

ISHP services/programmes have not yet been explored since it was not examined in the study. The researcher, therefore, recommends a follow-up research to explore the phenomenon.

- A follow-up study to be done to ascertain if there is any improvement in ISHP.

- Strengthening of stakeholders, NGOs, and a multidisciplinary approach

- Monitor and evaluate the implementation of ISHP programmes

- Improvement of policies for ISHP

- SGDS must be in place

- Induction and orientation programmes to enhance skills in ISHP

5.8. Summary of the findings

5.8.1. Findings in relation to the framework

5.8.1.1. Input Resources

The Integrated School Health Policy was revised by the Department of Health (DoH) in collaboration with Department of Basic Education (DoE) (ISHP, 2012). The revised policy made way for the launching the ISHP which was launched in 2012 to replace the existing school health programme of 2003. The policy was implemented to cater for all learners from grade R, up to grade 12, in collaboration with each unit school (ISHP, 2012). School health services are currently delivered by designated school health nurses who form part of the PHC staff component. A review undertaken of the implementation of the school health policy showed that nurses identified a number of issues that impact negatively on the provision of quality services. These includes:

- Insufficient staff and infrequent visits to schools which limits their ability to give learners the time and attention needed.

- Lack of facilities and a conducive environment in the classroom for proper screening and examining of the learners.

- Lack of sufficient basic equipment such as scales to weigh the learners.

- Unavailability of transport, poor road networks, and infrastructure in some cases curtails access to project centres.

- School health nurses used to come once a year, but this is not in line with the operational guidelines for the implementation of the programme.

Therefore, it could be concluded that the implementation of the programme is not consistent with the objectives of the School Health Policy (ISHP, 2012). Due to lack of infrastructure and shortages of nurses, the ISHP did not cover all schools. These findings were not expected and they came as a surprise to the researcher.

5.8.2. Additional findings of interest

The participants have shown an interest in the following findings, under the heading awareness of services that are offered in school which is aligned with the study objectives no 3. 131 respondents of the 269 were interested in "know your body" when compared with other activities. However, maybe it reveals, that during primary school level, these activities were implemented as we know that according to the ISHP the implementation of school health programme was initially targeted from grade R to grade 12.

5.8.2.1. Frequency of school health nurses (Level of satisfaction)

This questionnaire was graded on five levels of satisfaction:

How often does the school health nurse come to your school?

Out of 269 (n=120) respondents, mentioned that they are very satisfied with the frequency of nurses who comes every 6 months.

Lastly, under Perceptions related to ISHP implementation, the respondents showed an interest in the school health nurses:

- School health nurses are good about explaining the reason for screening tests out of (n=269) 183 respondents perceived that school health nurses are good about explaining the reason for screening tests.
- In the statement "My school health nurses treat me in a very friendly and courteous manner", 154 of the 269 respondents perceived that nurses were friendly and courteous.

- In the statement "The health information care I have been receiving is just about perfect" 145 of the 269 respondents agreed that they received health information care.

- In the statement "When I go for screening, they are careful to check everything when treating and examining me" 137 of the 269 respondents agreed the screening that they were receiving towards the services.

Process: What services are offered?

- Visual assessments
- Oral health
- Know your body
- Life style advice on drugs, smoking and alcohol etc.

5.9. Conclusion of the Study

According to the policy, it was mandated for all secondary schools to incorporate important health factors impacting on the development of children and youth of school-going age including issues related to sexuality, HIV and AIDS, reproductive health, trauma, violence, substance abuse and mental health problems. Such factors should be addressed through school health programmes and health promotion activities which are incorporated into the Life Orientation curriculum.

The study findings revealed that most ISHP programmes have not been successfully implemented in schools. Evaluation and monitoring of the progress and sustainability of these programmes are of paramount importance. Teachers need to be capacitated to enhance the skills that are congruent with learners needs.

Outputs were explored focusing on perceptions, awareness, satisfaction, and demographics described the extent to which the ISHP is reaching the people it is intended to impact as indicated above.

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APPENDIX A

Information Sheet and Consent Form to Participate in Research.

Title of research study: An Exploration of the learners' perceptions awareness and satisfactions regarding the implementation of Integrated School Health Program (ISHP) in selected Secondary Schools in uMgungundlovu District, KwaZulu-Natal, South Africa.

Principal Investigator: Ms T.R.Khoza

Supervisor: Professor G .G.Mchunu

Date:

Dear Participants

Warm greetings to you and thank you for taking time to read this letter. My name is Thabisile. R. Khoza a student registered for the Master's Degree programme at the University of KwaZulu–Natal.

I cordially invite you to participate in my research study entitled: Exploring the Perceptions, awareness and satisfaction of the learners on implementation of Integrated School Health Program (ISHP) in selected Secondary Schools in uMgungundlovu District in, KwaZulu-Natal, South Africa. A Process Evaluation Study: The aim of this research is to explore the perception of the learners in the implementation of ISH in selected Secondary Schools in uMgungundlovu District in KZN.

The study will be conducted at........ Secondary School in uMgungundlovu District in KZN. Upon granting consent to participate in the study you will be required to respond to a set of open ended questions pertaining to your perception related to the implementation of Integrated School Health Program in your school. A questionnaire will be used when the research is conducted for the purpose of getting the relevant data. As the researcher, I will ensure you for your anonymity and confidentiality, during the process of filling the questionnaires there will be no mention of personal details such as name and address. The research information will be safely stored where access will only be limited to those directly involved in the research.

The study does not pose any risks or harm of whatever sorts you will only be required to honestly detail your perceptions of the implementation of ISHP to your school. It is hope that the information generated from this study will be used to benefit educators, learners and the community/parents in identifying health problems affecting learners and ways to overcome them as well as increasing body of scientific knowledge, to contribute to the nursing programme of school health nursing curriculum, policies, laws need to be in line with ISHP so as to identify and the needs of learners in disadvantages of families. The study will help the learner to be safety awareness even in the schools by protecting them in the community. Hence depending on the results generated, the study may or may not have benefits for your school. The study will play a significant role in generating empirical knowledge in the school health programme in the context of South Africa, particularly KZN.

Participation in the research is voluntary; you may withdraw from participating in the study at any time without incurring any loss or penalty as a result of withdrawal.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Science Research Ethics Committee. In the event of any problems or queries you may contact the research ethics committee at UKZN as follows:

Research Office, Westville Campus

Durban

4000

KwaZulu-Natal, South Africa

Tel (031) 2604557-Fax (031)

Email. HSSREC.@ukzn.ac.za.

Supervisor Professor G. Mchunu

Telephone :(031)2601421

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My contact details are as follows:

Cell: 0834672953

APPENDIX B

STUDENT QUESTIONNAIRE

Title of research study: An Exploration of the learners' perceptions awareness and satisfactions regarding the implementation of Integrated School Health Program (ISHP) in selected Secondary Schools in uMgungundlovu District, KwaZulu-Natal, South Africa.

INTRODUCTION

The purpose of the study is to evaluate the progress in the implementation of School Health program in KwaZulu Natal. You are therefore, requested to answer questions below. The whole process will take about 45 minutes. Kindly be assured that confidentiality will be maintained throughout the research process and you are requested not to write your name on the questionnaire. Please indicate where you need help regarding a certain question so that clarity will be made. Kindly note that there is no right or wrong answer.

SECTION A

1. This section of the questionnaire comprises of closed ended questions. Kindly answer all questions provided below by means of using an <u>X</u> in an appropriate block.

Demographic Data

1. Gender

Male		Female	

2. Age

13		13 – 16 years		Over 16 years	

3. Race

White		African		Coloured		Indian	

4. School Name

Amakholwa sec		Phayipini sec		Sobantu sec		Woodlands sec				

5. School Grade

Grade 8		Grade 9		Grade 10		

2. Section B of the questionnaire comprises of closed ended questions.

2.1. How often do the school health nurses come to your school? Daily, Weekly, Monthly, Once in three months, or once in 6 months

1. Daily	2)weekly	3)Monthly	4)Once in three months	5)Once in 6 months

2.2. According to your knowledge what services are offered in the integrated School Health Programme (ISHP). Please tick next to the appropriate box.

Nutritional assessment	
Visions	
Oral health	
Ear examination	
Hearing	
Speeches	
Chronic illnesses	
Immunization	
Minor ailments	
T.B screen	
Anaemia	
Psychological support	

2.3. According to your knowledge what services are offered in your school? Tick any of this if it is relevant in your school health services.

Know your body	
HIV counselling	
Sexual Reproductive Health and Rights	
Life style information and Drugs, Alcohol, smoking, and Diet	

Medical male circumcision	
School feeding program	
Learners referred for further assessment.	
Personal and environmental hygiene	

2.4. How satisfied are you with the services at your school? Very satisfied, somewhat satisfied, neither satisfied nor satisfied, somewhat dissatisfied and very dissatisfied. Make a tick in the relevant answer.

Very satisfied	
Somewhat satisfied	
Neither satisfied nor dissatisfied	
Somewhat dissatisfied	
Very dissatisfied	

2.5. Which Integrated School Health Programme (ISHP) activities would you like to see at your school? (Please check all that apply).

HEALTH PROMOTION ACTIVITIES

a) Sexual and Reproductive Health:	Menstruation Sanitary towels Tampons		Contraception Male and female condoms. Family planning		STI's and HIV		Male medical circumcision CTOP,(choice on termination of pregnancy)		Teenage pregnancy Breastfeeding
b) Drugs and substances	Alcohol		suicide		smoking dagga		depression		
c) Mental health	Psychological support		Emotional support						
d) Abuse	Sexual, Tuberculosis		Physical abuse		emotional abuse		bullying		Violence

2.6. How strongly do you agree with each of the following statements? (Circle one number on each line).

	RATING	STRONGLY AGREE	AGREE	UNCERTAIN	DISAGREE	STRONGLY DISAGREE
		1	2	3	4	5
1.	School health nurses are good about explaining the reason for screening tests….					
2.	I think my School					

	health nurse's office has everything needed to provide complete health information assessment….				
3.	The health information care I have been receiving is just about perfect…				
4.	I feel confident that I can get the screening care I need without being set back …				
5.	When I go for screening, they are careful to check everything when treating and examining me…				
6.	Sometimes School health nurses make me wonder if their findings/diagnosis is correct……				
7.	I have to pay more to my screening assessment…				
8.	I have easy access to the referrals to the specialist I need…				
9.	Where I get assessment care, learners have to wait too long for emergency treatment…				
10.	School health nurses act too busy and impersonal towards me…				
11.	My school health nurses treat me in a very friendly and courteously….				
12.	Those who provide my health assessment/education sometimes hurry too				

	much when they examine me….				
13.	School health nurses sometimes ignore what I tell them…				
14.	I have some doubts about the ability of the school health nurses who treat me…				
15.	School health nurses usually spend plenty of time with me….				
16.	I find it hard to get appointment for referral right away….				
17.	I am dissatisfied with some things about the school health care that I receive…				
18.	I am able to get assessment care whenever I need it…..				

APPENDIX C

Consent and declaration

I ....(Full names of Participant, Guardian, Parent) hereby confirm that I understand the contents of this document and the nature of the research project, and I voluntarily consent to participating in the research project.

I understand that Aim at liberty to withdraw from the project at any time, should I so desire.

Additional consent, where applicable

I hereby provide consent to:

-Questionnaires –Demographic details

-Questionnaire: A five alternative Likert scale: Customer satisfaction question 5 sample (Short form learners satisfaction questionnaires (LSQ-18)

Signature of the participant.   Date:

Thank you for your co-operation and assistance.

APPENDIX D

P.O Box 2223

Pietermaritzburg

3201

KZN Department of Education

The Research Ethics Committee

Research unit

Resource Planning

KZN Department of Education

Office G25, 188 Pietermaritzburg Street

Pietermaritzburg3201

Email: sibusiso.alwar@kzndoe.gov.za

Dear Sir

Re: Request for Permission to Conduct Research

 My name is Ms T.R. Khoza as a student registered for the Master of Nursing Degree at the University of KwaZulu-Natal, Howard Campus. I kindly request permission to conduct research at your institution. The title of the study is Exploring the Perceptions, awareness and satisfaction of the learners in implementing Integrated School Health Programme in selected Secondary Schools in, uMgungundlovu District in KwaZulu-Natal. "Quantitate descriptive study". Please find the information sheet about the Research attached, the study will be ethically approved by the UKZN ethics committee. Currently the proposal has been submitted for review in order to obtain ethical clearance to conduct the study, once clearance has been obtained, evidence of this will be forwarded to you by the researcher.

The researcher should not take more than 30-45 minutes and will be giving the questionnaires after completion of explanation about the research. I also kindly request vacant classroom/hall if possible where I can conduct the research.

Should you require further information about the Research, contact details as follows:

Research Office, Westville Campus
Govan Mbeki Building
Private Bag x 54001
Durban
4000
KwaZulu-Natal, South Africa
Tell (031) 2604557
Email.HSSREC,@ukzn.ac.za

Supervisors contact details
Supervisor Professor G.Mchunu.
Telephone: (031) 2601421
Email:mchunug@ukzn.ac.za

My contact details are as follows:
Cell: 0834672953
Email:Thabisile.khoza@kznhealth.gov.za.

APPENDIX E

KwaZulu –Natal Department of Education
 Pietermaritzburg

P.O. Box 2223

3201

.........Secondary school

Pietermaritzburg

3201

Date:

Dear Sir /Madam

Re: Request for Permission to conduct Research.

My name is Ms T.R.Khoza. I am a student registered for the Masters of Nursing Degree at the University of Kwa Zulu –Natal, Howard Campus. I kindly request permission to conduct research at your institution. The title of the study is Exploring the Perception on implementation of School Health Services in selected Secondary schools in uMgungundlovu, District, in KwaZulu-Natal." A Quantitative descriptive study "Please find the information sheet about the research attached, the study will be ethically approved by the UKZN ethics committee. Currently the proposal has been submitted for review in order to obtain ethical clearance to conduct the study, once clearance has been obtained, evidence of this will be forwarded to you by the researcher.

The research should not take more than 30 to 45 minutes and will not impede on your classes as I will be giving the questionnaires after completion of explanation about the research. I also kindly request vacant classroom/hall if possible where I can conduct the research

Should you require further information about the Research, contact details as follows?

Research Office Westville Campus
Govan Mbeki Building
Private Bag x 54001
Durban
4000
KwaZulu-Natal, South Africa
Tel (031)2604557
Email: HSSREC.@ukzn.ac.za

Supervisor contact details
Supervisor Professor G.Mchunu
Telephone☺031) 2601421
Email:mchunug@ukzn.ac.za

My contact details are as follows:
Cell: 0834672953
Email:Thabisile.khoza@kznhealth.gov.za.

APPENDIX F

UNIVERSITY OF ᵀᴹ
KWAZULU-NATAL

INYUVESI
YAKWAZULU-NATALI

29 January 2016

Ms Thabisile Rebecca Khoza 210540811
School of Nursing and Public Health
Howard College Campus

Dear Ms Khoza

Protocol reference number: HSS/1750/015D
Project title: An exploration of the learners perceptions, awareness and satisfaction regarding the implementation of the Inte-grated School Health Program (ISHP) in selected secondary schools in Umsunduzi Municipality KwaZulu-Natal, South Africa

Full Approval – Expedited Application

In response to your application received 27 November 2015, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

....
Dr Shenuka Singh (Chair)
Humanitities & Social Scinces Research Committee

/pm

Cc Supervisor: Professor G Mchunu
cc.Academic Leader Research: Professor M Mars
School Administrator: Ms Caroline Dhanraj

APPENDIX G

Parental Permission for Children Participation in Research

Title: An exploration of the learner perceptions awareness and satisfaction regarding the implementation of the Integrated School Health Program (ISHP) in Selected Secondary Schools in UMsunduzi Municipality, KwaZulu- Natal, South Africa.

Introduction

The purpose of this form is to provide you (as the parent of a prospective research study participant) information that may affect your decision as to whether or not to let your child participate in this research study. The person performing the research will describe the study to you and answer all your questions. Read the information below and ask any questions you might have before deciding whether or not to give your permission for your child to take part. If you decide to let your child be involved in this study, this form will be used to record your permission.

Purpose of the Study

If you agree, your child will be asked to participate in a research study about **the learners' perceptions on the implementation of the Integrated School Health Programme.** The purpose of this study is **determined how learners feel about the implementation of the integrated school health programme in their school and if they are satisfied with the way the programme is being implemented.**

What is my child going to be asked to do?

They will be asked to **complete questionnaire with a list of questions relating to their satisfaction with the implementation of this programme and how they perceive the programme in general. They will also be asked to provide information about their age, gender, grade they are in and all activities carried out in the ISHP.** This study will take **about 15 minutes to complete and will be done during school break.**

What are the risks involved in this study?

There are no foreseeable risks to participating in this study.

What are the possible benefits of this study?

Your child will receive no direct benefit from participating in this study; however, it is hoped that **the findings of the study will be used to improve the programme, hence the health of the learners.**

Does my child have to participate?

Your child's participation in this study is voluntary. Your child may decline to participate or to withdraw from participation at any time. Withdrawal or refusing to participate will not affect their relationship with school in anyway. You can agree to allow your child to be in the study now and change your mind later without any penalty.

This research study will take place during regular school hours; however, if you do not want your child to participate, an alternate time will can be available.

What if my child does not want to participate?
If you child does not want to participate they will not be included in the study and there will be no penalty. If your child initially agrees to be in the study they can change their mind later without any penalty.

Will there be any compensation?
Neither you nor your child will receive any type of payment participating in this study.

How will your child's privacy and confidentiality be protected if s/he participates in this research study?

To ensure privacy a quiet environment will be provided for your child such as a classroom and for the confidentiality of your child's information, no names will be written on questionnaires but only numbers for coding purposes.

If it becomes necessary for the Institutional Ethics Committee to review the study records, information that can be linked to your child will be protected to the extent permitted by law. Your child's research records will not be released without your consent unless required by law or a court order. The data resulting from your child's participation may be made available to other researchers in the future for research purposes not detailed within this consent form. In these cases, the data will contain no identifying information that could associate it with your child, or with your child's participation in any study.

Whom to contact with questions about the study?
Prior, during or after your participation you can contact the researcher Mrs Thabisile Khoza at 0834672953 or send an email to Thabisile.khoza@kznhealth.gov.za for any questions or if you feel that you have been harmed. This study has been reviewed and approved by The University of KwaZulu-Natal's Ethics committee and the study number is 210540811

Whom to contact with questions concerning your rights as a research participant?
For questions about your rights or any dissatisfaction with any part of this study, you can contact, anonymously if you wish, the ethics committees details Research office, Westville, Campus.Govan Mbeki Building ,Private Bag x 54001,Durban,4000 KZN Tel (031) 2604557,Email address. HSSREC. @ ukzn.ac.za.

Signature
You are making a decision about allowing your child to participate in this study. Your signature below indicates that you have read the information provided above and have decided to allow them to participate in the study. If you later decide that you wish to withdraw your permission for your child to participate in the study you may discontinue his or her participation at any time. You will be given a copy of this document.

_____

Printed Name of Child

_____

Signature of Parent(s) or Legal Guardian   Date _____

_____

Signature of Investigator   Date _____

APPENDIX H

education

Department:
Education
PROVINCE OF KWAZULU-NATAL

Enquiries: Nomangisi Ngubane	Tel: 033 392 1004	Ref.:2/4/8/726

Ms TR Khoza
PO Box 2223
PIETERMARITZBURG
3201

Dear Ms Khoza

PERMISSION TO CONDUCT RESEARCH IN THE KZN DoE INSTITUTIONS

Your application to conduct research entitled: **"AN EXPLORATION OF THE LEARNERS PERCEPTIONS ON THE IMPLEMENTATION OF THE INTEGRATED SCHOOL HEALTH PROGRAM (ISHP) IN SELECTED SECONDARY SCHOOLS IN UMSUNDUZI MUNICIPALITY KWAZULU-NATAL, SOUTH AFRICA"**, in the KwaZulu-Natal Department of Education Institutions has been approved. The conditions of the approval are as follows:

1. The researcher will make all the arrangements concerning the research and interviews.
2. The researcher must ensure that Educator and learning programmes are not interrupted.
3. Interviews are not conducted during the time of writing examinations in schools.
4. Learners, Educators, Schools and Institutions are not identifiable in any way from the results of the research.
5. A copy of this letter is submitted to District Managers, Principals and Heads of Institutions where the intended research and interviews are to be conducted.
6. The period of investigation is limited to the period from 22 February 2016 to 31 March 2017.
7. Your research and interviews will be limited to the schools you have proposed and approved by the Head of Department. Please note that Principals, Educators, Departmental Officials and Learners are under no obligation to participate or assist you in your investigation.
8. Should you wish to extend the period of your survey at the school(s), please contact Miss Connie Kehologile at the contact numbers below.
9. Upon completion of the research, a brief summary of the findings, recommendations or a full report / dissertation / thesis must be submitted to the research office of the Department. Please address it to The Office of the HOD, Private Bag X9137, Pietermaritzburg, 3200.
10. Please note that your research and interviews will be limited to schools and institutions in KwaZulu-Natal Department of Education.

UMgungundlovu District

Nkosinathi S.P. Sishi, PhD
Head of Department: Education
Date: 19 February 2016
KWAZULU-NATAL DEPARTMENT OF EDUCATION

POSTAL: Private Bag X 9137, Pietermaritzburg, 3200, KwaZulu-Natal, Republic of South Africa   ...dedicated to service and performance
PHYSICAL: 247 Burger Street, Anton Lembede House, Pietermaritzburg, 3201. Tel. 033 392 1004beyond the call of duty

APPENDIX I

EDITORS LETTER

To whom it may concern

EDITING OF DISSERTATION FOR THABISILE KHOZA

I have a master's degree in Social Science, Research Psychology and TEFL qualification from UKZN. I also have 15 years of teaching experience. I have been editing academic theses for students from UKZN, UNISA and DUT for the past five years. I have further done editing, transcribing and other research work for private individuals and businesses.

I hereby confirm that I have edited **Thabisile Khoza's** dissertation titled **"An Exploration of the Learners Perceptions, Awareness and Satisfaction Regarding the Implementation of Integrated School Health Programme (ISHP) in Selected Secondary Schools in uMgungundlovu District, in KwaZulu-Natal, South Africa".** Corrections were made in respect of grammar, tenses, spelling and language usage using track changes in MS Word 2016. Once corrections have been attended to the dissertation should be grammatically correct**.**

Yours sincerely

Terry Shuttleworth (Tefl, UKZN, MSocSc, UKZN).

APPENDIX J

Proofwrite Solutions
WRITE • EDIT • RESEARCH • DESIGN

25th of February 2018

To whom it may concern

EDITING OF DISSERTATION FOR THABISILE KHOZA

I have a master's degree in Social Science, Research Psychology and TEFL qualification from UKZN. I also have 15 years of teaching experience. I have been editing academic theses for students from UKZN, UNISA and DUT for the past five years. I have further completed editing, transcribing and other research work for private individuals and businesses.

I hereby confirm that I have re-edited **Thabisile Khoza's** dissertation titled **"An Exploration of the Learners Perceptions, Awareness and Satisfaction Regarding the Implementation of Integrated School Health Programme (ISHP) in Selected Secondary Schools in UMgungundlovu District, in KwaZulu-Natal, South Africa"** based on the changes the examiner's queries and changes that needed to be made related to grammar and language issues. The version that was sent to both the student and her supervisor Prof G. Mchunu is titled "**Taby Final" date modified 25-02-2018 at 03:43pm.** Once the student has attended to corrections, the dissertation should be grammatically correct.

PLEASE NOTE: Should the student not attend to all the suggested corrections and/or add additional content after the dissertation has been re-edited on this day the 25th of February 2018, the editor cannot guarantee that the grammar and language in the dissertation is correct.

Yours sincerely

Shuttleworth

Terry Shuttleworth (TEFL, UKZN, MSocSc, UKZN).