ABSENTEEISM, AN INDICATOR OF THE HEALTH STATUS OF SCHOOL CHILDREN IN THE MIDDLE SCHOOLS OF THE MOLOPO REGION IN THE NORTH-WEST PROVINCE

by

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DECLARATION

I declare that this dissertation entitled ***Absenteeism, an indicator of the health status of school children in the middle schools of the Molopo region in the North-West Province*** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

This dissertation has not been submitted previously for any degree or examination to any other University.

M M Hlonipho

MARIA MOLEBOGENG HLONIPHO **DATE:** 12/05/95

DEDICATION

I dedicate this dissertation to my late parents, Lobatlo and Rerekilwe Mekoa, to my dear sons, Mpumelelo and Andile, let this be an inspiration, as well as to my brother, De-Villiers Mekoa.

To my heavenly Father, for grace and blessings bestowed in abundance, without which I would not have had the strength and ability to complete this study.

SUMMARY

Health related absenteeism was identified as a problem in the schools in the Molopo region, needing a multi-disciplinary approach which included the parents.

A conceptual framework on absenteeism was used as a guideline for the descriptive research design. Using a convenience sampling technique 426 absentees, 22 teachers and 2 school nurses filled in three separate questionnaires in ten schools selected to determine the extent of absenteeism due to health related and other problems, the control measures taken and the awareness of school personnel.

Health problems were identified as the main reasons for absenteeism. Inadequate communication between the schools and parents as well as lack of guidelines on the control of absenteeism, were other problems identified.

Recommendations made related to the provision of school health services that promote the health status of the pupils based on Primary Health Care principles, parental involvement in school health matters and the formulation of policies aimed at controlling absenteeism in schools.

Title of dissertation:

Absenteeism, an indicator of the health status of school children in the middle schools of the Molopo region in the North-West Province.

Key terms:

Absenteeism; health problems; school absences; school health nursing; attendance control; health status; health assessment; parents' socio-economic status; pupils' lifestyles; non-attendance; school refusal; medical conditions; school children illnesses.

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CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION

A satisfactory health status of school going children is an essential pre-requisite for academic achievement. The child needs to be healthy in totality, i.e. physically, psychologically, spiritually, and socially. The relationship between these health components needs to be maintained at all times so as to avoid possible health problems.

Health problems are common during school going age, and often affect school attendance, when the child has to consult with health care professionals. Other children may prefer to be at home to be looked after by the family.

Although illness is a legitimate reason for being absent from school, it is often difficult to ascertain whether a child's absence is due to illness or not. Galloway (1981: 27) for instance, states in this regard that it is difficult to determine at which point a slight cold turns into an upper respiratory tract infection which might require medical intervention and legitimise absence from school.

The number of days that a child will be absent from school will depend on factors such as the child's resistance to infection, or the type and severity of the disease. The child, the parents, the school, as well as health professionals all play a role in the prevention of illness and the promotion of health. The combined effort of these individuals all contribute to the child's achievements in the educational system.

School absenteeism becomes an educational and social problem in the school administration, as well as in the daily operation of classes. A study conducted by Weitzman (1986: 799) suggested that health problems of students and the effects thereof on families, could play a significant role in contributing to the problem of absenteeism. Children with chronic illness such as epilepsy, asthma and so forth, are poor school attenders, and as a result experience academic and emotional problems in the classroom. These children have unmet health needs due to poorly managed chronic illnesses and a failure to effectively address psycho-social and educational problems that were caused by the illness. Inadequate attempts are usually made to ensure that schools are positive in the approach to the sick child, whilst teachers feel incompetent to teach and handle any medical emergencies that might arise. This is also confirmed by a study conducted by Eiser and Town (1987: 57) who identified that during their training, teachers are not given enough medical information or advice

about teaching sick children or how to handle them when they are sick in class.

It becomes difficult for teachers to identify health deviations when they have not been prepared for such responsibilities. It then becomes the responsibility of health professionals to educate the teachers, school-children and parents, about health and common minor illnesses which may easily be identified and which would benefit from being treated early.

Children who are frequently absent from school due to illness, become frustrated because they cannot engage in school activities effectively. The result is that they develop a sense of futility, and their motivation to learn becomes affected. According to Weitzman (1986: 799), the anticipation of attending medical follow up sessions, falling behind with school work, and the need to make up, can result in significant anxiety and subsequent stress related health problems which may interfere with cognitive skills and the child's ability to concentrate at school.

1.2 BACKGROUND TO THE PROBLEM

School absenteeism in the Molopo region appears to be a common problem although no literature could be found to substantiate this statement. Informal discussions held with a number of teachers at the local schools indicated that absenteeism is definitely a problem that needs urgent attention. The main problem is that pupils do not submit medical certificates to account for health-related absenteeism.

Such pupils are often seen in uniform at the clinics or hospitals, and on public transport

during school hours, and are in such instances noted as being absent from school. Health problems can therefore be associated with school absenteeism in the Molopo region, although little is known about the characteristics of pupils who are frequently absent from school. The problem of absenteeism has implications for many areas of education, such as the relevance that the curriculum would have for these pupils, and the effectiveness of teachers to motivate pupils who experience health problems. In addition, there are also problems related to the attitudes and perceptions held by teachers, pupils and parents about different health issues. According to Smith and Bardley (1984: 173), children with health problems are often poorly motivated to learn, or to attend school, and are unable to benefit fully from the education provided at school. According to teachers this is also true about school-children in the Molopo region.

Weitzman et al (1985: 378) reported that excessive absenteeism could contribute towards unhealthy lifestyle practices such as cigarette smoking, drug abuse, alcohol consumption and so forth. These practices could then in turn contribute to ill-health.

1.3 STATEMENT OF THE PROBLEM

Absenteeism is both an educational and a health problem to all those who are concerned with the total health of school children. The researcher has observed that health problems experienced by pupils are managed inadequately by the school health personnel mainly due to shortage of staff and inadequate physical facilities. This situation could easily contribute to absenteeism.

The researcher is of the opinion that pupils who become ill at school are usually referred by the teachers to the clinics or general medical practitioners for curative services. This appears to be supported by current literature. Such children are then attending health institutions during school hours, whilst the healthy children are attending school on a regular basis. The teachers are not in a position to help the sick pupils at school, and can only refer them to relevent health services. The pupils who get sick at home, are taken to health institutions by their parents, and subsequently miss school on those days.

Health services should be available to school children, where their health needs can be attended to through the prevention of ill-health and the promotion of optimum health. Assistance should also be given to pupils who are in need of rehabilitation services. Inadequate school health services in the various sections of the region however, make these realisations an impossibility.

The researcher became aware of a significant incidence of absenteeism in the middle schools of the Molopo region in the North-West Province. This prompted the nature of this research study.

Although absenteeism has not been monitored and researched in the middle schools of the Molopo region, it has been recorded by the class teachers in the school registers. What needs to be established is the extent of this problem and what is done about it in the schools. Health problems experienced by school children might be identified at home or at school. Constant communication between all the stakeholders in school health is of fundamental importance in the maintenance of an optimum

health status of school children.

The current position in schools is that poor communication exists between the schools and the parents of sick children, because there are no school policies which require cooperation and communication between the schools, the home and the health personnel who attend to the sick child in the health institution.

1.4 RESEARCH QUESTIONS

- What is the extent of health-related absenteeism in the middle schools in the Molopo region?
- Are health problems the main cause of absenteeism among school children?
- Are rules and regulations available in schools for monitoring absenteeism due to health problems?
- Are there other factors that have an influence on absenteeism among pupils in the middle schools in the Molopo region?

1.5 PURPOSE OF THE STUDY

The health status of school children is a concern of health service personnel whose main aim is to improve and maintain their health at an optimal level. Provision of preventive and promotive health care ensures the achievement of the above aim. Healthy children are able to utilise educational opportunities for academic achievement. School health services which are available, accessible and affordable to the school community, are a key to a successful educational system.

The health service personnel provide health education programmes targeted at the school children and their parents, the school administrative staff, as well as the teaching personnel. These programmes address current health problems, potential health problems as well as the role of the participants in the prevention of illness and the promotion of health. The objectives of this study are to

- determine the extent of absenteeism due to health problems in the middle schools in the Molopo region
- identify the problems that contribute to absenteeism
- determine to what extent school health services are available in schools
- determine whether the school personnel are made aware of the health problems of pupils
- determine what remedial actions were taken to monitor and control the problem of health related absenteeism

1.6 SIGNIFICANCE OF THE STUDY

The researcher was unable to identify any studies that investigated the health status of school children, or the incidence of absenteeism due to health problems in schools in the Molopo region. The researcher could also not identify any studies regarding potential mechanisms to monitor absenteeism in these schools. It is for this reason that the researcher decided to investigate the reasons for absenteeism in the selected schools, and to determine what policies are available for monitoring absenteeism.

The health status of school children should be the concern of the health service personnel, in cooperation with the school community, the family and the community as a whole. All the above-mentioned stakeholders will benefit from the findings and recommendations of this study.

It is hoped that the information gained from this study will assist the health authorities, the education authorities, the family, and the community in becoming more sensitive to the health needs of school children when planning for the restructuring and development of the school health services in the region.

Furthermore, the information from this study will form a body of knowledge to be used as base line data by nursing education authorities to revise and update the curriculum of community health nursing with specific reference to school health nursing.

The findings should also contribute to the drawing up of attendance policies that monitor and control health-related absenteeism more effectively amongst school children.

1.7 DEFINITION OF TERMS

For the purpose of clarification, specific concepts used in this study are defined as listed.

- **Health-related attendance policies/laws**

Health-related attendance policies/laws are established by the education authorities and the schools in the North-West Province for the control and management of students who are absent from school due to health problems.

- **Health-related problems**

Health-related problems are deviations of health associated with the physical, social and psychological well-being of school children in the Molopo region.

- **Absenteeism**

Absenteeism is defined as the practice of pupils in standard 5, 6, and 7, in the schools in the Molopo region to be away from school for three days or more in one term due to health problems.

- **School**

A school is a middle school in the Molopo region in the North-West Province made up only of standard 5, 6 and 7 for the education of children.

- **Pupil**

A pupil is an individual, male or female, between the ages of 12 and 17 years, in standard 5, 6 or 7, who attend a middle school in the Molopo region in the North-West Province.

- **School term**

The school term refers to a four month period of regular school attendance from September to December 1993.

- **Health status**

The health status of school children between the ages 12 and 17 years indicates the presence or absence of health problems.

- **Indicator**

An indicator in this study refers to the rules and regulations in schools, used to determine the extent of school absenteeism due to ill-health.

1.8 ORGANISATION OF THE RESEARCH REPORT

Chapter one gives an overview of the research problem, its significance, and a justification for the need to conduct the study.

Chapter two includes a selective review of literature relevant to school health, with special reference to absenteeism and the effect this has on the health of the child.

Chapter three outlines the research methodology used in the study.

Chapter four outlines the analysis of data obtained from the school health nurses.

Chapter five outlines the analysis of data collected from the teachers.

Chapter six outlines the analysis of data obtained from the pupils.

Chapter seven gives the conclusions, recommendations and summary of the study.

1.9 CONCLUSION

In this chapter the background to the problem of school absenteeism, the statement of the problem, as well as the purpose and significance of the study, were discussed. In the next chapter literature relevant to absenteeism, school influences, peer associations, home influences and health problems, will be reviewed.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

In this chapter, selected literature that is relevant to school absenteeism is reviewed, and the theoretical framework used for the study is discussed.

Various authors, inter alia Bond and Beer (1990: 817), Smith and Bradley (1984: 175), Weitzman et al (1986: 314), Weitzman et al (1985: 799) and Galloway (1981: 609), provide evidence that a considerable amount of research on absenteeism has been conducted internationally. These studies indicate that poor school attendance causes concern among teachers, parents, members of the educational support services, health school administrators, and the pupils themselves. It is pointed out that the feeling of

concern is often expressed differently by the affected individuals.

Absenteeism is also a sensitive topic, often linked to families who experience social problems such as poverty, unemployment, alcoholism and delinquency. The social environment of such families creates conflict, poor self esteem and disruption of the socialisation process of children. According to Galloway (1981: 631), *direct and/or indirect results of social problems such as unemployment and alcoholism, is the poor health status of family members.* Weitzman (1986: 800), reported that children are the hardest hit where the poor health status leads to illness and occurrence of disease. The health problems which arise from such a scenario affect the children's school attendance, which may be a direct result of children having to consult clinics, doctors or hospitals.

2.2 CONCEPTUAL FRAMEWORK

The conceptual framework chosen for this study is a causal model which includes factors which influence school attendance, such as health problems, home determinants, school environment as well as peer associations. See figure 2.1 in this regard. This causal model depicts a direct and/or indirect relationship between the above mentioned factors and school absenteeism and has been adapted from Richards model (Richards 1978: 49).

This model was selected as it appears to be most suited as a framework for an investigation into absenteeism.

According to MacMahon and Pugh (1970: 48) this multifactoral causality model depicts an association between categories of events or characteristics, which are followed by a change in the other characteristic or event. Cause and effect relationship is recognised to exist whenever evidence indicates that the factors form part of the complex circumstances that increase the probability of the occurrence of a disease or a change in behaviour. The reduction of one or more of these factors or events decrease the frequency of occurence of that disease or behaviour (MacMahon and Pugh 1970: 293).

The above is true in relation to absenteeism which increases or decreases according to whether the causative factors are controlled or eliminated.

This particular conceptual model of absenteeism was chosen as a framework for this research study because it depicts absenteeism as a focal point that has resulted due to the factors surrounding it, such as the home, the school, the peers, and health problems.

2.3 THE CONCEPT ABSENTEEISM

Absenteeism is the central focus of the causal model on absenteeism. At the periphery there are factors which lead to absenteeism. Figure 2.1 shows a relationship between the factors at the periphery and absenteeism in the centre (Richards 1978: 49). In such a cause-effect relationship, health deviations could affect school attendance as shown by the arrows from the periphery to the centre. The diagram also indicates that the relationship may be reversed when remedial actions are taken

to solve the problem of absenteeism (Bond and Beer 1990: 817; Smith and Bardley 1984: 175; Weitzman et al 1986: 313, 314, 805; Lindsay and Powell 1989: 173; Reid 1984: 326 and Galloway 1981: 610).

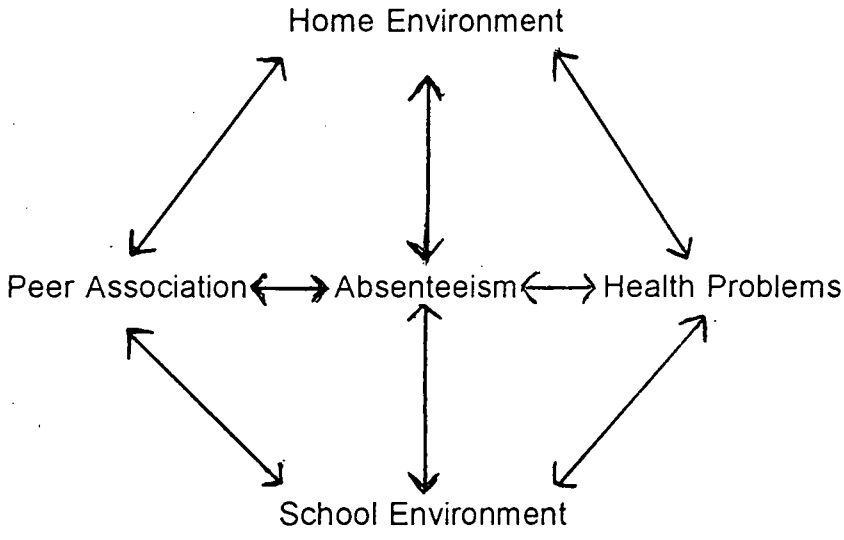

Figure 2.1

Causal model of absenteeism

adapted from Richards 1978: 49

According to Paterson (1989: 10), absenteeism shows two kinds of absence from school. The first is truancy, when the child stays away from school without the permission of either the parent or the school. The second kind of absenteeism is refusal to attend school, sometimes referred to as school phobia. The child is unwilling to go to school, and remains at home with or without parental knowledge.

The reasons for being absent from school usually indicate a variety of psychosomatic symptoms offered as an excuse for missing school. These complaints occur during the week and are seldom present during weekends, public holidays and vacation. The illness disappears when the child is allowed to stay at home (Berg et al 1985: 157).

A study conducted by Smith and Bradley (1984: 172), emphasises that whatever the primary cause of absenteeism, or the causal relationship, there is an assumption that students who are frequently absent from school show signs of poor health, poor achievement and inadequate adjustment to school.

In Galloway's view (1981: 610), students who are excessively absent from school have unmet health needs such as poorly managed chronic illnesses, and/or failure to address the social and educational dimensions of illness. Excessive school absences could thus serve as an indicator for identifying students with physical, mental and social health needs. According to Fowler et al (1987: 683), children at increased risk for school dysfunction and absenteeism, are those with acute or chronic illnesses or handicaps. Bond and Beer (1990: 817) as well as Reid (1984: 326), added that children are vulnerable not only because of the medical aspects of the chronic disorders, but also because of the secondary effects that the illness could have on the children's self-concept and family function.

The problem of absenteeism is thus multifactorial, ranging from personal, family, school and peer association problems to health problems.

2.3.1 Management of absenteeism

A teacher who is keenly aware of the importance of health in the overall development of students can perform a vital role in facilitating the delivery of medical, paramedical and nursing services to those pupils who require such health services. In this way, the teacher could monitor the incidence of absenteeism due to ill-health, and by promoting

communication amongst all the professionals who are involved in health promotion in the school, could also participate in health programmes (Stumphauzer 1985: 141; Rood 1989: 21; Lee and Erikson 1990: 37).

Parents and teachers also come into contact with school children on a regular basis. This prolonged contact enables the parents and teachers to make significant contributions to the health status of the school child, and thus reduce the incidence of absenteeism (Rood 1989: 22; Lee and Erikson 1990: 38; Eastwold 1989: 29).

Children should be encouraged to attend school and should be given the necessary support and encouragement so that the child has the confidence he/she needs to meet realistic expectations and goals, (Lee and Erikson 1990: 42; Sturgeon and Beer 1990: 759, 760). Haslam and Vallentutti (1975: 6) maintain that failure in this regard could give rise to psycho-social problems which could ultimately lead to health problems.

2.3.2 Management of pupils with health problems

According to a number of authors monitoring absenteeism relevant to a particular pupil starts with ruling out serious organic pathology or addressing medical factors that are contributing to the behaviour (Lee and Erikson 1990: 40).

Absenteeism also deals with the pupil's, and the family's health beliefs, as well as with screening for emotional and social problems that influence school attendance. Counselling services for this purpose are considered essential.

Health education in this regard should start early and address issues such as self-esteem and decision-making skills, and should provide a broad base of health knowledge. The community must also be given information about common health problems relevant to the school population with specific emphasis on conditions such as asthma, epilepsy, bronchitis and gastro-enteritis.

School children with health problems need medical attention as well as support programmes offered by the school personnel, peers and family members.

The teacher, as part of his/her duties, must appreciate the special needs of pupils with health problems, for example, a pupil with hearing problems may require auditory training, the use of hearing aids, special seating arrangements and so forth, whereas pupils with visual problems may require adequate classroom lighting, suitable colours of walls and ceilings, and special equipment such as tape recorders and so forth.

Pupils suffering from chronic conditions such as epilepsy, asthma and other chronic conditions, also benefit from the assistance given by the teacher and/or school health nurse to other pupils to come to terms with their own feelings towards their sick classmates, so that the mystery, myths and stigma associated with these conditions could be reduced. A positive attitude towards pupils with medical problems will help to prevent the development of problems such as low self esteem, fear of school failure, hostility and failure to attend school regularly. In actual fact, the conditions can be stabilized and constant school attendance will be promoted with such behaviour (Fromer 1983: 351; Clark 1984: 29; Lee and Erikson 1990: 40).

Certain medical conditions may require the pupil to take medication during school hours. In schools where there is a school health nurse, the nurse could supervise the administration of medication, or, in the absence of a school health nurse, this function may well need to be carried out by the teachers.

Haslam and Valletutti (1975: 11) maintain in this regard that the responsibility for administering medication taxes not only the teacher's emotional reserves but also takes up the time available for teaching.

According to Weitzman et al (1982: 317), programmes for monitoring absenteeism include the following:

- examination of all available school and health records of the pupils
- home visits and family assessments
- the attendance, by the school nurse, of conferences organised with the class teachers, the pupils and the principal
- phone calls, meetings and written communication between relevant parties, and accurate record-keeping

2.3.3 Administrative programmes for monitoring absenteeism

A number of the programmes developed to improve school attendance focus on administrative problems and are an attempt to create or enforce school policies. Such programmes should stipulate exactly what steps should be taken to prevent and control absenteeism caused by health problems. Clear attendance rules, consistent rewards

and punishment, improved record-keeping and telephone and written notification to parents, are some of the ways in which such programmes monitor absenteeism (Rood 1989: 24). Principals of individual schools may also design internal policies which may only be relevant to that particular school, depending on what the causes of the health problems are, and what the extent of the problem is at the particulr school (Rood 1989: 24).

2.3.3.1 Discipline

Punishment of school children for non-attendance at school can be counter-productive, especially when school absence is associated with health related problems. The school child may also associate school with unpleasant experiences, thus making the child more inclined to stay away from school (Rood 1984: 24).

Rogers, Hutchins and Johnson (1990: 41) view school attendance mainly as a result of the following two important variables:

- *the student's ability to attend school, and*
- *the student's motivation to attend school*

There are many situations in which a pupil may have a high motivation to attend school, but is not able to do so due to unavoidable limitations such as illness and accidents, family problems, peer pressure and school related problems.

Eastwold (1989: 29), is of the opinion that discipline without punishment is based on adequate self respect, coupled with the behaviour brought to the attention of the

absentee in a prompt and friendly manner.

Non-punitive discipline can take place in three steps:

- a friendly verbal reminder of the content of the schools attendance policy
- a written statement of the problem and goals to which both parties should subscribe, with the understanding that change of behaviour is needed
- a note from the health professional consulted as required, e.g. a medical certificate (Rood 1989: 25)

Eastwold (1989: 28) and Rood (1989: 24) also remind us however that non-punitive discipline shifts the responsibility from the school administrators to the absentee and the parents.

2.3.3.2 Attendance policies

For policy formulation and implementation to be effective, the people affected should be allowed to have an input. The people concerned with policy formulation and implementation include individuals such as the principal, school teachers, parents, pupils and health professionals. Among the aspects to be included in the document should be health related issues that could be introduced to control absenteeism that occurs due to health problems.

The policy should provide for firm but fair administration of consequences, namely those of reinforcement and consistency regarding adherence to policy requirements.

Refer in this regard to Eastwold (1989: 29), Sturgeon and Beer (1990: 760), and Rood (1989: 24).

These authors are all also in agreement that everyone affected by the policy should know about its contents through wide publicity and explanations where necessary, before it is implemented.

The policy should be aligned with the health philosophy of the health departments concerned, and the educational philosophy of the school district, and should aim at developing a positive attitude towards attendance. In addition, the policy should clearly state that attendance at school is the responsibility both of the parents and the students (Eastwold 1989: 29; Sturgeon and Beer 1990: 760; Rood 1989: 24). This is of particular importance when the reason for non-attendance is health-related.

According to Eastwold (1989: 29) and Rood (1989:24), schools with effective attendance policies use a monitoring and recording system, and have a follow-up procedure for absenteeism. Such policies stipulate the following:

- When a student is sick at school, a school health nurse should be consulted or an appointed clinic should be visited for consultation.
- On return, a sick-note should be handed to the class teacher indicating the health care services rendered.
- If the student is sick at home, the parents should notify the school per phone, or send a written note, or report personally to the class teacher.
- A medical certificate should be handed to the class teacher if the student was

seen by a doctor or attended a hospital or clinic.

Weitzman et al (1986: 79) in discussing the incidence of absenteeism at Lake Oswego High School Oregon, state that according to the school policy, absences are only excused if they are pre-arranged, or if there is student illness, family illness or an emergency. Otherwise, students are expected to attend all classes every day.

2.4 HOME ENVIRONMENT

The home environment has a direct influence on the physical, psychological, spiritual and social development of the child. Primary socialisation determines good health practices, acceptable lifestyles and academic aspirations.

The home environment refers to the healthy and/or unhealthy parent-child relationship, and is an important construct which has a behaviourial dimension. According to Richards (1987: 151), the home environment may also entail feelings of love, proper upbringing and external motivation by parents. In figure 2.1, the arrow leading from the home environment to absenteeism, predicts an inverse relationship, namely that the healthier the home environment in terms of physical, psychological, emotional and social health aspects, the lesser the chances of absenteeism, due to the relative lack of health problems which could lead to absenteeism. The unwritten assumption is the control theory which reasons that a youth who comes from a good home has a greater stake in conformity to acceptable health practices. Similarly, a child who stays away from school, may have been affected by poor health practices in the family setting (O'Neil et al 1985: 238; Klerman et al 1987: 427; Reid 1984: 67).

The home environment has a significant influence on health. In the home setting, optimal health is promoted, diseases are prevented, and medical intervention is sought to restore function. These are achieved by provision of proper nutrition, personal and environmental cleanliness, ventilation, exercises and so forth. Non-attendance at school can be a family problem related to negative attitudes of the parents towards the promotion of health and prevention of illness at home.

Of equal importance is the general attitude of the parents to education (Walter 1972: 23; Billings and Stokes 1986: 484; Paterson 1989: 89).

Richards (1987: 151) is of the opinion that the family as an institution has a major psychosocial influence on the child, even before the child goes to school.

2.4.1 Parents as role models

Parents are the first role models for a child, and are the main source for development and information. The family plays an important role in the health education of children in setting health related goals and objectives that will ensure that children are brought up in a family where a healthy lifestyle is the order of the day.

Although every family would like to ensure that the above aim is achieved, it may not be possible for families with a poor socio-economic status (James and Mott 1988: 308).

2.4.2 Socio-economic factors

Poverty is a state of chronic want and material deprivation, characterised mainly by features such as disease, hunger and malnutrition. Major infectious diseases which are related to poor socio-economic conditions include gastro-intestinal diseases, respiratory infections such as tuberculosis, measles parasitic and viral infections, as well as sexually transmitted diseases. Poor education regarding personal hygiene, inadequate housing, overcrowding and poor sanitation could all result in poor hygienic standards. The above factors undermine the health status of school children, exposing them to ill-health and subsequently to absenteeism (Vlok 1991: 240).

According to Paterson (1989: 33) and Vlok (1991: 240), when there is no money to buy food for the family, malnutrition, hunger and starvation will occur. Children from poor families are ill-fed and hungry when going to school in the morning, and in addition are sometimes exhausted from walking long distances.

They therefore lack energy and enthusiasm to do school work due to the socio-economic problems that exist at home. In some instances, the child is made to do adult duties, such as looking after siblings and doing domestic chores when they should be at school. Parents of such children may have been forced to work in order to be able to support their children. Such children are physically and psychologically too tired to effectively participate in the school activities. Children from such poor families become victims of poverty a situation which may manifest as absenteeism (Vlok 1991: 240).

Poverty is a socio-political problem which is not confined to any one particular group, although it is a fact that it is more prominent in the coloured and black people. The incidence is worse in rural and farming areas, as well as in the former black homelands, North-West Province being one such area (Vlok 1991: 240).

The North-West Province is predominantly rural, with the majority of black residents being unemployed. According to Vlok (1991: 241), in 1980, 50% of the total population living in South Africa, including the former homelands, were living below subsistence level as measured by the urban Minimum Living Level (MLL). The percentage rose to 81% in the homelands and an average of more than 60,5% for blacks throughout the country.

As a result of poverty, the child's general health may be undermined, resulting in the child being susceptible to common colds and other illnesses due to malnutrition and a lack of proper clothing. In some instances the child may be ill due to physical needs not being met, as the mother is overworked, ignorant and poor. The mother may be unable to take the child to the clinic or doctor for medical intervention, resulting in the child being kept away from school (Abbott and Brechinridge 1970: 128). Social class, particularly the income level and interaction patterns associated with it, seems to be influential in determining factors such as the health status of the child, his social involvement, the type of school the child attends, as well as his achievements. Adolescents in the lower social class often need to help support the family financially.

This entails working after school, during weekends and school holidays to earn money which is never sufficient to cater for family needs such as food, clothing, transport or

medical care. The situation in some families may be so bad that the school child stays away from school to utilise extra days to earn sufficient money. The money earned may also be used for school requirements. The health status of children from poor families is often undermined by deficiency diseases, and other systemic diseases (James and Mott 1988: 209).

Poor families often live under poor housing conditions which also contribute to health problems as a result of unhygienic environmental conditions, poor ventilation and lighting.

The houses are often overcrowded which adds to the danger of cross infection when communicable diseases occur. Due to the poor health status of such families, children are required to consult the doctor, clinic or hospital for medical attention. Such visits to the health centres may be done during school time. The number of days that the child is absent from school will depend on the severity of the condition and the response of the disease to medical intervention. If the classes that were missed are not made up, poor performance and failure, or withdrawal from school, may result. The school child may also be unable to participate in enriching extra-curricular activities and remedial classes where needed. Opportunities for peer activities and involvement in school clubs or projects are limited, leading to poor class achievement, bitterness, frustrations and stress. These psychological problems may manifest themselves as fear to leave home for school, resulting in absenteeism (James and Mott 1988: 209; Anderson et al 1983: 491).

2.4.3 Working mothers

In the urban and peri-urban areas of the North-West Province, many mothers are working to help provide for the needs of their children. Working mothers who are unable to provide for the care of children after school, may be faced with problems of children who get sick during the course of the day whilst she is at work.

Such children may return home where they are then looked after by older children, who may have to run errands, or by the child-minder employed to help with housework. The working mother, especially the unskilled labourer, may experience problems in getting time to take the sick child for medical intervention due to fear of losing her job or getting her salary reduced. The recovery of a sick child under the above conditions is slow, thus adding to the number of days the sick child will be absent from school (Paterson 1989: 35).

2.4.4 Absence of natural parents

A study conducted by Anderson, Bailey, Cooper, Palmer and West (1983: 783), revealed that absence of a natural parent in the household, is probably indicative of family stress. The association of the situation with increased school absenteeism, confirms the findings of McNichol, Williams, Allan and McAndrew (1973: 17) in Melbourne, who confirm that poor emotional health in the mother is likely to affect children severely. Stress is important as an etiological factor, or could be associated with differences in treatment or illness behaviour of the child. It may be manifested as headaches which contribute to school absenteeism. The study by Anderson et al

(1983: 491), also indicate that poor maternal mental health was associated with less than adequate treatment of the asthmatic child, and as a result the child's condition could become destabilised. According to Paterson (1989: 35) the number of school attendance days would be reduced when the child is taken for medical consultations.

2.5 SCHOOL ENVIRONMENT

The school plays an important role in the socialisation of children. In the school environment, children comply with academic requirements, and learn about social skills and health related issues.

School attendance plays an important role in the development of a growing child. The purpose of attending school is to help each child to develop his potential to the fullest, including the development of his sense of responsibility.

The school provides an environment for completion of tasks which are carried out by the child with confidence. A sick child finds it difficult to cope with the physical and psychological demands of the school. A climate of social interaction is impaired and inhibits the child's interaction with peers and teachers in the school setting (James and Mott 1988: 792).

Despite the fact that pupils are the central focus in the school, Klerman et al (1987: 429) maintain that the pupils seem to be frustrated and stressed by circumstances related to their interactions with the teachers and peers. The frustration occurs when they experience problems of poor performance at school, ill-health and rejection by the

peer group. According to Hockaday (1985: 102) and Brodbelt (1985: 66), the pupil's confusion and frustration are real, but she/he might not be in a position to explain or express her/his feelings or experiences. As a result, the pupil may develop psycho-somatic illnesses which could result in hospitalisation and school absenteeism (Lazerson et al (1988: 253) and Richards (1987: 152).

2.5.1 The role of the teacher in health matters

Teachers play an important role in health education and role modelling. Personal health beliefs are communicated to children by teachers as well as by parents. Demonstrating positive health attitudes and behaviours is effective even when a health course is not established. James and Mott (1988: 308) state that teachers often need resources such as books, magazines, journals and so forth. supplied by the school nurse to enable them to assist children in managing and finding answers to their health concerns.

They continue by describing the role of the school in health education as being

- supplementary to the parents' role as primary health educators
- providing instruction based on the needs of children
- offering supportive health services, and
- maintaining a safe and healthy environment as health activities to enhance health promotion (Haslam and Valletutti 1975: 2)

Teachers have an opportunity to observe the behaviour of children during school

hours, and thus can identify possible signals of potential medical problems. The sensory modalities through which learning occurs are those of vision and hearing. It is logical that a pupil with deficits in vision or hearing might have difficulty in acquiring academic skills.

The pupil might also have difficulty in perceiving the teacher's cues which indicate desired behaviour (Haslam and Valletutti 1975: 2). Weitzman et al (1985: 744), in turn maintain that the teacher must also ask whether a pupil with a medical problem requires assistance in coping with the curriculum. They also point out that paediatricians and other health personnel have become increasingly aware of the importance of schools and school personnel as advocates for child health.

Schools are also referred to as settings where childhood illnesses and injuries occur (Weitzman et al 1985: 745). Negative health experiences in school such as headache, stress and so forth produce a lowering of expectations, increase the sense of strain, and consequently, the pupil may absent himself/herself from school. Walter (1972: 22) makes a similar assertion and adds that the school is often a decisive factor in attendance. Factors which contribute to non-attendance are over-populated schools, poor educational facilities, less understanding and less interested teachers and principals. The problem is compounded by health problems such as poor hearing, impaired vision, malnutrition, and so forth.

2.5.2 The role of the school health nurse

School health nursing is a service provided by school nurses to cater for the health

needs of school children. The primary objective is to ensure that every child benefits from learning through disease prevention and health promotion and maximum attendance.

The growing interest in holistic care and self care affords nurses the opportunity to move into the forefront as health promoters.

Nurses need to become more involved in health promotion, for instance, by speaking to parent groups and teachers, participating in career and health awareness programmes and counselling at health fairs (James and Mott 1988: 309).

The health and education professionals in the schools are expected to make important contributions to a successful school health programme. The Department of Health and Social Services in the North-West Province is responsible for the financing, policy making, organisation, coordination and monitoring of school health services, a policy for which has been drawn up. (See Annexure I).

2.5.2.1 Assessment

The purpose of medical and nursing assessment of school entrants is to identify health problems early, and to institute early intervention. Mowat and White (1985: 395), McFadyen et al (1988: 409) and Sturgeon and Beer (1990: 759), have all reported a high incidence of absenteeism during the first years of high school attendance.

The collection of data about the health status of the pupils should be systematic and

continuous. The cumulative health record is commenced when the pupil first enrols in a school.

School health services which are accessible and affordable to the school community are a key to a successful educational system. The health service personnel should provide structured health education programmes which are targeted at the school children and their parents, as well as the teaching personnel. These programmes may indirectly address the problem of absenteeism by discussing current health problems, potential health and academic problems, and the role of participants in the prevention of illness and the promotion of health (Lee and Erikson 1990: 39; Sturgeon and Beer 1990: 759; Haslam and Valletutti 1975: 12).

School health administrators should be made more aware of the health problems which affect school children in their area of jurisdiction.

This information is vital in the planning of school health services with particular emphasis on the improvement of the staffing patterns of the school health service personnel who are required to render health services to pupils.

The facilities which are required for this essential service should be well planned. A specific area of planning is related to financial budgeting which will make it possible for school health services to be improved (Lee and Erikson 1990: 39).

2.5.2.2 *Screening of school children*

School health services are basically preventive and promotive in nature. The school nurse screens children. Any deviation in health is brought to the attention of the parent who will, in turn, take the child to a family doctor, clinic or hospital. The child's problem may be a reflection of a problem at home or in the community. The child is not treated in isolation but the therapy or support of the family must be undertaken on an ongoing basis by the school health nurse. Clark (1984: 320), Hopp (1990: 380), and Fromer (1983: 397) maintain that referral and cross referral then develops between the school nurse and the local clinic nurses.

2.5.2.3 *Setting of priorities*

The nursing care plan includes priorities and nursing approaches or measures to achieve the goals. The nursing actions provide for joint participation in health promotion, maintenance and restoration. The school nurse may give preventive or therapeutic treatment according to medical directions. When the family has made informed decisions, the nurse may assist them to accept and resume responsibility for providing care and guide them toward self-help. She will help them understand normal patterns of growth and development, as well as changes in health status. The family and pupil may be assisted in adjusting to their limitations (Fromer 1983: 399 and Clark 1984: 320).

2.5.2.4 Home visits

Home visits are done according to the school health service policies. These may be done when the student is repeatedly absent from school due to health related factors. The visits may be conducted to evaluate the health status of the pupil or to provide counselling and supervision of treatment. Home visits ensure continuity of care when the pupil is on medical treatment. The school nurse should visit the child at home whenever there is a history of continuous health-related absenteeism.

2.5.2.5 Collaboration with the school

Although the child is the focal point of school health services, the child is viewed as a member of a family, of the school community, and of the larger community. It is not practical to evaluate each child in this context, due to the large number of school children, although it is essential to manage a sick child in his/her totality. The child should be reviewed physically, psychologically and socially, to obtain a holistic overview of the child's health status. This approach is essential for providing a comprehensive service. While respecting limits posed by confidentiality, the child and his problems are discussed with the principal and class teacher, to allow all those concerned with the child, to make informed decisions in relation to the rendering of relevant solutions.

By making the teachers aware of health, it will be easier for them to monitor and detect health deviations, and to alert the school health nurse to the problem timeously (Hopp 1990: 380; Stone and Perry 1990: 297; Nader 1990: 134).

Fromer (1983: 387) reminds us that the nurse as part of the school team, instigates her participation in school health matters and often addresses meetings on health matters in general, or on specific health problems affecting that particular school.

2.5.2.6 Evaluation

Nursing actions involve ongoing assessment, reorganisation of priorities, setting of new goals, and revision of nursing interventions planned for the sick school child. The decision to try alternative actions, or to terminate nursing services, are mutually arrived at by the school health team after reassessment, evaluation, and discussion of alternatives (Fromer 1983: 398; Hopp 1990: 380).

2.5.2.7 Record-keeping

Record-keeping is essential as it forms part of the pupils' health record. Factors such as the health history, screening tests, immunizations, physical and emotional problem, referrals to and from health personnel or agencies, conferences, treatments and home visits, should be recorded. Both Fromer (1983: 391) and Clark (1984: 309), stress the importance of maintaining confidentiality at all times.

The record-keeping system should allow for frequent updating of information as well as for easy retrieval of important data. Planned follow-up of problems are recorded on a day to day basis, to allow the nurse ready reference to whatever problems that may require her attention (Fromer 1983: 397). This exercise is essential to detect health problems early in order to minimise the days absent from school.

2.5.2.8 The nurse as a referral agent

Eastwold (1989: 29), as well as Lee and Erikson (1990: 39), discuss the significant role played by the nurse in the early diagnosis of health problems and behavioural and social problems which may indicate possible pathology. The nurse's role should be expanded to assist in the identification of available school health services such as physical, speech and hearing therapy. The nurse must often initiate the referral process because she may be the first adult to observe health deviations because of the singular opportunity she has to observe the pupil at school over a long period of time.

The nurse must be familiar with specific individuals, agencies and clinics available in her community for the provision of nursing, medical and paramedical assistance. She should be aware of hospital related programmes, as well as public and private agencies. Many general hospitals offer a variety of clinics as part of their comprehensive health care services. There are also clinics based in the communities which offer diagnostic and therapeutic services.

2.6 PEER ASSOCIATION

Children do not develop in isolation, and are therefore able to form associations with other individuals, a form of secondary socialisation.

Johnson (1979: 2) suggests that the characteristic subculture perspective whereby the pupil is a member of a peer group, is related to the view that the pupil is drawn to

his/her peers in an attempt to live up to perceived expectations and norms of the peer group. Lewis and Lewis (1984: 582) and Reid (1983: 113), refer to the adverse influence which peergroups could have on lifestyle practices, and mention specifically habits such as cigarette smoking, alcohol abuse, use of drugs, and so forth.

These groups may later develop into gangs with delinquent behaviour patterns. Peer group pressures pose a dilemma for many school children. Attempts to impress group members by living up to the standard of the group in order to become more popular, may force the child to deviate from family standards. Decisions about the use of drugs, or developing sexual relations, for example, are major decisions with far-reaching consequences that the child may have to take.

Parents and health professionals need to acknowledge the cognitive, social and physical dimensions of development when planning sexuality education. The adolescent's perception of sexual intercourse is a myth and stereotype about how to be popular with their peers, how to achieve adult status, and how to prove one's identity.

James and Mott (1988: 206) as well as Cookfair (1991: 213), in discussing the issue of adolescent sexual activity, refer inter alia to the fact that many adolescents get involved in sexual intercourse due to peer pressure. The authors also discuss the potential danger of unplanned teenage pregnancy, sexually transmitted diseases, and maintain that these health problems could possibly contribute to absenteeism when attending health services for treatment.

The importance of being well informed about the prevention of unwanted teenage pregnancies is highlighted. Teenagers should be well informed about premarital sexuality and the personal responsibility related to sexual activity.

Reid (1983: 113) and Lewis and Lewis (1984: 58), warn that experimentation as a result of peer pressure, can have undesirable consequences such as teenage pregnancy, or fatal injuries due to drunken driving, drug dependency and so forth. Peer pressure at school may also lead to problems of absenteeism due to fear of intimidation and humiliation (Mott, James and Sperlac 1990: 678). The school child may be associated with other children who are participating in glue sniffing and drug or alcohol abuse, and may subsequently become unfit to attend school. Gallop (1989: 112) points out that afternoon classes would be more often affected by such behaviour than what would be the case in morning classes.

Threats of violence from aggressive colleagues, may actually keep the child from attending school due to fear of physical injury. Their lives may be so threatened that they carry weapons for self protection (Bamber 1979: 32). This state of affairs may result in stress and psychosomatic illness (Reid 1983: 112).

2.7 HEALTH PROBLEMS

Health care professionals are monitoring an increasing number of school children with health problems, particularly of a chronic nature. Weitzman (1986: 799), maintains that much more emphasis still needs to be given to preventive and promotive health.

School children may suffer from a variety of diseases such as defective teeth, tonsillitis, impaired vision, poor nutrition, skin diseases and many others. A majority of the children are booked off sick, some are referred to the school nurse, or the clinics and hospitals, for evaluation and treatment (Abbott and Brenchinridge 1970: 177; Weitzman et al 1985: 742; Billings and Stokes 1986: 486).

2.7.1 Health status of school children

Current concerns about the health status of children have been extended to include social and emotional perspectives, as well as health promotional measures. The emphasis of child health care has shifted from the prevention of communicable diseases and poor nutrition towards the promotion of wellness and the eradication of factors which contribute to ill-health or illness. In discussions presented by authors, such as Stark and Siddons (1983: 208) and McMahon and Pugh (1970: 26), it is stated health protection and health promotion describe the activities that maintain and enhance health to promote school attendance.

Health promotion strategies benefit the individual directly. Children and families make decisions and take responsibility for activities that relate to health promotion. The activities are most beneficial when they form an active part of living, and are performed before the occurrence of illness. Anticipatory guidance refers to the methods used by the nurse to guide parents with the process of anticipating child health problems and what interventions to implement before they occur. It is a tool which is used to help parents learn what physical, developmental, and behavioural changes to expect in their children. According to Clark (1984: 201), parents are taught in a collaborative and

supportive manner, allowing them to be active participants in child care. Cookfair (1991: 28) added that parents may be assisted in parenting skills such as methods of discipline, management of normal developmental concerns, communication with children, and safety principles. Other health promotion measures include the promotion of good nutrition, exercise, and rest, as well as the development of a healthy self-concept (Jepson 1983: 79).

Self-care, as a concept of health promotion, is a major personal characteristic that affects the commitment to wellness. It is an action taken by individuals to care for, or cure themselves.

In late childhood and throughout adolescence, the predominant problem experienced, is safety. Children at this developmental stage participate actively in sports activities such as athletics, and in addition are greatly exposed to the hazards of substance abuse, injury or illness. They need support from parents to deal and cope with the increasing demands of peer pressure which sometimes involve unsafe or unhealthy practices (James and Mott 1988: 302; Clark 1984: 201).

2.7.2 Health care needs of adolescents

The basic physical health needs of adolescents undergo modification due to maturational changes. Failure to provide relevant health care education to meet these needs, could lead to health problems and subsequently the adolescent's absenteeism from school.

In this regard, it is vital that adequate attention is given to hygiene, including personal hygiene during the entire menstrual phase, as well as during the other developmental stages of the adolescent.

Due to developmental maturation in females, menstruation may be accompanied by premenstrual tension and dysmenorrhoea. Menstrual pain could be so severe that girls take medication and stay away from school (James and Mott 1988: 223; Clark 1984: 200).

With regard to nutrition, much has been written about the needs of the adolescents. It is stated for instance that adolescents show an increased need for kilojoules, to cope with aspects relevant to their growth, energy, emotional control, appearance and health. Problems regarding nutrition may be mild and easily solved, or complex and controlled only with professional help.

Adolescence is marked by an increase in physical growth, as well as changes in life style and eating habits. Eating and food choices are reactions to a variety of physical, emotional and psychosocial motivations or impulses. Nutritional requirements of males are greater than those of adolescent females, and can also vary with age, body build, activity and physiological state.

Poor eating habits could undermine the health status by lowering the resistance of the body against infections, thus exposing the adolescent to numerous infections which could keep him out of school (Clark 1984: 206; Jepson 1983: 86; Mott et al 1990: 91).

Another basic health care need of the adolescent is related to dental care. Self direction in dental care is usually achieved by the time mid-adolescence is reached, although regular professional care, such as dental check-ups and treatment must still be sought. Poor dental care leads to dental cavities and gum problems. James and Mott (1988: 220) and Clark (1984: 202) remind us however that visiting the dentist during school hours, could contribute to legitimate absenteeism.

It is also necessary to take note of the need for physical activity that will assist in supporting normal growth of bones and muscles, in order to prevent health problems such as arteriosclerotic vascular disease in later life, or to motivate lifelong activity involvement, and to enhance learning in the classroom. Exercises yield physical and psychological benefits, as pointed by James and Mott (1988: 222-223) and McFadyen (1988: 410).

2.8 SPECIFIC HEALTH PROBLEMS

The practice of doing medical examinations on school entrants is essential for the early detection of medical problems which could directly affect the progress, and the attendance of the child, at school. Health problems such as headaches, epilepsy, menstrual pains, poor vision, hearing problems, asthma, allergy, cancer, speech problems, orthopaedic conditions, rheumatic fever, and others, could affect school-going children.

Chronic illnesses do not only contribute to school absenteeism. They can also interfere with a child's academic performance and peer relations. These factors have

been discussed extensively by various authors, including Weitzman (1986: 799), Frank (1990: 34), Billings and Stokes (1986: 486) and Whaley and Wong (1987: 107).

A study conducted by Mowat and White (1985: 396) indicates that non-attenders of medical examination during the first year of high school, were absent more often than attenders, because health problems were identified and treated in those pupils who were examined. Similar studies were conducted by Weitzman (1986: 780) and Frank (1990: 36).

2.8.1 Epilepsy

Nurses in the community and in the school setting are in an ideal position to monitor epilepsy in school children, as well as the effect thereof on school attendance (James and Mott 1988: 1085; Frank 1990: 34; Billings and Stokes 1986: 487).

Proper monitoring and management of a child who has a seizure, could ensure regular school attendance of such a child, as regular administration of medications prevents the occurrence of seizures. The child with epilepsy should be protected from embarrassment when a seizure occurs, by asking onlookers to leave the area and allowing the affected child some privacy to rest in comfort (Newachek and Taylor 1992: 366; Eiser and Town 1987: 57; Frank 1990: 35; Fowler, Johnson, Welshimer and Atkinson 1987: 132).

Many children with epilepsy attend regular schools and participate in a wide range of school activities. These children may experience additional stresses related to poor

self-image, dependency, and a feeling of being different, particularly due to the loss of control experienced during seizures, which leaves the child with feelings of inferiority and insecurity. Such a child may be rejected by friends at a time when peer group acceptance is vitally important.

Health education is a vital aspect of the rehabilitation of a child with epilepsy.

Brochures or pamphlets explaining the cause, effects and management of epilepsy should be made available to the family and the school personnel. The importance of daily medication to achieve therapeutic levels, must be stressed.

Concurring with the above discussion, authors such as Haslam and Valletutti (1975: 96), Frank (1990: 34), Billings and Stokes (1986: 488) Kvist et al (1990: 134) remind us that the child may have to miss school whilst attending check up appoinments. This situation further contributes to the problem of absenteeism.

2.8.2 Asthma

Asthma is a major cause of school absenteeism due to chronic diseases in childhood, and accounts for about 20% of school days lost in elementary and high schools. Anderson et al (1983: 771) illustrated the scope of this problem in a study conducted in Croyden, England. Of 11,1% of children reported to have a wheezing illness during the preceding twelve months, 58% had one or more incidence of school absence, and 12% of these absences amounted to thirty days. According to Colver (1984: 450) and McNichol et al (1973: 17), it has been reported that although the periods of regular

absenteeism due to asthma is usually brief, it is more harmful academically than the occasional long periods of absenteeism.

One preventable cause of absenteeism could be the lack of understanding of the medical problem and its ramifications by the parent or the school personnel. Some pupils may for instance miss school because the parents fear that an asthma attack may be provoked as a result of bad weather. Some children may also miss school due to on erroneous assumptions of the parents, teacher, or nurse that the pupils' allergic symptoms are those of an infection, and that the pupil could be infectious. These attitudes about asthma have been described by inter alia, Mak et al (1982: 367).

It is also pointed out that asthma, as well as the treatment thereof, have a potential for adversely affecting school performance. Children with this medical condition are troubled by the symptoms, and tend to tire easily due to loss of sleep, reducing their attention span, and impairing their concentration.

Periodic hearing loss is not an uncommon complication in children with asthma and can affect academic performance. Unfortunately, medication used in the treatment of asthma could also have an occasional potential for causing sleepiness, nervousness, and irritability as well as other side effects, which together could further contribute towards school absenteeism (Anderson 1983: 778).

James and Mott (1988: 693), Anderson (1983: 778), and Colver (1984: 451), are all of the opinion that exercise could provoke symptoms in most asthmatic children, depending on factors such as the type and duration of the exercise, prevailing

environmental temperature, air pollution levels, presence of airborne allergens, severity of the asthma condition, and the use of medication by the particular child. Asthma is however, more likely to follow activities such as running and swimming. The physical education instructor should therefore have a good understanding of the limitations of the asthmatic child, as well as the use of medication prior to exercise.

Anderson et al (1983: 183) reported that poor maternal health was associated with loss of adequate treatment of the asthmatic child, and as a result the child's condition became uncontrolled, leading to school absences. Among the children with asthma, socio-economic indicators were found to be associated with increased school absence. In many instances, the indicators were related to the home environment, and included factors such as absence of one or both natural parents, renting accommodation, more than three children in the family, and lack of access to a car (Colver 1984: 452).

Data of a survey conducted by Parcel et al (1979: 882), on a number of children with wheezing, revealed that 7% of children in the sample had been absent from school in the previous year as a result of asthma. Absence from school was largely influenced by undiagnosed cases and non-compliance of treatment. Poor control of asthma which leads to disturbed sleep at night, as well as exercise induced wheezing, can result in poor academic performance or lack of participation in sports. The study further suggests that asthma is currently diagnosed more frequenrly than in the past, and that school children would certainly benefit from a more aggressive policy towards diagnosis and treatment.

In a study conducted by Parcel et al (1979: 880), on school children with asthma, it was found that several of the children included in the study, missed more than thirty days of school, and one missed seventy two days of school during a specified period.

Parcel et al (1979: 880), suggest that coordinating the required care of the asthmatic child with the school, to include administration of medication and other self-management procedures, may be a way to reduce unnecessary school absence due to asthma.

2.8.3 Cardiovascular problems

Weitzman et al (1986: 808) and Fowler et al (1987: 1319), agree that children with heart conditions need careful ongoing assessment by the school health nurse, clinic nurse or hospital nurse. The condition of a child with cardiac problems can change rapidly, thus requiring expert attention. The teacher needs to have knowledge of common conditions affecting his/her pupils to be in a position to summon medical assistance when needed.

James and Mott (1988: 784) point out that a child who presents with the signs and symptoms of respiratory and cardiac difficulties needs specialised medical and nursing intervention in hospital.

While undergoing assessment and treatment in the hospital, the child will definitely miss out on school days (Fowler et al 1987: 1319). The amount of school work missed will depend on how long the child stayed in hospital. Weitzman et al (1986: 808),

reported that parents and teachers may be apprehensive about a child with a current or previous cardiac disorder, mainly because they lack knowledge of what to do if the child gets an attack.

2.8.4 Vision and hearing problems

Among the physical reasons which might account for pupil absenteeism are impairments in sensory functioning. The teacher should be alert to pupil behaviour which suggest that a sensory deficit might exist. Behaviour such as failure to respond to verbal instructions, confusion in implementing verbal directions, omissions, and so forth, may be indicative of hearing problems. Pupils with such problems need further investigation, and it is at this point that the observant teacher performs a significant professional function of referring the pupil to relevant members of the team.

School going children may be affected by eye problems which may be identified when the child holds a book at a peculiar distance from the face, either too far or too near. The child may not pay attention to doing homework, reading, and chalkboard activities, or may show a general lack of interest, and failing to participate in certain games and group activities.

The child may complain of dizziness or headache, burning or scratchy eyes after doing school work. Common eye problems of children include strabismus, cataract, corneal abrasion, penetrating eye injuries, and eye infections. The teacher or school health nurse who identifies visual problems, should refer the child to hospital for an intensive ophthalmological examination, including follow-up treatment, depending on the nature

or extent of the condition diagnosed. During the time that the child attends diagnostic tests and treatment, classes may be be missed, adding to the incidence of absenteeism (James and Mott 1988: 1123).

2.8.5 Psychiatric disturbances

Bille (1962: 150) suggested certain neurotic disturbances that are associated with absenteeism. Boys, who are more likely to be affected, showed a tendency of neurotic symptoms such as anxiety, misery, neurasthenia and social isolation. The neurotic problems may significantly affect school attendance without the scholar being necessarily identified and treated as a school refuser.

2.8.6 Headaches

In school children, headaches may arise due to ear or tooth ache, due to the side effects of medication, or may occur as a result of a minor head injury (Illingworth 1978: 49).

Headaches are common in school children, and this is supported by studies conducted by Bille (1962: 91) and Collins, Hockaday and Waters (1985: 245), in which it is suggested that some children who suffer from headaches are frequently absent from school, and are therefore at risk of becoming under achievers.

The possibility that headache may contribute to school failure, either directly by interfering with learning, or indirectly by causing frequent school absence, is sometimes

considered an indication for long term preventive treatment with specific remedies.

The absences which were due to headaches, as referred by Collins et al (1985: 246), were usually brief, namely one day or few hours. The number of children recorded as being sent home from school due to a headache, was very small, whereas a larger proportion of pupils were attended to at the sick bay, and were then sent back to class after receiving treatment.

The importance of easy availability of such simple management within the school is thus emphasized.

Most importantly, when headaches are frequent, or cause handicaps such as school absence, it should be regarded as different from the ordinary headaches of childhood, and the possibility of a more serious cause should by investigated (Collins et al 1985: 246).

2.8.7 Menstrual pain

A widely used indicator of the severity of menstrual pain is the incidence of absenteeism due to such pain. It is generally accepted that menstrual pain is one of the major causes, sometimes the most important single cause, of school absenteeism among adolescent girls.

According to Teperi and Rimpela (1989: 163) certain reports indicate that 10% of girls in their late teens stay at home during every menstruation. Other indicators include

the need for bed rest, the need of medical intervention, limitation of normal activities, and the use of medication.

The results of the study conducted by Teperi and Rimpela (1989: 164) revealed that menstrual pain increases with age. According to their study, twelve year old girls included in the study, experienced mild menstrual pains, while the eighteen year olds experienced severe menstrual pain. The use of medication and absenteeism due to menstrual pain correlated to the severity of the pain reported.

Among sixteen year old girls who experienced severe pain, 69% had used medication, and 54% had stayed at home during the last six months.

Menstrual pain is one of the most important perceived health problems in adolescence. When menstrual causes repeated absenteeism, and regular use of painkillers, there is a strong need for seeking clinical expertise.

2.8.8 Accidents and sport injuries

Feldman et al (1983: 1282) reported that accidents or injuries are a major and important cause of childhood disease, disability and death. Motor vehicle accidents and injuries related to recreational activities are leading causes of long term hospitalisation and death (Potter and Perry 1989: 597).

In a study conducted by McFadyen et al (1988: 406) on school characteristics and injuries, the authors reported an increase in the incidence of injury rate among pupils

attending school.

According to James and Mott (1988: 326) and Feldman et al (1983: 1282) children can learn to make safe health behaviour an integral part of their lives. Safe health practices will lower the risk of injury and the frustration of major lifestyle changes necessitated by a preventable health crisis.

As a role model, the nurse can positively influence parents, teachers, children, and other health professionals. She can provide information about safety hazards and can promote the effective use of health resources by children and their significant others. James and Mott (1988: 326) are of the opinion that successful practice will result when the practitioner can cite examples that confirm the value of a safe, healthy lifestyle as a practical reality.

Characteristics such as age, developmental stage, sex, locomotor skills, activity level, peer influence, cognitive ability, and so forth, will influence the incidence, type, and severity of injury in children. School going children are more likely to be injured due to poisoning, burns, falls, sports injuries, motor vehicle accidents and home injuries.

James and Mott (1988: 327) refer to such injuries as possible indications for hospitalisation.

2.8.9 Cigarette smoking and alcohol consumption

According to Flisher et al (1993: 480), alcohol consumption in adolescents has increased over the past thirty to fourty years, both with regard to in quantity and frequency. The age at which children start drinking is becoming younger. Alcohol consumption in the short term, is associated with consequences of interpersonal violence, motor vehicle accidents and drowning. No literature could be found that deals specifically with alcohol consumption and absenteeism in South Africa and the North-West Province.

Flisher et al (1993: 477) reported in a study regarding the incidence of cigarette smoking in high schools in the Cape Peninsula, that at least 59,3% of the respondents had smoked cigarettes. No literature could be identified which deals with smoking and absenteeism in South Africa and the North-West Province.

It would appear, when considering the literature referred to, that health problems pose a great threat to the health status of school children.

2.9 CONCLUSION

In this chapter, the researcher discussed the literature which was reviewed to identify factors that could contribute to school absenteeism, as indicated by the conceptual framework used in this study.

The literature reviewed revealed a remarkable consistency in the influence of ill health

on the pupils school attendance. The literature consulted also assisted with the conceptualisation as well as the operationalization of the present study.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

The purpose of this study was to determine the extent to which health problems contribute to absenteeism in the middle schools in the Molopo region. The study was conducted over a period of three years from January 1992 to November 1994.

3.2 RESEARCH DESIGN

A quantitative research design, using an exploratory descriptive survey method, was selected to obtain information about the extent to which students in standard 5, 6, and 7 in ten middle schools in the Molopo region were absent from school due to health

reasons, in the last term of 1993. The extent to which health absenteeism was monitored and the role school health services played in the promotion of health was also considered.

3.3 PERMISSION TO CONDUCT THE STUDY

Permission to carry out the study was obtained from the Department of Education, the Department of Health and Social Services in the North-West Province as well as the principals of the selected schools, and the parents of school children absent from school. (See Annexure B, C, D and E.)

All participants were informed verbally that the information given would be treated in the strictest confidence, and that no names would be written on the questionnaires.

3.4 POPULATION

Three specific groups were selected for the study, namely pupils, teachers and school nurses.

- The pupil population totaled 6166 pupils in standard 5, 6 and 7 in the twenty eight (28) middle schools in the Molopo region.
- The teacher population comprised of four hundred and thirty four (434) teachers responsible for teaching pupils in standard 5, 6 and 7 in the schools selected for the study.
- The school health nurse section of the population included two school nurses

who were responsible for the provision of services to school children in the selected schools.

3.5 SAMPLE SELECTION

3.5.1 Schools

From the twenty eight (28) middle schools at the Molopo region using a convenience sampling technique a total of ten (10) schools was selected from the twenty eight (28) schools listed. The criteria used for the sample collected was based on the proximity of the schools to Mmabatho and to each other. The five (5) urban schools selected were all the middle schools in Mmabatho area excluding the middle school used for pretesting of the instrument. The five (5) rural schools selected were those middle schools the closest to Mmabatho. (See Annexure A.)

3.5.2 Pupils

Four hundred and twenty six (426) pupils, who were absent for more than three (3) days from school during the period September 1993 to November 1993, were selected from the attendance register kept in standard 5, 6 and 7 of the ten (10) schools selected to participate in the study.

3.5.3 Teachers

The school principals of the ten (10) selected schools in the Molopo region identified

the twenty two (22) teachers responsible for teaching pupils in standard 5, 6 and 7 who would be available to complete the questionnaires on the day planned to collect the data. Orgininally it was planned to select the various class teachers but it was found that all the school teachers taught specific subjects and no one teacher was responsible for a specific class. Appointments were then made with the relevant teachers.

3.5.4 School health nurses

Only two (2) professional school health nurses were available to participate in the study. The school nurses were those that worked in the ten (10) schools selected for the study. One (1) of the school nurses was employed by a particular principal and the relevant school committee and worked full time at that school only, whilst the other school nurse was employed by the Department of Health and Social Services.

3.6 DATA COLLECTION

Data was collected by means of three separate questionnaires presented to pupils, teachers and school health nurses. (See Annexure F, G, H).

3.6.1 Reasons for selecting the instrument

The questionnaire method was chosen in preference to the observational and interview methods for the following reasons:

- The large number and variety of respondents made it impossible to interview respondents individually.
- The questionnaire enabled respondents to give their own opinions and also gave them time to consider their responses.
- The questionnaire method ensured a wider response.

3.6.2 Development of the data collection instrument

Three separate open and closed ended questionnaires were designed for the pupils, the teachers and the school health nurses respectively. (See Annexure F, G, H). The questionnaires were structured in accordance with the conceptual model of absenteeism (refer to Figure 2.1). The content of the questionnaire was determined by the literature on absenteeism and health-related issue.

3.6.3 Questionnaire presented to the school health nurses

The questions listed in the school health nurses' questionnaires were concerned with matters such as school health services, home influences, health problems and lifestyles of school children, and the control of health related absenteeism.

3.6.4 Questionnaire presented to the teachers

The teachers' questionnaires revolved around the school health administration, health problems and lifestyles of the school children, absenteeism, home-related issues, the control of absenteeism and the provision of School Health Services.

3.6.5 Questionnaire presented to the pupils

The pupils' questionnaires specifically addressed aspects such as their demographic profile, the incidence of absenteeism, school related issues, home influences, peer associations, health problems and lifestyles.

3.6.6 Pretesting of the instrument

According to Polit and Hungler (1987: 176) pretesting of a data collecting instrument is done to evaluate factors such as the length, wording and validity. Reliability is also explained as *the extent to which a measurement yields consistent observation of the same facts from one time to another and from one situation to another.* All three questionnaires were tested for face and content validity.

3.6.6.1 Reliability

Reliability of the instrument used in this study was sought by pretesting the instrument in one of the middle schools in the Mmabatho area not included in the main study, in which the situation was similar to the one envisaged for the main study. Using a convenience sampling technique, twenty (20) pupils and three (3) teachers were selected. The twenty (20) pupils selected were those in standard 5, 6 and 7 who had according to the class register kept been absent for three or more days. The three (3) teachers selected were those identified by the school principal who were available on the day and involved in teaching pupils in standard 5, 6 and 7. The purpose of the research was explained to the subjects, as well as the necessary instructions for

completion of the questionnaire.

3.6.6.2 Face and content validity

Validity is a judgement of the extent to which a component of an instrument reflects the theory or variable that it is intended to measure. If an instrument is valid, it should measure what it purports to measure (Polit and Hungler 1987: 178).

Content validity is a valuable assessment tool for validity, because its focus is on balance and representation of items relating to the study. It ensures that all possible observations were selected. Face validity measures the extent to which the instrument appears to be logically appropriate.

In this study, face and content validity was evaluated for all three questionnaires by a panel of five community health nurses from the department of Nursing Science at the University of the North-West, and three Community Health Nurses from "The Stadt Clinic".

Certain alterations and additions were made to the questions.

3.6.6.3 Problems and comments

- It took the pupils in particular approximately fifty five (55) minutes to complete the questionnaires, due to the need to explain the meaning of certain of the terms used in the questionnaire. The teachers and school nurses did not

appear to have any problems in this regard.

- Some of the questions were ambiguous.
- The use of medical terms posed some difficulty.
- The pupils experienced difficulty in understanding the English used in the questionnaire.

All criticism, such as the above-mentioned problems and shortcomings, were taken into consideration when making the following important alterations to the instrument:

- Ambiguous questions were re-phrased to ensure that the questions were clear, concise and specific.
- Some questions were eliminated and new questions were formulated.
- The sentences were re-phrased, using basic English.
- Medical terms were limited, and words which were more familiar to the pupils and teachers were used.
- The questionnaires were shortened to ensure that they could be completed in approximately forty minutes, which would be equivalent to approximately one school period.

The three (3) questionnaires were then reorganised to make them more user friendly. The final questionnaires were discussed with the promoter, co-promoter and a statistician who approved them.

3.6.7 Data collection process

Towards the end of the last school term in November 1993, appointments were made with the principals of the ten (10) selected Middle Schools in the Molopo region.

The majority of schools indicated that the most convenient time to fill in the questionnaires was during the daily long break period. Some of the appointments for data collection were set to take place during study periods. To reduce bias, data collection was undertaken by presenting the questionnaire the same way, and order by the researcher.

Pupils

At each school, the pupils identified were gathered in one classroom or school hall. After the necessary introductions were made, the researcher explained the purpose of the study and assured all that confidentiality would be maintained. Thereafter, the questionnaires were distributed by the researcher to the pupils for completion. Throughout the session, questions and concerns expressed were addressed by the researcher. The school principals and teachers were not involved in the administration of the questionnaires completed by the pupils, so that the whole exercise was viewed with ease and confidence by the pupil respondents. This eliminated any suspicion that may have been felt by the respondents.

- **School nurses**

Both school health nurses were included in the sample and they answered all the questions listed in the questionnaire.

- **Teachers**

The teachers identified were handed questionnaires to be completed in their staff offices.

- **Response rate**

The response rate by pupils, teachers and school nurses was 100% as all questionnaires submitted were answered and returned to the researcher on the same day.

- **Problems experienced**

The following problems were experienced during the process of data collection:

- Lack of preparation of venues and respondents at some schools, resulted in teaching time being used to collect data.
- Some of the items were not answered by all the respondents.
- Some of the pupils experienced difficulty in recalling the exact number of days that they were absent from school, as well as the nature of the health problems they experienced.

- During the time data was collected, which was in November, the pupils and teachers were slightly impatient and irritable because they were preparing for the end of year examinations.

Questions and concerns raised by the pupils and teachers whilst completing the questionnaires, were addressed to clarify the questions, so that they were able to respond clearly to the various questions.

3.7 ANALYSIS OF DATA

The computer programme used to analyse the data collected was the South African Software Programme (SAS). Data obtained from the questionnaires were entered onto coding sheets by the researcher. These sheets were submitted to the Computer Services of the University of South Africa where the data processing was done.

The computer programme material was checked for coding errors, and where such errors occurred, the information was redefined. Frequency tables were used extensively in the data analysis which consisted of frequency distributions, percentage, and cross tabulations. All statistical tables and graphs are presented in chapters four, five, and six.

3.8 CONCLUSION

In this chapter the methodology of the study, the method of sampling and data collection, the data analysis method used, as well as the limitations of the study, were

discussed.

The next three chapters will present an analysis of the collected data.

CHAPTER 4

ANALYSES AND PRESENTATION OF DATA: QUESTIONNAIRE FOR THE SCHOOL HEALTH NURSE

4.1 INTRODUCTION

The statistical information presented in this chapter was obtained from the completed questionnaires returned by the two school health nurses, one of whom was employed by the Department of Health and Social Services and one employed by a school board.

Analysis of data was done using the SAS Basic Version Package. The statistical

methods used for data analysis include percentages, frequency distributions and correlations. Data obtained is presented in the form of tables and figures.

4.2 SECTION 1: SCHOOL ENVIRONMENT (ITEMS 1-14)

4.2.1 Item 1: Philosophy of the school health service

Both the school health nurses in the Molopo region use the philosophy of the school health service of the Department of Health and Social Services in the North-West Province. This is considered important as a philosophy ensures a standardised approach in the delivery of school health services offered.

4.2.2 Item 2: Goals of the school health programme

The goals of the school health programmes identified by the two school health nurses were as follows:

- to provide health care to school children
- to promote the physical, mental, social and spiritual well-being of school children
- to give health education regarding self-care and environmental hygiene

These findings indicate that the school health nurse is aware of the goals set for school health programmes in her area.

4.2.3 Item 3: Schools visited by the school health nurses in the Molopo region

Table 4.1: Number of schools visited by the school nurses (n = 2)

SCHOOLS VISITED	NURSE DEPARTMENT OF HEALTH	PRIVATE SCHOOL NURSE
Batswana	1	-
Boingotlo	1	-
Boitseanape	1	-
Boitshoko	1	-
Makgetla	1	-
Mmabatho	-	1
Molema	1	-
Montshiwa Memorial	1	-
Redibone	1	-
Tetlano	1	-
TOTAL	9	1

According to Table 4.1, the school nurse under the control of the Department of Health and Social Services had nine (9) schools under their jurisdiction, whereas the school nurse under the control of a particular school principal, looks after children in one (1) school only. Hereafter, the nurse employed by the Department of Health and Social Services will be referred to as the HSS nurse, whilst the second nurse respondent will

be referred to as the private school nurse.

4.2.4 Item 4: Frequency of visits to schools

The information obtained indicates that the HSS school nurse visited the schools assigned to her once a year, whilst the private school health nurse saw pupils daily as her office is situated in the sick bay at the particular school. It would appear that of the ten (10) schools selected for the sample, one (1) school was never visited by any school nurse, whilst eight (8) of the schools received an annual visit from the HSS nurse. The tenth school had the services of a school nurse on a full time basis. These findings do not correlate with the findings in 4.2.3 in which it would appear that the HSS school nurse visits all the schools except the school which had its own school health nurse.

These findings give rise to concern as it would appear that school health service coverage in general is insufficient.

4.2.5 Item 5: Average number of pupils seen per visit

Table 4.2: Number of pupils seen per visit (n = 2)

SPECIFIC SCHOOL HEALTH NURSE	AVERAGE NUMBER OF PUPILS SEEN PER VISIT/DAY
Department of Health and Social Services (HSS)	± 200 per visit
Private School Nurse	35 - 114 per day

Table 4.2 indicates that the number of children seen by the school health nurse employed by the Department of Health and Social Services was approximately two hunderd (200) pupils per visit.

The number of pupils seen by the private school nurse varied between thirty five (35) and one hundred and fourteen (114) per month. The statistics in this instance refer to the number of pupils seen per day, not per visit, as the private nurse was available every day, and the numbers varied from day to day.

4.2.6 Item 6: Pupils examined during visit to school

The private school health nurse, indicated that she did a full examination on all new pupils at the school, whereas the school health nurse employed by the Department of Health and Social Services stated that she examined all new pupils, as well as those who reported sick, and those who were due for tests such as hearing tests.

4.2.7 Item 7: Members involved in the school health programme (n = 2)

Both school health nurses indicated that the school health team involved in the school health programme was made up of the school nurse, the school administrator and teachers. It is significant to note that the parents and students as well as the other members listed who could belong to a multi-disciplinary team were not represented.

4.2.8 Item 8: Frequency of multi-disciplinary school health team meeting

Data collected indicated that the private school nurse and her multidisciplinary team held monthly meetings, whilst the HSS nurse and her team only held meetings when necessary.

4.2.9 Item 9: Identification of sick pupils

Both school nurses indicated that sick pupils were identified by the class teacher. In the school where the private nurse was employed some of the pupils presented themselves to the school health nurse at the sick bay on their own accord.

4.2.10 Item 10: School health records

This was an open-ended question. Both school health nurses indicated that the following records were kept:

- weekly and monthly reports
- annual reports
- work schedules which indicated the daily work programme
- records of individual students seen at the sick bay
- in addition, the HSS school nurse indicated that she kept records on home visits, whilst the private school nurse did not report on any visits done to the homes of pupils

4.2.11 Item 11: Place where records are kept

This was an open-ended question. The school health nurse under the control of the Department of Health and Social Services kept records in her own office, and sent a copy of the records to the supervisors of school health services, the senior nursing service manager and to the head office. The private school health nurse under the control of the school principal, kept records in her own office, and submitted copies to the relevant principal as well as to the head office of the Department of Education.

4.2.12 Item 12: Control of school health records

Both school health nurses indicated that they were responsible for keeping the school health records up to date. This is significant for continuity and follow-up purposes.

4.2.13 Item 13: General practice after examining sick pupils

Both school nurses referred sick pupils to the doctors for further assessment and interventions. The private school nurse also indicated that she gave medication for minor ailments, and did not necessarily refer the pupil to the clinic. The HSS school nurse stated that she did not give any medication to the pupils, but referred sick pupils to the clinic where treatment of minor ailments would be given and referral to the doctor or hospital would be done if necessary.

4.2.14 Item 14: School visit report given to the head of the department

The HSS school nurse confirmed that she submitted reports on school visits to her supervisors, whilst the private school nurse submitted the health reports to the principal of the school. This is important for planning and control purposes.

4.3 SECTION 2: HEALTH PROBLEMS (ITEM 15-17)

4.3.1 Item 15: Individuals involved when a pupil is sick

Both school nurses discussed the pupils health problems with the pupil, the teacher, the school principal and the parents. In addition, the HSS school nurse indicated that she discussed relevant problems with the head of the school health nursing services.

4.3.2 Item 16: Health care practices

Both school health nurses indicated that they carried out the following practices:

- periodic physical examination
- periodic history taking
- eye tests
- hearing tests
- health education

The HSS school health nurse indicated that she also did immunizations.

4.3.3 Item 17: Health problems that resulted in absenteeism

The HSS school health nurse identified the following problems that resulted in absenteeism: stomachache, diarrhoea, vomiting, headache, burns, operations, sports injuries and painful ears. The private school nurse in turn only identified headache and menstrual pains as health problems that resulted in absenteeism at the school where she was involved.

4.4 SECTION 3: ABSENTEEISM (ITEMS 18-19)

4.4.1 Item 18: School nursing policy when pupil is absent due to health problems

This was an open-ended question. The HSS school health nurse responded in the following manner when a pupil was absent from school due to health problems. She

- paid a visit to the home of the sick pupil
- assessed and identified health problem relevant ot the pupil
- counselled the sick pupil
- referred the sick pupil to the clinic or doctor if necessary

The private school health nurse did not respond to this item which might indicate that she does not function according to a specific policy in this regard.

4.4.2 Item 19: Persons responsible for reporting health related absenteeism to the school health nurse

Both nurses stated that the teacher would generally identify sick pupils. In addition, the HSS school health nurse mentioned that the principal and the student counsellor had at times identified sick pupils. The private school nurse also indicated that a pupil on occasions also informed her of his/her illness when visiting the sick bay.

4.5 SECTION 4: PEER INFLUENCE (ITEM 20)

4.5.1 Item 20: Lifestyle activities

Both school health nurses identified that cigarette smoking occurred at school. The HSS school health nurse added that alcohol consumption, sniffing of glue, dagga smoking, taking of drugs and sexual encounters also occurred. It would appear that in the private school these additional activities were not practised.

4.6 SECTION 5: HOME ENVIRONMENT (ITEMS 21-24)

4.6.1 Item 21: Home visit

The HSS school health nurse indicated that she did on occasion visit sick pupils and their families at home, whereas the private school nurse stated that she did not visit the homes of sick pupils.

4.6.2 Item 22: Purpose of home visits

Only the HSS school health nurse answered this question. Her reasons for conducting visits to the homes of sick pupils were as follows:

- to do sanitary inspections
- to conduct follow-up visits of sick pupils identified during school visits
- to monitor pupils reported as being absent from school
- to monitor pupils who experienced social problems
- to interview the parents of sick pupils
- to interview the pupils at home
- to provide health education to pupils and their families

4.6.3 Item 23: Topics for health education session

The HSS school health nurse stated that education regarding sexuality, hygiene, headaches, epilepsy, Aids and drug abuse, were topics generally used for health education at schools. The private school nurse emphasized the need for education regarding personal hygiene, particularly for girls during menstruation, as well as education regarding environmental hygiene. It is significant to note that it would appear that family planning was not included in these talks.

4.6.4 Item 24: Health information brochures

Both school health nurses stated that they issued health information brochures to the

teachers and the pupils. In such a way it would appear that both the teacher and the pupils are made aware of current health problems.

CHAPTER 5

ANALYSIS AND PRESENTATION OF DATA: QUESTIONNAIRE FOR TEACHERS

5.1 INTRODUCTION

In this chapter, an analysis of the information collected from the twenty two (22) teachers who participated in the study, will be presented.

5.2 SECTION 1: SCHOOL ENVIRONMENT (ITEMS 1-8)

5.2.1 Item 1: Standards taught by teachers

Table 5.1: Standards taught by teachers (n = 14)

STANDARDS TAUGHT	TEACHERS' RESPONSES	
	FREQUENCY	PERCENT
7	7	50,0
5	5	35,7
6	2	14,3
TOTAL	**14**	**100,0**

Only fourteen (14) teachers responded to this item.

Table 5.1 indicates that seven (50%) of the teachers included in the sample taught pupils in standard 7, five (35,7%) taught standard five pupils, whilst only two (14,3%) taught standard 6 pupils. These teachers were responsible for subject teaching only. In terms of control and knowing the needs of the school children consistency was a problem, as there appeared to be no specific class teacher.

5.2.2 Item 2: Keeping of a daily class attendance register

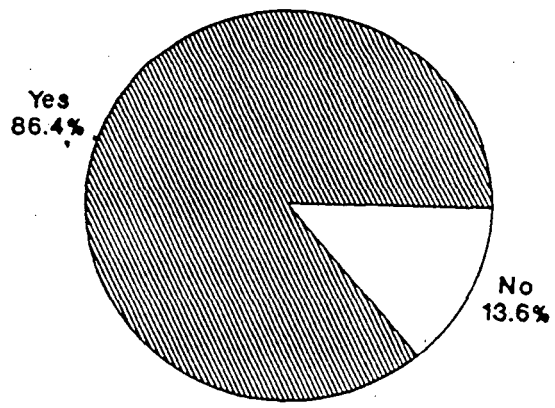

Figure 5.1

Keeping of daily class attendance register (n = 22)

Figure 5.1 shows that nineteen (86,4%) of the teachers kept a daily class attendance register, and that three (13,6%) did not keep a daily attendance register. The reason for this could possibly be that the teachers included in the sample were only subject teachers, and were therefore not responsible for keeping class attendance registers of a particular class.

5.2.3 Item 3: Period of the day when the register was marked

Table 5.2: Period of the day when the register was marked (n = 21)

PART OF THE DAY	NUMBER OF RESPONDENTS	
	FREQUENCY	PERCENT
Afternoon	11	52,4
Morning	8	38,1
Not marked	2	9,5
TOTAL	**21**	**100,0**

According to Table 5.2 eleven (52,4%) of the teachers marked the attendance registers in the afternoon, eight (38,1%) did so in the morning, and two (9,5%) did not mark the registers at all. It is presumed that the teacher who did not respond to this question also did not mark the register. This has implications in terms of absenteeism as it is not clear how the teacher would know whether all the children were present or not.

5.2.4 Item 4: The availability of written class attendance rules and regulations

Table 5.3: The availability of written class attendance rules and regulations (n = 20)

ATTENDANCE RULES AND REGULATIONS AVAILABLE	NUMBER OF RESPONDENTS	
	FREQUENCY	PERCENT
Yes	14	70,0
No	6	30,0
TOTAL	**20**	**100,0**

According to Table 5.3, the number of teachers who acknowledged that they have written class attendance rules and regulations amounted to fourteen (70%), whilst six (30%) of the respondents indicated that they did not have any written attendance rules and regulations.

5.2.5 Item 5: Title of the school rules and regulations (n = 1)

This was an open-ended question to which only one (1) teacher responded. The title of the school rules on attendance in this instance was indicated as being "Instructions for Register". (See Annexure I).

5.2.6 Item 6: Contents of school rules on attendance and absenteeism (n = 1)

This was an open-ended question and only one (1) respondent answered this question. The respondent indicated that the contents of the school rules on attendance and

absenteeism related to "Rules for keeping and recording the register".

These findings appear to indicate that the majority of the school teachers are unaware of the availability of rules for the keeping of class registers.

5.2.7 Item 7: Title of the attendance and absenteeism regulations from the Department of Education and Training (n = 1)

This was an open-ended question. Only one (1) response was received, and this indicated that the title of the Department of Education regulation merely indicated "Instructions".

5.2.8 Item 8: Contents of the attendance and absenteeism regulations from the Department of Education and Training

No response was received regarding the question on the contents of the regulations of the Department of Education. This could indicate that the schools are possibly only using internal school regulations, or that the contents have not been discussed with them. It would appear however, in terms of the daily functions of the teachers these regulations are not in use.

5.3 SECTION 2: ABSENTEEISM (ITEMS 9-18)

5.3.1 Item 9: Absenteeism contributes to poor performance at school

Table 5.4: Absenteeism contributes to poor performance (n = 20)

ABSENTEEISM CONTRIBUTES TO POOR PERFORMANCE	NUMBER OF RESPONDENTS	
	FREQUENCY	PERCENT
Agreed	18	90,0
Do not agree	2	10,0
TOTAL	**20**	**100,0**

According to Table 5.4 eighteen (90%) of the respondents agreed that absenteeism did contribute to poor performance. Two respondents (10%) were of the opinion that absenteeism did not contribute to poor performance and two (10%) did not respond to this item.

5.3.2 Item 10: Reasons for poor performance due to absenteeism

This was an open-ended question and no respondent answered the question regarding the reasons that contributed to poor performance by absentees in the classroom situation. This may indicate that due to the fact that there appeared to be no class teacher responsible for controlling the absentee registers teachers were unaware of the degree to which pupils were absent.

5.3.3 Item 11: Part of the day indicated by teachers when pupils were absent from class

Table 5.5: Part of the day when pupils were absent from class as indicated by teachers (n = 22)

PART OF DAY	NUMBER OF RESPONDENTS	
	FREQUENCY	PERCENT
Morning	6	27,3
Afternoon	6	27,3
Whole day	10	45,4
TOTAL	**22**	**100,0**

According to Table 5.5 ten (45,4%) of the teachers indicated that pupils were absent for the whole day, six (27,3%) reported absenteeism to have occurred only in the mornings, and the remaining six (27,3%) of the teachers indicated that pupils were only absent in the afternoon. It would have been of value to have known why pupils were absent during the different times indicated.

5.3.4 Item 12: Days of the week when pupils were absent from school (n = 28)

More than one (1) response was possible for this question. The response received from sixteen (57,1%) teachers indicated that pupils were absent on Mondays, ten (35,7%) indicated that pupils were absent on Fridays, and two (7,14%) teachers indicated pupils were absent from class for the whole week.

5.3.5 Item 13: Measures taken according to school policy to control health related absenteeism

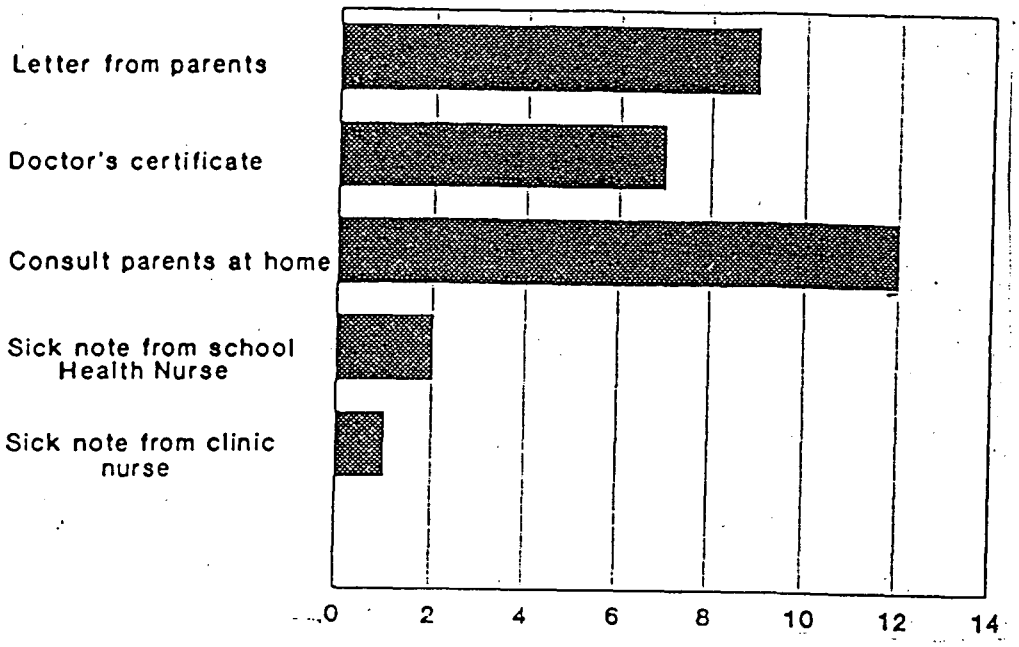

Figure 5.2

Measures taken according to school policy to control health related absenteeism (n = 22)

Although the number of respondents for this item was twenty two (22) it was noted that certain respondents gave more than one (1) response to the item. Figure 5.2 indicates that nine teachers required the absentee to submit a letter from the parents when absent from school, thirteen teachers required a medical certificate to be submitted, four teachers consulted the parents at home, and fourteen teachers required a sick note from the clinic nurse who had attended to the sick pupil. This indicates that individual schools have their own internal policies regarding health-related absenteeism.

5.3.6 Item 14: Measures taken to control health related absenteeism

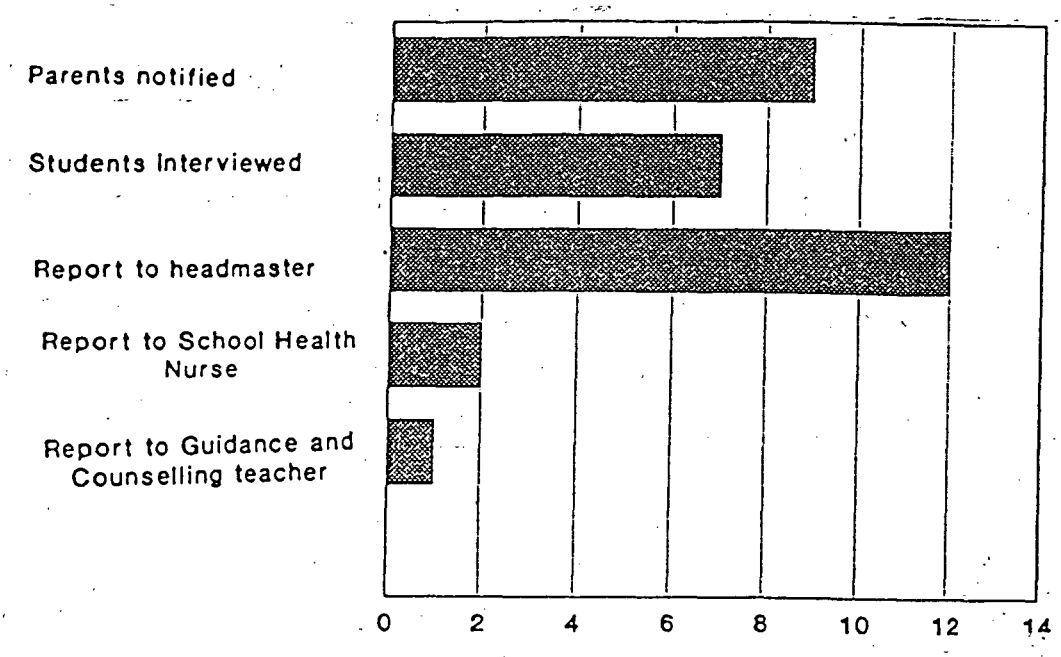

Figure 5.3

Measures taken to control health related absenteeism (n = 22)

Although the number of respondents to this item was twenty two (22), it was noted that certain respondents gave more than one (1) response to the item. Twelve (12) teachers reported the sick pupils to the headmaster, nine (9) teachers notified the parents that the pupils were absent from school, seven (7) teachers interviewed the sick pupils, two (2) teachers indicated that they would report sick pupils to the school nurse, and only one (1) teacher said that the incidence would be reported to the guidance and counselling teacher.

5.3.7 Item 15: School personnel who interviewed parents of pupils consistently absent from school

Table 5.6: School personnel who interviewed parents of pupils consistently absent from school (n = 22)

INTERVIEWER SCHOOL PERSONNEL	NUMBER OF RESPONDENTS
Principal	16
Departmental head	7
Teacher	7
Nobody	3
TOTAL RESPONSES	**33**

Although the number of respondents to the item was twenty two (22), it was noted that certain respondents gave more than one (1) response to the items listed. According to Table 5.6, sixteen (16) teachers pointed out that the principal interviewed parents of pupils persistently absent from school, seven (7) stated that the departmental head did so, and another seven (7) indicated that the class teacher interviewed the parents. Only three (3) teachers indicated that nobody interviewed the parents of pupils who were absent from school.

5.3.8 Item 16: School personnel who interviewed absent pupils

Table 5.7: School personnel who interviewed absent pupils (n = 22)

PERSON WHO CONDUCTED THE INTERVIEW	NUMBER OF RESPONDENTS
Teacher	19
Principal	9
Departmental head	7
Nobody	1
TOTAL RESPONSES	**36**

Although the number of respondents was twenty two (22), the data indicated that some respondents gave more than one response. According to Table 5.7 nineteen (19) teachers indicated that the class teacher was the person who interviewed the absent pupils. Nine (9) teachers indicated that the principal did the interviewing, seven (7) teachers indicated that the departmental head interviewed pupils, whilst only one (1) teacher said that nobody interviewed the absent pupils.

5.3.9 Item 17: Rewards given for excellent school attendance

Table 5.8: Rewards given for excellent school attendance (n = 20)

REWARDS GIVEN FOR EXCELLENT SCHOOL ATTENDANCE	NUMBER OF RESPONDENTS
No reward given	11
Remarks made on reports	3
Written individual praise given	6
A prize given	0
A certificate of recognition given	0
TOTAL	**20**

Table 5.8 shows that eleven (11) teachers did not reward pupils who had an excellent school attendance record. Six (6) teachers indicated that written praise for such pupils was given, whilst three (3) teachers responded that a remark had been made in the pupils school performance report. None of the respondents indicated that a prize or a certificate of recognition had been given to pupils with an excellent attendance record.

5.3.10 Item 18: Delinquency associated with absenteeism (n = 21)

Sixteen (76,2%) of the respondents confirmed that delinquency was associated with absenteeism whilst five (23,8%) indicated that there was no association between delinquency and absenteeism.

5.4 SECTION 2: PEER ASSOCIATION (ITEMS 19-20)

5.4.1 Item 19: Lifestyle activities of pupils in class

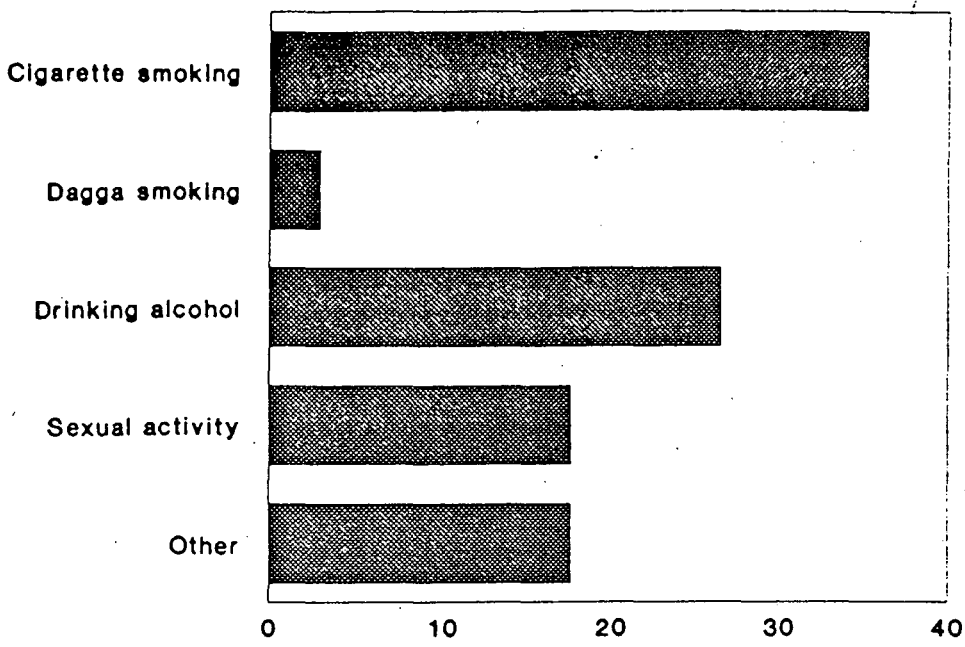

Figure 5.4

Lifestyle activities of pupils (n = 22)

Although the number of respondents to this question was twenty two (22) the data indicated that some respondents gave more than one response. According to Figure 5.4 twelve (35,3%) teachers indicated that pupils smoked cigarettes, nine (26,5%) teachers said that pupils consumed alcohol, six (17,6%) teachers mentioned that pupils were involved in sexual encounters, another six (17,6%) teachers said that pupils were practising glue sniffing, and one (3%) teacher indicated that certain pupils smoked dagga.

5.4.2 Item 20: Health problems resulting in absenteeism

Table 5.9: Health problems resulting in absenteeism (n = 22)

HEALTH PROBLEMS	NUMBER OF RESPONDENTS
Flu	20
Stomachache	16
Menstrual pain	7
Headache	5
Eye problems	1
TOTAL	**49**

Table 5.9 indicated the responses made by the twenty two (22) teachers interviewed in relation to the health problems which led to absenteeism in their classes.

Twenty (40,8%) teachers indicated flu/colds, sixteen (32,7%) mentioned stomachache, seven (14,3%) listed menstrual pain, five (10,2%) indicated headache, and one (2%) said that eye problems resulted in absenteeism. The rest of the health problems listed in the questionnaire were not mentioned which indicated that these problems were most likely not identified as a problem in terms of absenteeism.

5.5 SECTION 3: SCHOOL HEALTH SERVICES (ITEMS 21-27)

5.5.1 Item 21: Availability of school health nurse

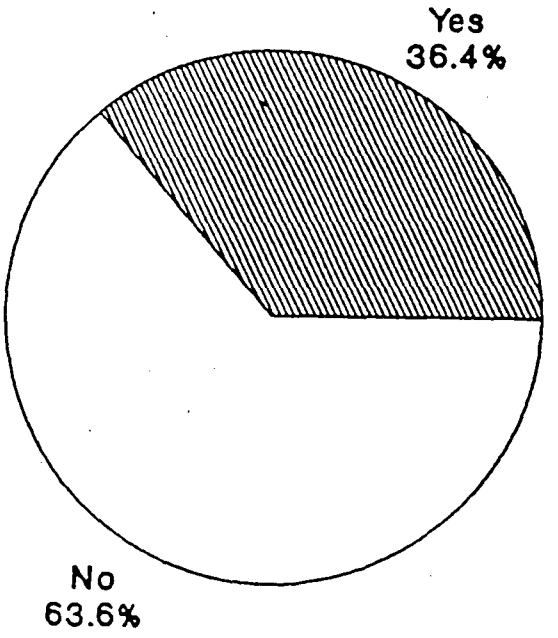

Figure 5.5

Schools with and without a school health nurse (n = 22)

Of the twenty two (22) respondents, fourteen (63,6%) stated that there is no school health nurse at their schools, whilst eight (36,4%) teachers said that there is a school health nurse at their schools. See Figure 5.5 in this regard.

This does not correlate with the responses given by the school nurses in which it was stated that all ten (10) schools selected were covered by school health services to a certain degree.

5.5.2 Item 22: Frequency of school health nurses' visits to schools

Table 5.10: Frequency of school nurses' visits to schools as interpreted by teachers (n = 22)

FREQUENCY OF SCHOOL NURSES VISITS TO SCHOOLS	NUMBER OF RESPONDENTS	PERCENT
Does not visit school	14	63,7
Always at school	4	18,2
Visits school once a month	3	13,6
Visits school once a term	1	4,5
TOTAL	**22**	**100,0**

Table 5.10 indicates that fourteen (63,7%) of the teachers said that a school nurse at no time visited their schools. Four (18,2%) respondents from the school with a permanent school nurse stated that the school nurse was always available at school, three (13,6%) of the teachers indicated that the school nurse visited their school on a monthly basis, and one (4,5%) indicated that the nurse visited her/his school once a term. These findings do not correspond with the responses of the school nurses and may indicate that there is little knowledge of the available school health services.

5.5.3 Item 23: Examination of new pupils in schools (n = 22)

Nineteen (19) teachers indicated that the school nurse did not examine pupils who enrolled at their schools for the first time, whilst three (3) of the teachers did not

respond to this item indicating that perhaps new pupils were not examined. These findings once again do not correlate with the responses of the school health nurses indicating again little awareness of what the school health nurse does.

5.5.4 Item 24: Health records kept at school (n = 19)

Sixteen (84,2%) of the teachers indicated that no health records for pupils were kept at their schools. Only three (15,8%) teachers indicated that health records were kept at their schools. These findings in terms of the school health nurses' responses indicate that the teachers are unaware of what is done. Lack of adequate school health records could have serious implications in terms of control and follow-up of the child frequently absent from school.

5.5.5 Item 25: Persons who identified sick pupils at school

Table 5.11: Persons who identified sick pupils at school (n = 22)

PERSON WHO IDENTIFIED SICK PUPILS	NUMBER OF RESPONDENTS
The class teacher	18
The school nurse	5
The principal of the school	1
Pupils	3
TOTAL RESPONSES	**27**

Some respondents gave more than one (1) response to this item. According to Table 5.11, eighteen (66,7%) of the twenty two (22) teachers included in the sample stated that sick pupils were identified by the relevant class teachers, five (18,5%) indicated that this was done by the school health nurse, three (11,1%) said that the pupils themselves reported their illness. Only one (3,7%) teacher indicated the principal was the person who identified a sick pupil.

5.5.6 Item 26: Health education given by school health nurse

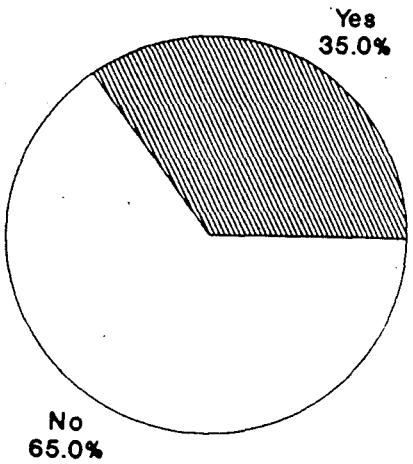

Figure 5.6

Health education given by the school nurse (n = 20)

Figure 5.6 indicates that thirteen (65%) of the teachers do not know whether the school health nurse gave health education to pupils, whilst seven (35%) of the teachers indicated that health education was given in the school. These findings once again do not correspond with the responses given by the school health nurse indicating that in general the functions of the school health nurse is not know. This may be due to the fact that visits to the schools are infrequent.

5.5.7 Item 27: Topics used for health education in the school

Table 5.12: Topics used for health education in the school (n = 22)

HEALTH EDUCATION TOPIC	NUMBER OF RESPONDENTS
Sex education	5
Family planning	2
Aids	2
Drug abuse	1
Hygiene	1
TOTAL	**11**

According to Table 5.12 only five (22,7%) respondents indicated that the school nurse gave health education on sex. Two (9,1%) respondents listed family planning as a topic being presented, two (9,1%) respondents gave AIDS as a topic, whilst only one (4,5%) respondent stated that drug abuse and hygiene were included as topics. None of the respondents listed topics such as nutrition, sport injuries, colds/flu, epilepsy and headache as topics being addressed during health education sessions. The remaining twelve (54,5%) respondents indicated that they knew of no topics taught.

It is interesting to note that family planning is indicated as a topic discussed but is not mentioned by the school health nurses.

5.5.8 Item 28: Aspects of health care provided by the school nurse as perceived by teachers (n = 9)

Four (44,6%) teachers indicated that the school nurse gave immunization at their schools, three (33,3%) indicated that the nurse was responsible for giving health education, one (11%) teacher indicated that the nurse did periodic physical examinations of pupils, and another one (11%) indicated that the nurse performed hearing tests on pupils. The remaining thirteen (13) teachers who formed part of the sample of twenty two (22), did not respond to this item, indicating that perhaps little was know about the function of the school health nurse.

5.5.9 Item 29: Home visits to sick pupils' homes (n = 22)

Nineteen (86,4%) teachers indicated that they had no knowledge of the school nurse visiting sick pupils at home, whilst the remaining three (13.6%) teachers did not respond to this item indicating that home visits were probably not done.

5.5.10 Item 30: Meetings of the teachers and the school nurse (n = 22)

All twenty two (100%) of the teachers interviewed, stated that they have at no time attended any meetings with the school nurse. These findings are significant as it would appear that the responses of the teachers and school health nurses differ substantially indicating that perhaps there is little communication between the two groups.

5.5.11 Item 31: Information materials (brochures) on health issues

Table 5.13: Provision of information materials on health issues (n = 18)

INFORMATIVE MATERIAL PROVIDED	NUMBER OF TEACHERS WHO RESPONDED	PERCENT
No	17	94,4
Yes	1	5,6
TOTAL	**18**	**100,0**

Table 5.13 indicates that seventeen (94,4%) of the teachers did not receive any informative material on health issues from the nurse, whereas one (1) teacher (5,6% of the sample) indicated that she had received information on health issues from the school health nurse. The remaining teachers did not respond to this item indicating that the availability of health information brochures was not known.

Once again the views of the two groups differ as in terms of the school health nurses' responses health information material is provided. These findings give rise to concern as it would appear information on health and health related issues is not generally available in the ten (10) schools selected.

CHAPTER 6

ANALYSIS AND PRESENTATION OF DATA: QUESTIONNAIRE FOR PUPILS

6.1 INTRODUCTION

The statistical information presented in this chapter was obtained from the four hundred and twenty six (426) pupils in standard 5, 6 and 7 in ten (10) schools selected for the sample. Analysis of the data was done using the SAS basic version package.

6.2 SECTION 1: HOME ENVIRONMENT (ITEMS 1-8)

6.2.1 Item 1: Age distribution

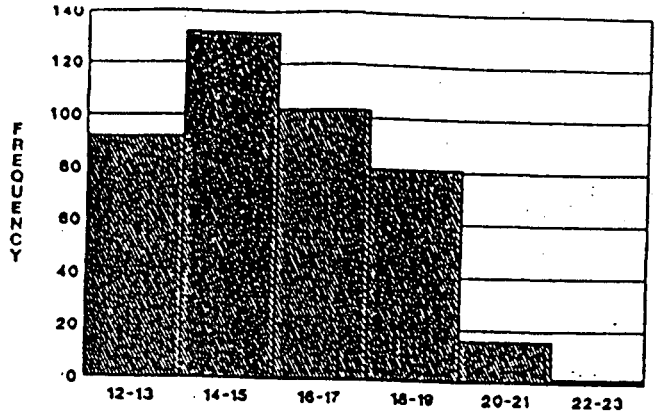

Figure 6.1

Age distribution of respondents (n = 426)

Figure 6.1 shows that the ages of respondents varied from 12 to 23 years. The respondents between 12 to 13 years amounted to ninety two (21,6% of the sample) and those 14 to 15 years amounted to one hundred and thirty one (31% of the sample). One hundred and three (24,2%) pupils were between 16 to 17 years of age, eighty one (19%) between 18 to 19 years, sixteen (3,8%) between 20 to 21 years, and two (0,5%) were 22 or 23 years old.

6.2.2 Item 2: Gender distribution

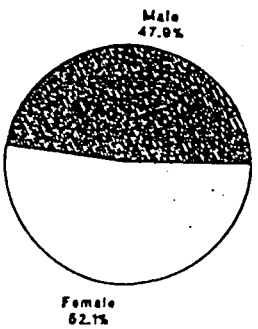

Figure 6.2

Gender distribution of respondents (n = 426)

According to Figure 6.2, there were two hunderd and twenty two (52,1%) female respondents and two hunderd and four (47,9%) male respondents in the sample.

6.2.2.1 Gender and number of days absent from school

Table 6.1: Number of days pupils were absent from school in relation to gender (n = 426)

GENDER	DAYS ABSENT FROM SCHOOL		
	1-7 DAYS	8-15 DAYS	16-31 DAYS
Male (n = 204)	151 (35,7%)	45 (10,6%)	8 (1,8%)
Female (n = 222)	153 (36,2%)	62 (14,2%)	7 (1,5%)
TOTAL (n = 426)	**304 (71,9%)**	**107(24,8%)**	**15 (3,3%)**

According to Table 6.1, there were more female pupils absent from school, namely two hunderd and twenty two (51,9%) females, than males two hundred and four (48,1%). One hundred and fifty three (36,2%) female pupils, and one hundred and fifty one (35,7%) male pupils were absent for one to seven days, sixty two (14,2 %) females and forty five (10,6%) males were absent for between eight (8) to fifteen (15) days, and seven (1,5%) female pupils and eight (1,8%) males were absent for periods between sixteen (16) and thirty one (31) days.

Gender appears unrelated to the number of days respondents were absent from school. The p value is not less than 0,05%, therefore the statistic is not significant.

6.2.3 Item 3: Place of residence of respondents

Table 6.2: Place of residence of respondents (n = 426)

PLACE OF RESIDENCE	PUPILS' RESPONSES	
	FREQUENCY	PERCENT
Mmabatho (Urban)	105	24,6
Montshiwa (Urban)	41	9,66
Motlhabeng (Rural)	46	10,8
Magogwe (Rural)	61	14,3
Majemantsho (Rural)	33	7,7
Lomanyaneng (Rural)	25	5,9
Dibate (Rural)	16	3,8
Ramosadi (Rural)	46	10,8
Molelwane (Rural)	53	12,4
TOTAL	**426**	**100,0**

The majority of respondents, namely 280 (65,7%) of the sample, reside in the rural areas represented by the last seven villages listed in Table 6.2 above. Respondents from the urban areas, namely Mmabatho and Montshiwa, constitute one 146 (34,3%) of the total number of respondents.

6.2.3.1 Absenteeism according to place of residence

Table 6.3: Number of days pupils were absent from school according to area of residence (n = 426)

AREA OF RESIDENCE	DAYS ABSENT FROM SCHOOL FREQUENCY AND PERCENTAGE			
	1-7 DAYS	8-15 DAYS	16-31 DAYS	TOTAL
Urban	107 (25,3%)	29 (6,86%)	10 (2,36%)	146 (34,52%)
Rural	197 (46,57%)	75 (17,73%)	8 (1,18%)	280 (65,48%)
TOTAL	**304 (71,87%)**	**104 (24,59%)**	**18 (3,55%)**	**426 (100,0%)**

Table 6.3 indicates the number of days that pupils were absent from school in relation to their area of residence.

More specifically, Table 6.3 indicates that a large number of rural respondents, namely 197 (46,57% of the sample), were absent for periods ranging between one (1) to seven (7) days, 75 (17,73% of the sample) were absent for eight (8) to fifteen (15) days at a time, whilst eight, (1,18% of the sample), were absent for longer periods, namely between sixteen (16) to thirty one (31) days at a time. With regard to pupils from the urban areas, it was found that 107 (25,3%) were absent for periods of one (1) to seven (7) days, 29 (6,86%) were absent for eight (8) to fifteen (15) days, and 10 (2,36% of the sample) were absent for as long as sixteen (16) to thirty one (31) days at a time. A total of 146 (34,52% of the sample) urban respondents, were reported absent from school, and 280 (65,48% of the sample) of rural respondents, were reported to be absent from school at various times.

In this analysis it should be noted that absenteeism only related to pupils absent for three (3) days or more and did not reflect the absenteeism due to periods less than this.

The area of residence of the respondents appears to be unrelated to the number of days respondents were absent from school. The p value of 1,1% indicates that this statistic is not significant.

6.2.4 Item 4: Persons with whom pupils are living

Table 6.4: Persons with whom pupils are living (n = 426)

PERSON(S)	PUPILS' RESPONSES	
	FREQUENCY	PERCENT
Both parents	212	49,8
Mother	138	32,4
Father	17	4,0
Grandmother	34	8,0
Aunt	20	4,6
Friend	5	1,2
TOTAL	**426**	**100,0**

Table 6.4 indicates that 212 (49,8%) of the respondents lived with both their parents, while 138 (32,4%) lived with their mothers only. Those respondents who live with their fathers, grandmothers or a friend, amount to 17,8% of the sample.

6.2.5 Item 5: Marital status of parents

Table 6.5: Marital status of parents (n = 426)

MARITAL STATUS OF PARENTS	PUPILS' RESPONSES	
	FREQUENCY	PERCENT
Married	257	60,3
Divorced	39	9,2
Widowed	49	11,5
Separated	19	4,5
Single	62	14,6
TOTAL	**426**	**100,0**

According to Table 6.5, the parents of 257 (60,3%) of the respondents are married, whilst the remaining 169 (39,7%) of respondents are from single parent households.

6.2.6 Item 6: Family size

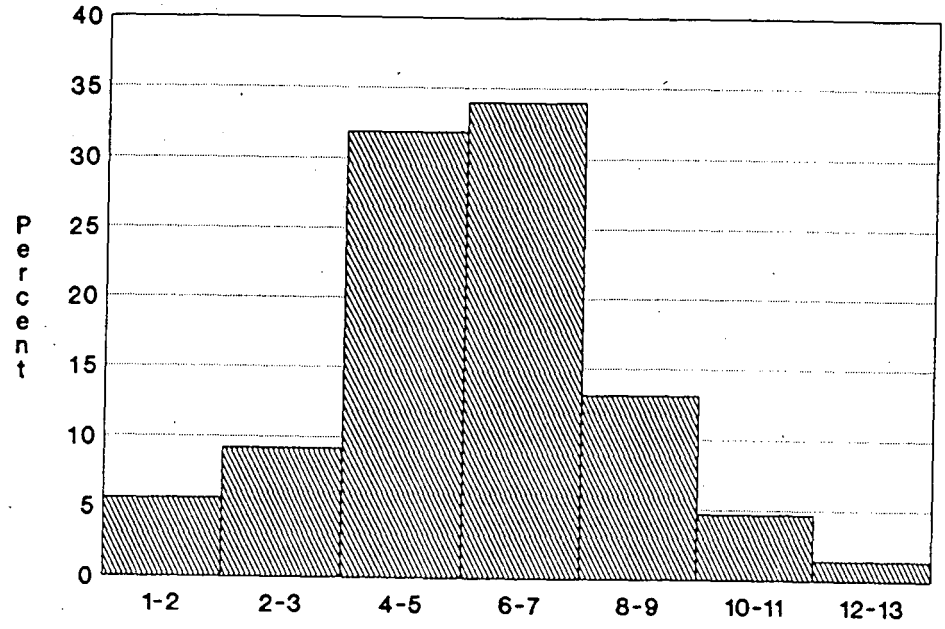

Figure 6.3

Number of members per family (n = 426)

Figure 6.3 indicates the number of members in a family. Twenty four (5,6%) of the respondents reported that there are either one or two members in their families. There were thirty nine (9,2%) respondents who stated that they have two or three family members, whilst 136 (31,9%) of the respondents, have either four or five family members. The number of respondents who reported that they have between six and thirteen family members amounted to two hundred and twenty seven (53,3%). These findings indicate that the pupils come from large families.

6.2.7 Item 7: Occupation of pupils' fathers

Table 6.6: Occupation of pupils' fathers (n = 388)

OCCUPATION OF FATHER	PUPILS' RESPONSES	
	FREQUENCY	PERCENT
Labourer	127	32,7
Nil (Father deceased)	74	19,1
Businessman	49	12,6
Manager	25	6,4
Teacher	24	6,2
Unemployed	18	4,6
Police	17	4,4
Clerk	17	4,4
Administrator	14	3,6
Lecturer	11	2,8
Consultant	6	1,5
Pensioner	2	0,5
Priest	1	0,3
Engineer	1	0,3
Carpenter	1	0,3
Driver	1	0,3
TOTAL	**388**	**100,0**

Table 6.6 indicates that the majority of the fathers of the pupils who responded to this

item, are either labourers, businessmen or some kind of manager. Seventy four (19,1%) of the respondents stated that their fathers had passed away. A significant number of the fathers, namely eighty nine (23%), are either teachers, policemen, clerks, administrators, lecturers or consultants. The occupations of the fathers of the remaining respondents are reflected in Table 6.6.

6.2.7.1 Number of absences in relation to fathers' occupation

Table 6.7 Number of days pupils are absent in relation to fathers' occupations (n = 388)

FATHERS' OCCUPATION	PUPILS' RESPONSES (FREQUENCY AND PERCENT)			
	1-7 DAYS	8-15 DAYS	16-31 DAYS	TOTAL
Professional	60 (15,58%)	19 (4,94%)	5 (1,3%)	84 (21,82%)
Clerical	54 (14,3%)	20 (5,19%)	6 (1,56%)	80 (20,78%)
Unskilled	96 (24,68%)	28 (7,01%)	5 (1,04%)	129 (32,73%)
Deceased	55 (14,29%)	19 (4,94%)	0 (0%)	74 (19,22%)
Other	15 (3,9%)	6 (1,56%)	0 (0%)	21 (5,45%)
TOTAL	280 (72,47)	92 (23,64)	16 (3,9%)	**388 (100%)**

When considering the information tabulated in Table 6.7, it would appear that the majority of the respondents, regardless of the occupation of their fathers, were absent from school for periods ranging from one to seven days. In all categories, the number of respondents who were absent for longer periods decreased. It can be deduced that there is is no direct relationship between the nature of the occupation of the pupils' fathers and the number of days that the pupil would be absent from school. The p

value is 3,75%, therefore the statistic is not significant.

6.2.8 Item 8: Occupation of pupils' mothers

Table 6.8: Occupation of pupils' mothers (n = 403)

OCCUPATION OF MOTHER	PUPILS' RESPONSES	
	FREQUENCY	PERCENT
Housewife	145	35,9
Domestic Helper	60	14,9
Labourer	40	9,9
Unemployed	37	9,2
School Teacher	36	8,9
Secretary	27	6,7
Nurse	19	4,7
Manageress	17	4,2
Self Employed	11	2,7
Deceased	5	1,2
Police	3	0,7
Pensioner	2	0,5
Soldier (Defence force)	1	0,2
TOTAL	**403**	**100,0**

According to Table 6.8 it can be deduced that the mothers of more than 213 (50%) of the respondents who answered this item of the questionnaire, are either housewives or domestic helpers. Less than 107 (25%) of the respondents' mothers are employed

in a professional capacity, whilst approximately ten percent are unemployed.

6.2.8.1 Number of days of pupils' absenteeism in relation to mothers' occupation

Table 6.9: Number of days of pupils' absenteeism in relation to mothers' occupation (n = 403)

MOTHERS' OCCUPATION	PUPILS' RESPONSES (FREQUENCY AND PERCENT)			
	1-7 DAYS	8-14 DAYS	15-31 DAYS	TOTAL
Housewife	104 (25,94%)	35 (8,73%)	5 (1,25%)	144 (35,91%)
Professional	56 (13,97%)	17 (4,24%)	2 (0,50%)	75 (18,70%)
Clerical	29 (7,23%)	5 (1,25%)	4 (1,0%)	38 (9,48%)
Unskilled	69 (17,21%)	28 (6,98%)	2 (0,50%)	99 (24,99%)
Deceased	4 (1%)	1 (0,25%)	0 (0,0%)	5 (1,25%)
Other	24 (5,99%)	14 (3,49%)	2 (0,50%)	42 (9,98%)
TOTAL	**288 (71,32%)**	**100 (24,94%)**	**15 (3,74%)**	**403 (100%)**

The information tabulated in Table 6.9 indicates that the absenteeism profile of children whose mothers hold a professional job, is no different to that of pupils whose mothers are employed as unskilled labourers, or who are housewives. In all categories, the majority of absenteeism was reported to be for periods of between one to seven days.

6.3 SECTION 2: SCHOOL ENVIRONMENT (ITEMS 9-10)

6.3.1 Item 9: Standards of the pupils

Table 6.10: School standards of the pupils (n = 426)

STANDARD	PUPILS' RESPONSES	
	FREQUENCY	PERCENT
5	166	39,0
6	142	33,3
7	118	27,7
TOTAL	**426**	**100,0**

Table 6.10 indicates that the largest number of respondents who were absent for three (3) days or more were in standard 5 at the time the questionnaires were completed.

6.3.1.2 Standards in relation to the number of days absent from school

Table 6.11: Number of days pupils were absent from school in relation to their standards (n 426)

STANDARD	PUPILS' RESPONSES (FREQUENCY AND PERCENT)			
	1-7 DAYS	8-15 DAYS	15-31 DAYS	TOTAL
Standard 5	125 (29,5%)	35 (8,27%)	5 (1,18%)	165 (39,01%)
Standard 6	96 (22,9%)	38 (8,98%)	6 (1,42%)	140 (33,1%)
Standard 7	83 (19,6%)	31 (7,3%)	4 (0,98%)	118 (27,9%)
TOTAL	**304 (71,87%)**	**104 (24,59 %)**	**15 (3,55%)**	**423 (100%)**

As seen in Table 6.11, a total of 165 (39,01%) of the respondents in standard 5 were absent from school at some stage, whilst one hundred and forty (140) of the standard 6 pupils, and one hundred and eighteen (118) of the standard 7 pupils, were absent from school during periods which varied from one to thirty one days.

It can be deduced from Table 6.11 that the class standard of the respondents had no direct relation to the number of days that respondents were absent from school. The p value is 6,96%, therefore the statistic is not significant.

6.3.2 Item 10: Pupils repeating a standard

Table 6.12: The number of pupils repeating a standard (n = 410)

REPEATING A STANDARD	PUPILS' RESPONSES	
	FREQUENCY	PERCENT
Yes	111	27,1
No	299	72,9
TOTAL	**410**	**100,0**

Table 6.12 indicates that pupils who were repeating a specific year of study totalled one hundred an eleven (27,1%), whilst those attending a specific class for the first time were two hundred and ninety nine (72,9%).

6.3.2.1 The incidence of absenteeism among pupils in a standard for the first time and those repeating a standard

Table 6.13: The incidence of absenteeism amoung pupils in a standard for the first time and those repeating a standard (n = 410)

REPEATING A STANDARD	PUPILS' RESPONSES TO SPECIFIED PERIODS OF ABSENTEEISM			
	1-7 DAYS	8-15 DAYS	16-31 DAYS	TOTAL
Yes	83 (20,34%)	24 (5,88%)	4 (0,98%)	111 (27,07%)
No	231 (51,72%)	75 (18,38%)	11 (2,70%)	299 (72,93%)
TOTAL	**296 (72,06%)**	**99 (24,26%)**	**15 (3,68%)**	**410 (100%)**

Table 6.13 indicates that the respondents who were not repeating their particular year of study, had a higher incidence of absenteeism, than those respondents who were repeating the year of study. The p value is 6,96%, therefore the statistic is not significant.

6.4 SECTION 3: HEALTH PROBLEMS (ITEMS 11-15)

6.4.1 Item 11: The health problems that contributed to absenteeism

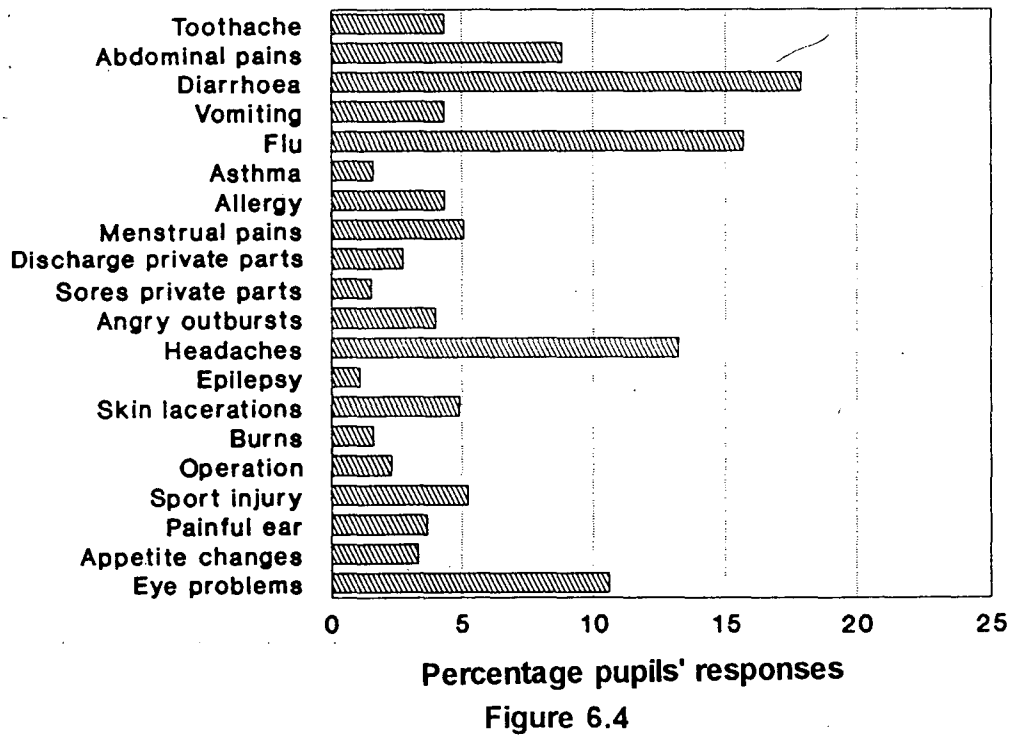

Figure 6.4

Health problems that contributed to absenteeism (n = 426)

According to Figure 6.4, the major causes for absenteeism in order of magnitute were diarrhoea and flu, followed by headaches, eye problems and abdominal pain followed by a number of other health problems that contributed to absenteeism. These findings are similar to those reported by the school nurse and the teachers.

6.4.2 Item 12: Health practitioners who examined sick pupils

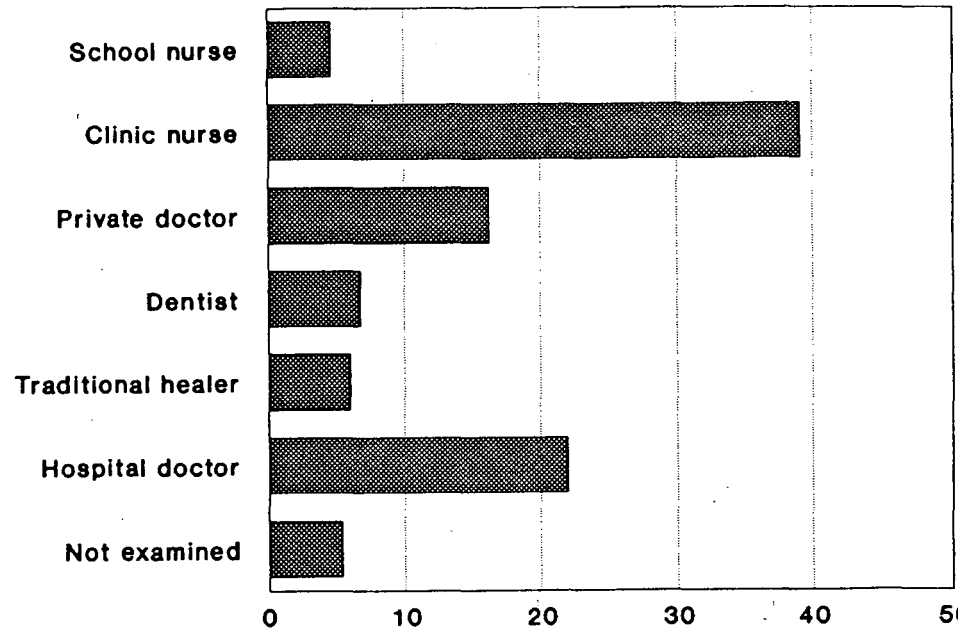

Figure 6.5

Health practitioners who examined sick pupils (n = 483)

More than one (1) response was given for this question. A large number of respondents, namely two hunderd and two (202), said that they had been examined by the clinic nurse. One hundred and ninety eight (198) had been examined by either the hospital doctor or the private practitioner, whilst thirty one (31) had been attended to by a traditional healer. According to the data the school nurse was only responsible for twenty four (24) of the examinations done. It would appear that twenty eight (28) respondents had not been examined at all.

6.4.3 Item 13 and 14: Referral for treatment after examination

Table 6.14: Referral for treatment after examination (n = 426)

REFERRAL FOR TREATMENT	PUPILS' RESPONSES	
	FREQUENCY	PERCENT
Not referred	165	38,8
Hospital	153	35,9
Clinic	104	24,4
Specialist	4	0,9
TOTAL	**426**	**100,0**

Table 6.14 indicates that the majority of pupils were referred for further consultation and intervention. Only one hundred and sixty five (38,3%) of the respondents were not referred to other health services. The data obtained also indicated that a total of eighty five (19%) absentees had been hospitalised after referral.

6.4.4 Item 15: Reasons for admission to hospital

Table 6.15: Reasons for admission to hospital (n = 77)

REASONS FOR ADMISSION TO HOSPITAL	PUPILS' RESPONSES	
	FREQUENCY	PERCENT
Abdominal pain	14	18,2
Sport injury/Broken bone	29	37,7
Heart problems	6	7,8
Operations	13	16,9
Sexually transmitted diseases	3	3,9
Painful tonsils	5	6,5
Ear problems	3	3,9
Asthma	3	3,9
Menstrual pain	1	1,3
TOTAL	**77**	**100,0**

This was an open-ended question. Table 6.15 indicates that only seventy seven (90,5%) of the eighty five (85) pupils who had been hospitalised after referral responded to this item. Top of the list of reasons for hospitalization was sport injury followed by abdominal pains and operations. Heart problems and tonsillitis contributed to six and five of the admissions respectively.

6.5 SECTION 4: ABSENTEEISM (ITEMS 16-30)

6.5.1 Item 16: School related reasons for absenteeism

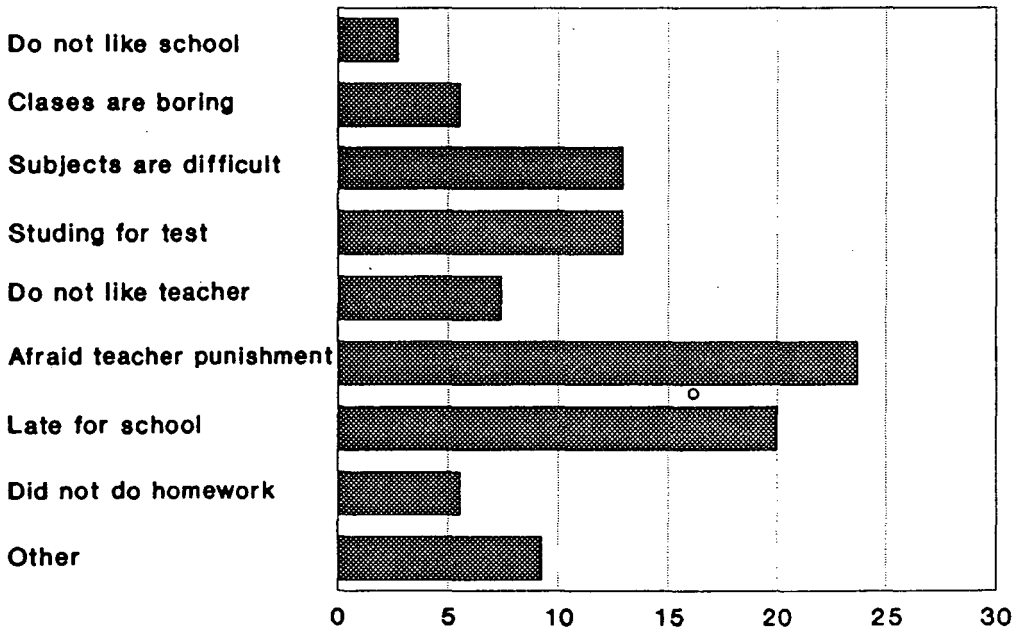

Figure 6.6

School related reasons for absenteeism (n = 426)

According to Figure 6.6, fear of punishment was cited by seventy seven (77) respondents as their reason for being absent from school. Difficult subjects and preparing for a test were reasons given by eighty four (84) respondents as to why they stayed away from school. A large number of the respondents, namely sixty five (65), indicated that when they would be late for school, they would rather stayed away from school altogether. Twenty four (24) of the respondents indicated that they did not like the teacher, whilst eighteen (18) merely felt that classes were boring and they therfore did not want to attend school.

6.5.2 Item 17: Family related reasons for absenteeism at school

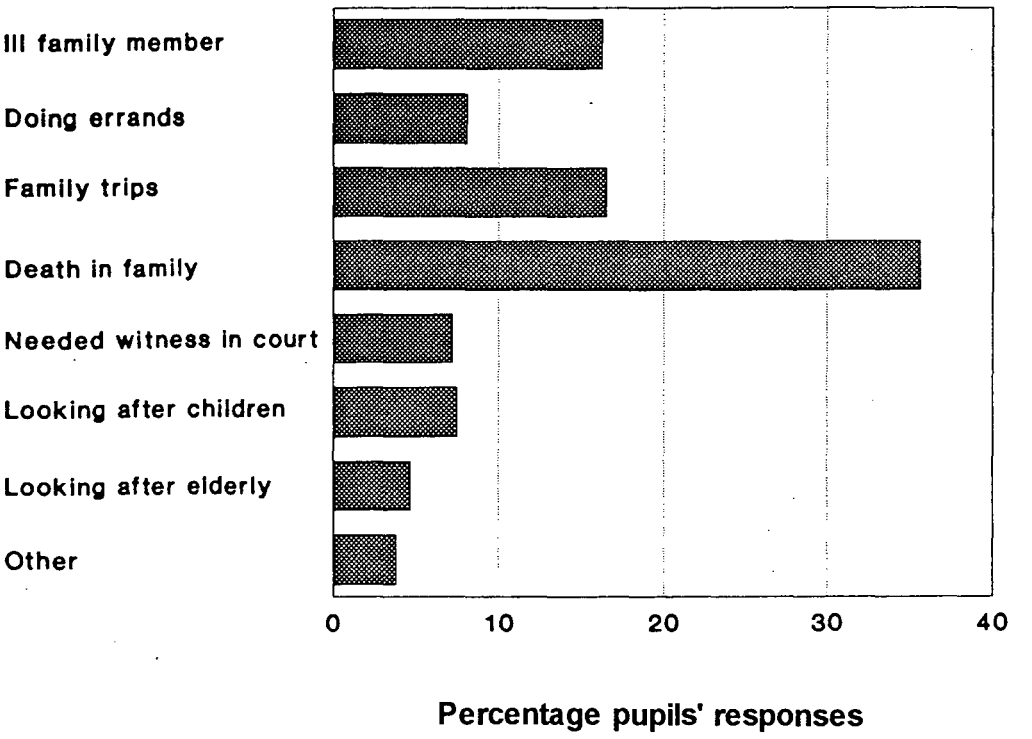

Figure 6.7

Family related reasons for absenteeism at school (n = 426)

Figure 6.7 indicates that the family related reasons as to why pupils did not attend school included the following in order of frequency:

- death in the family
- participation in a family trip
- illness of a family member
- the need to run errands
- looking after siblings
- having to appear as a witness in a court case
- looking after a sick elderly person

6.5.3 Item 18: Personal reasons for being absent from school

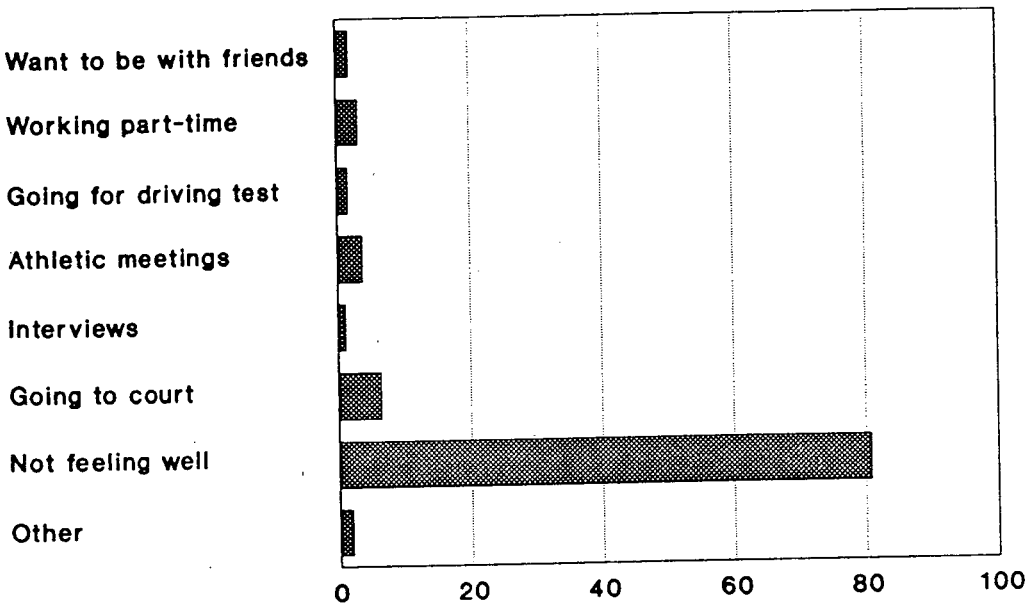

Figure 6.8

Personal reasons for being absent from school (n = 426)

As seen in Figure 6.8, the majority of the respondents were absent because they were not feeling well. Additional personal reasons given for being absent from school, included having to attend court, participation in athletic events, part-time work.

The responses made by the pupils that in the majority of times health related issues gave rise to absenteeism (not feeling well) corresponds with the teachers' responses who indicated health related problems as the major cause of absenteeism.

6.5.4 Item 19: Activities of pupils absent from school

Table 6.16: Activities of pupils absent from school (n = 426)

ACTIVITIES DONE BY PUPILS WHILST ABSENT FROM SCHOOL	PUPILS' RESPONSES	
	FREQUENCY	PERCENT
Visit clinic	166	39,0
Visit friend's home	8	18,8
Stay at home	121	28,03
Visit to doctor	120	28,16
Involved with a group of friends	8	18,8
Other activities	3	0,75
TOTAL	**426**	**100,0**

According to Table 6.16, one hundred and sixty six (39%) of respondents visited the clinic when they were sick. One hundred and twenty one (28,03%) of respondents stayed at home, a further one hundred and twenty (28%) visited the doctor, whilst eight (18,8%) merely visited their friends when they were absent from school.

Once again the activities of the majority of pupils (67,1%) whilst absent from school were health related.

6.5.5 Item 20: Number of days absent from school in the last term of 1993

The initial data obtained from the respondents illustrated a lot of empty cells in the table of cross-tabulations. Following the advice of the statistician, the data was collapsed as indicated in the Table below. The number of days that pupils were absent from school is presented in Table 6.17. The responses are presented according to the occurrence of the absenteeism in the various schools included in the sample.

Table 6.17: Determination of the degree of absenteeism in the urban and rural schools in the Molopo area (n = 426)

SCHOOL	RESPONSES OF PUPILS			
	1-7 DAYS	8-15 DAYS	16-31 DAYS	TOTAL
Redibone (U)	64 (15,13%)	15 (3,55%)	4 (0,95%)	83 (19, 48)
Tetlano (R)	0 (0%)	6 (1,42%)	0 (0%)	6 (4,41)
Sebopiwa Molema (R)	23 (5,44%)	14 (3,31%)	1 (0,24%)	38 (8,92)
Mmabatho (U)	44 (10,4%)	18 (4,26%)	5 (1,18%)	67 (15,73)
Batswana (U)	6 (1,42%)	2 (0,47%)	0 (0%)	8 (1,88)
Boingotlo (U)	41 (9,69%)	12 (2,84%)	4 (0,95%)	57 (13,38)
Boitshoko (R)	30 (7,09%)	11 (2,6%)	1 (0,24%)	42 (9,86)
Boitseanape (U)	20 (4,73%)	4 (0,95%)	1 (0,24%)	25 (5,87)
Makgetla (R)	39 (9,22%)	11 (2,6%)	1 (0,24%)	51 (11,97)
Montshiwa Memorial (R)	37 (8,75%)	11 (2,6%)	1 (0,24%)	49 (11,50)
TOTAL	**304 (71,87%)**	**104 (24,59%)**	**18 (3,55%)**	**426 (100,0)**

Key: U = Urban

R = Rural

Table 6.17 suggests that the highest incidence of absenteeism occurred at Redibone and Mmabatho Middle Schools, both urban schools, whilst only six (6) cases of absenteeism were reported to have occurred at Tetlano Middle school. This may have been due to poor record-keeping.

6.5.6 Item 21: Frequency of absenteeism

Table 6.18: Frequency of absenteeism (n = 426)

FREQUENCY OF ABSENTEEISM	PUPILS' RESPONSES	
	FREQUENCY	PERCENT
Once every week	121	28,4
Once every two weeks	62	14,6
Once every month	91	21,4
Three times every week	38	8,9
Random	87	20,4
Continuous	27	6,3
TOTAL	**426**	**100,0**

The responses received regarding this question indicated that 121 (28,4%) respondents reported being absent from school once every week. Ninety one (21,4%) said that they were absent once every month, whilst eighty seven (20,4%) were absent at random, not according to a specific pattern. Twenty seven (6,3%) respondents were absent from school on a continuous basis, in other words for more than one (1) week.

6.5.7 Item 22: Specific day/days of the week pupils were absent from school

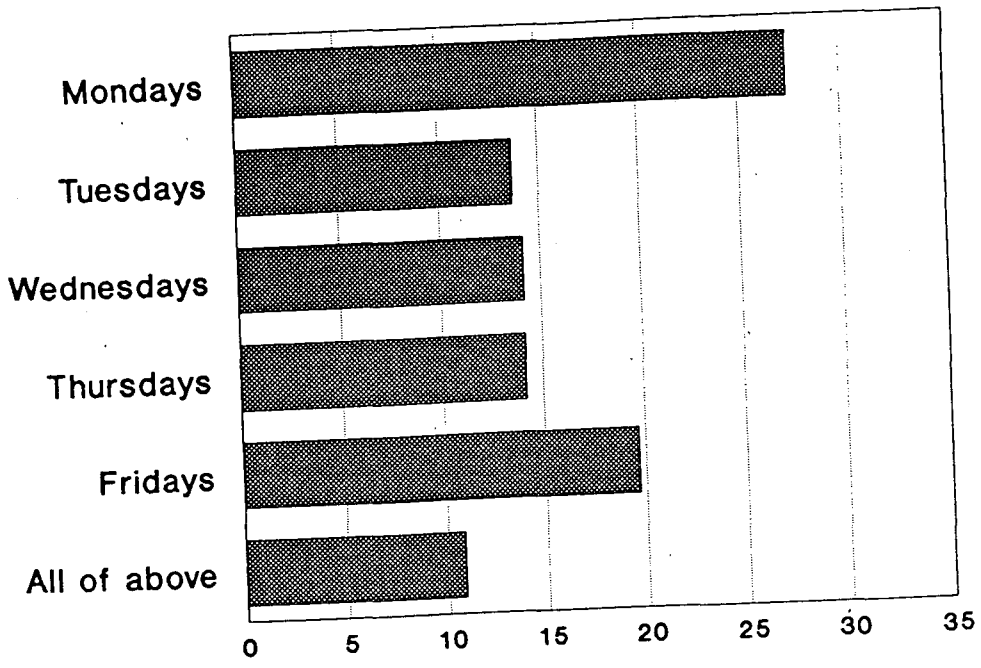

Figure 6.9

Specific day/days of week pupils were absent from school (n = 368)

Only three hundred and sixty eight (368) of the respondents responded to this item and a large number of them gave more than one response. According to Figure 6.9, the majority of respondents, namely one hunderd and seventy four (174) were absent from school on Mondays, whilst one hundred and twenty five (125) were absent on Fridays. Those absent on Wednesdays and Thursdays totalled ninety (90) respondents for each day. Eighty seven (87) respondents were absent on Tuesdays and sixty nine (69) were absent from school for the whole week. The poor response rate to this item may indicate that the pupils could not remember the actual days they were absent from school. These findings correlate with the responses made by the teachers.

6.5.8 Item 23: Specific reasons for being absent from school on a particular day/days

Table 6.19: Reasons for absence on specific days of the week (n = 368)

REASONS FOR ABSENTEEISM	PUPILS' RESPONSES	
	FREQUENCY	PERCENT
Went to the clinic	260	70,7
Errands	60	16,3
Family sick	16	4,3
Family trip	11	3,0
Attend funeral	7	1,9
See specialist	6	1,6
Athletics meeting	2	0,5
Other	6	1,6
TOTAL	**368**	**100,0**

This was an open-ended question. Table 6.19 shows that the most frequent reason given for being absent from school two hundred and sixty (70%) of responses was that respondents had to attend the clinic. Sixty (16,3%) respondents stated that they had to run errands for their parents, whilst sixteen (4,3%) were absent due to the illness of a family member. A number of other reasons were also mentioned, as outlined in Table 6.19. These findings indicate that 72,3% of the reasons given for absenteeism on specific days are health related.

6.5.9 Item 24: Period of the day when pupils were absent from school

Table 6.20: Period of the day when pupils were absent from school (n = 401)

PERIOD OF THE DAY ABSENT FROM SCHOOL	PUPILS' RESPONSES	
	FREQUENCY	PERCENT
Whole day	287	71,6
Morning	69	17,2
Afternoon	45	11,2
TOTAL	**401**	**100,0**

According to Table 6.20, the majority of respondents namely 287 (71,6%) stayed away from school for the entire day.

6.5.10 Item 25: Parents notified of absenteeism (n = 426)

It would appear that in most instances of pupil absenteeism, the parents of 239 (56,1%) pupils were notified of the absenteeism, whilst the parents of 182 (42,7%) pupils were not notified. Only five (5%) respondents indicated that their parents gave permission for them to be absent from school for family commitments.

6.5.11 Item 26: Who informed the parents of their children's absence from school?

Table 6.21: Who notified the parents of their childrens' absence from school? (n = 264)

PERSON WHO NOTIFIED THE PARENTS WHEN PUPILS WHERE ABSENT	PUPILS' RESPONSES	
	FREQUENCY	PERCENT
The teacher	118	44,7
The principal	36	13,6
The departmental head	10	3,8
The pupil herself/himself	75	28,4
Colleague (pupil)	22	8,3
Hostel guardian	3	1,1
TOTAL	**264**	**100,0**

Table 6.21 indicates that the teacher who has most contact with the pupil was indicated by one hundred and eighteen (44,7%) of the respondents as being the person who notified the parents of the pupils' absent. Thirty six (13,6%) respondents indicated that the principal reported the incident to their parents. It is significant to note that seventy five (28,4%) of the pupils themselves and twenty two (8,3%) of their colleagues notified the parents. Table 6.21 also gives an indication of all other persons responsible for notifying the parents of the absenteeism of their children.

6.5.12 Item 27: School policy regarding action to be taken following absenteeism (n = 426)

According to the information received from the pupils who participated in the survey, various actions are taken in terms of school health policy when pupils are absent from school and most respondents gave more than one response to this item. The majority of three hundred and ninety three (393) respondents stated that they were required to submit a doctors' medical certificate when they were absent from school, three hundred and sixty one (361) respondents submitted a sick note which they obtained from the clinic nurse, whilst two hundred and seventy seven (277) respondents submitted a letter from their parents. Some of the other actions reported by the respondents included submitting a sick note from the school health nurse (sixty two) and being interviewed, together with their parents, at their homes (twenty seven).

6.5.13 Item 28: Persons who interviewed parent/guardian of pupils absent from school (n = 426)

It would appear that some instances the parents/guardians of the pupils who were absent from school were interviewed by more than one of the individuals listed in the questionnaire. Three hundred and forty two (342) respondents indicated that nobody had interviewed their parents or guardians about their absenteeism. Forty one (41) respondents indicated that the school principal interviewed their parents. The departmental head was responsible for eight (8) interviews, whilst in seventy two (72) cases of absenteeism, the class teacher interviewed relevant parents or guardians.

6.5.14 Item 29: Persons who interviewed pupils absent from school (n = 426)

More than one (1) response was possible for this item. Five (5) of the respondents stated that they were not interviewed at any stage when they were absent from school. Thirty two (32) said they were interviewed by the principal, two (2) by the departmental head and four hundred and three (403) by their class teacher.

6.5.15 Item 30: Mode of transport to school (n = 426)

As in previous items discussed, it was found that respondents again gave more than one response to the item. The majority of respondents stated that they usually make use of buses to go to school. A total of three hundred and sixty one (361) respondents said that at times friends would give them a lift to school, whilst two hundred and seventy seven (277) were taken to school by means of family cars. The remaining respondents either walked to school, or made use of taxis or bicycles.

6.6 SECTION 5: PEER ASSOCIATION (ITEMS 31-35)

6.6.1 Item 31: Incidence of cigarette smoking in schools

Table 6.22: Incidence of cigarette smoking in schools (n = 416)

FREQUENCY OF CIGARETTE SMOKING	PUPILS' RESPONSES	
	FREQUENCY	PERCENT
Very regularly	141	33,9
Regularly	35	8,4
Sometimes	70	16,8
Seldom	28	6,7
Never	142	34,1
TOTAL	**416**	**100,0**

Table 6.22 indicates that the majority of respondents who responded to this item admitted that they had been smoking in varying degrees. One hundred and forty one (339%) pupils said that they smoked cigarettes regularly, whilst 142 (34,1%) said that they do not smoke at all.

6.6.1.1 Absenteeism related to cigarette smoking

Table 6.23: Relationship between absenteeism and cigarette smoking (n = 426)

INCIDENCE OF CIGARETTE SMOKING	NUMBER OF RESPONDENTS ABSENT FROM SCHOOL			
	1-7 DAYS	8-15 DAYS	16-31 DAYS	TOTAL
Smoking	192 (46,38%)	75 (18,12%)	7 (1,45%)	274 (65,94%)
Not Smoking	105 (23,36%)	28 (6,76%)	9 (1,98%)	142 (34,1%)
TOTAL	**297 (71,74%)**	**103 (24,88%)**	**16 (3,43%)**	**426 (100,0%)**

Table 6.23 shows that the respondents who admitted to smoking, showed a much higher incidence of absenteeism than those who do not smoke. From the information gathered, it would however appear that cigarette smoking is not significant in terms of the number of days respondents were absent from school. The p value is 5,8% and the statistic is therefore not significant.

6.6.2 Item 32: Incidence of dagga smoking in schools

Table 6.24: Incidence of dagga smoking in schools (n = 415)

INCIDENCE OF DAGGA SMOKING	PUPILS' RESPONSES	
	FREQUENCY	PERCENT
Smoking	66	16,0
Not smoking	349	84,0
TOTAL	**415**	**100,0**

Table 6.24 illustrates the extent to which respondents were involved in dagga smoking. Only sixty six (16%) of the respondents said that they smoked dagga, whilst the majority, three hundred and forty nine (84%) said that they had never smoked dagga.

6.6.2.1 Relationship between absenteeism and dagga smoking

Table 6.25: Relationship between absenteeism and dagga smoking (n = 415)

INCIDENCE OF DAGGA SMOKING	NUMBER OF RESPONDENTS ABSENT FROM SCHOOL			
	1-7 DAYS	8-15 DAYS	16-31 DAYS	TOTAL
Smoked dagga	48 (11,16%)	15 (3,63%)	3 (0,73%)	66 (16%)
Did not smoke dagga	249 (59,81%)	88 (21,31%)	12 (2,91%)	349 (84%)
TOTAL	**297 (71,43%)**	**103 (24,94%)**	**15 (3,63%)**	**415 (100,0%)**

From the information outlined in Table 6.25, it can be deduced that dagga smoking does not significantly influence the number of days respondents were absent from school. The p value is 8,38%, therefore the statistic is not significant.

6.6.3 Items 33 and 34: Incidence of glue sniffing and drug taking (n = 419)

Of the four hundred and nineteen (419) respondents who answered question number 33, only seventeen (4,1%) admitted that they had sniffed glue at some stage. The response to Item 34 gave s similar result, as only eighteen (4,3%) respondents stated that they do take drugs.

According to the responses received, there appeared to be no significant influence on absenteeism as a result of either glue sniffing or drug taking.

6.6.4 Item 35: Incidence of alcohol consumption

Table 6.26: Frequency of alcohol consumption (n = 419)

ALCOHOL CONSUMPTION	PUPILS' RESPONSES	
	FREQUENCY	PERCENT
Yes	225	54%
No	192	46%
TOTAL	**417**	**100,0**

Table 6.26 illustrates that two hunderd and twenty five (54%) of the repondents admitted that they consumed alcohol, whilst one hundred and ninety two (46%) said that they do not take alcohol.

There appeared to be no significant difference in incidence of absenteeism amongst respondents who consumed alcohol and those who did not.

6.7 SECTION 6: HEALTH PROBLEMS (ITEMS 36-45)

6.7.1 Item 36: Pupils on medication (n = 426)

Respondents who were taking prescribed medication at the time of this study totalled

thirty nine (9,4%). The remainder said that they were not taking any medication.

6.7.2 Item 37: Reasons for taking medicines

Table 6.27: Reasons for taking medicines (n = 54)

REASONS FOR MEDICATION	PUPILS' RESPONSES	
	FREQUENCY	PERCENT
Allergy	11	20,4
Asthma	8	14,8
Sexually transmitted diseases	15	27,8
Epilepsy	20	37,0
TOTAL	**54**	**100,0**

Although only thirty nine (39) respondents stated that they were on medication at the time of this study (Item 36), fifty four (54) responded to Item 37 which was an open-ended question.

It would be assumed that some of the respondents who answered Item 37 might have referred to medication that they took on a previous occasion. Table 6.27 indicates that eleven (20,4%) respondents were using medication as a result of some allergy, eight (14,8%) for the treatment of asthma, fifteen (27,8%) for the treatment of sexually transmitted diseases, whilst twenty (37%) respondents were taking medication for the treatment of epilepsy.

6.7.3 Items 38 and 39: Pupils' knowledge of school health policy when sick

Only two hundred and fifty one (251) of the respondents answered these questions. It is therefore not clear whether those who did not respond know what to do should they become ill at school.

Table 6.28: Steps taken by pupils when sick at school

(n = 251)

ACTION TAKEN BY PUPILS WHEN SICK AT SCHOOL	PUPILS' RESPONSES	
	FREQUENCY	PERCENT
Report to clinic	12	4,8
Report to class	176	70,1
Report to sick bay	59	23,5
Do not know what to do	3	1,2
Go home	1	0,4
TOTAL	**251**	**100,0**

Table 6.28 indicates that only twelve (4,8%) of the respondents indicated that they reported directly to the clinic when they were ill. The majority one hundred and seventy six (70,1%) reported to the class teacher when they became ill at school. and fifty nine (23,5%) reported to sick bay. The remaining pupils, three (1,2%), did not know or one (0,4%) went home. In view of the poor response to this item it could be presumed that the pupils did not know what to do or had not fallen sick at school.

6.7.4 Item 40: Availability of the school nurse (n = 425)

Only sixty six (15,5%) of the pupils who took part in this study indicated that they have the services of a school nurse at their school. It was not clear from the responses made whether these pupils attended the school where the school health nurse was full-time employed by the relevant principal and school committee (referred to as the private school nurse). It would appear that the majority of pupils are not aware of the services of the school nurse. These findings appear to correlate with the responses made by the teachers and may relate to the fact that in nine (9) of the schools selected the school nurse only visits once a year.

6.7.5 Item 41: Frequency of visits by the school nurse to schools

Table 6.29: Frequency of visits by the school nurse to schools (n = 422)

FREQUENCY OF VISITS BY THE SCHOOL NURSE	PUPILS' RESPONSES	
	FREQUENCY	PERCENT
Daily	37	8,6
Once a term	7	1,7
Once in six months	0	0
Does not visit the school*	378	89,6
TOTAL	**422**	**100,0**

Table 6.29 indicates that four hundred and twenty two (422) pupils responded to this item. Thirty seven (8,6%) of the respondents reported that a school health nurse visited their school on a daily basis. Seven (1,7%) pupils said that the nurse visited their school once a term. The remaining pupils said that a nurse does not visit their

school.

6.7.6 Item 42: Health education given by the school health nurse (n = 426)

Of the four hundred and twenty six respondents, seventy one (16,6%) said that they received health education. Three hundred and fifty five (83,4%) respondents indicated that they were not given any health education. It would appear that in general health education is not given in schools. These findings correspond with the response made by the teachers but do not correspond with those made by the school nurse.

6.7.7 Item 43: Health education topics (n = 426)

Respondents could answer more than one (1) question. According to the seventy one (71) respondents who answered yes to Item 42, the topics given in the health education talks included the following: hygiene, sport injuries, AIDS, drug abuse, sexual education, nutrition, family planning, and colds and flu.

It is of interest to note that in the response made by the school nurse, family planning was not one of the topics mentioned.

6.7.8 Item 44: Visit to homes of sick pupils by the school nurse (n = 421)

All four hundred and twenty one (100%) respondents who answered this item indicated that the school health nurse had never paid a visit to their homes. It is presumed that those who did not answer this question were also unaware of visits made by the

school nurse to their homes. Once again these findings correlate with the responses made by the teachers but do not correlate with the responses made by the school nurses.

6.7.9 Item 45: Information brochures on health issues (n = 421)

According to 421 (100%) respondents who answered this question, they had never received any information brochures on health issues from the school health nurse. It is presumed as well that those who did not answer this question were not aware of health information brochures. In their responses the teachers indicated as well that information brochures were not available. These responses do not correlate with those of the school health nurses.

6.8 CONCLUSION

There appears to be discrepancies in the views of the pupils, the teacher and the school nurse on the health service available in the school. The results, as discussed in this chapter, are not encouraging. A summary of the problems identified will be presented in the following chapter together with conclusions and specific recommendations for future practice and research.

CHAPTER 7

SUMMARY, LIMITATIONS, CONCLUSIONS AND RECOMMENDATIONS

7.1 INTRODUCTION

This chapter gives a summary of the finding and the limitations as well as the overall conclusions and recommendations based on the data analyses.

As indicated in the introductory chapter, and the chapter on literature review, a conceptual framework on absenteeism was used as a guideline in the investigation of health-related absenteeism in schools.

The empirical investigation was done in ten middle schools in the Molopo region of the

North-West Province. The respondents were four hundred and twenty six (426) pupils in standard five, six, and seven who had been absent from school for three days or more in the last term of 1993, twenty two (22) teachers and two (2) school health nurses.

7.2 SUMMARY

7.2.1 Statement of the problem

The control and monitoring of absenteeism due to health related problems in schools is considered extremely important, not only in terms of the health status of the pupils, but in terms of the progress made at schools and the overall development of the child.

Absenteeism in the schools in the Molopo area, especially in standard 5, 6 and 7, was identified as a major problem. Based on the problem and using a conceptual model on absenteeism, the researcher attempted to answer the following questions:

- What is the extent of health related absenteeism in the middle schools in the Molopo region?
- Are health problems the main cause of absenteeism among school children?
- Are rules and regulations available in schools for monitoring absenteeism due to health problems?
- Are there other factors that have an influence on absenteeism among pupils in the middle schools in the Molopo region?

7.2.2 Purpose of the study

The purpose of the study was to determine the degree of absenteeism, the health related reasons for absenteeism, and the measures taken to monitor and maintain the health status of the pupil in the middle schools of the Molopo region.

7.2.3 Specific objectives of the study

The focus of the study was to

- determine the extent of absenteeism due to health problems in the middle schools of the Molopo region
- identify the problems that contribute to absenteeism
- determine to what extent school health services are available in schools
- determine whether school personnel are made aware of the health problems of pupils and
- determine what remedial actions were taken to monitor and control the problem of health related absenteeism

7.2.4 The overview of the research methodology

A quantitative research design, using an exploratory survey method was used to obtain information about the degree to which pupils in standard 5, 6, and 7 in the middle schools were absent due to health reasons in the Molopo region. Three separate questionnaires were administered to the selected samples.

7.3 LIMITATIONS OF THE STUDY

Limitations are important factors in reducing the validity and reliability of the study. The following limitations of this study should be noted:

- It was difficult to correlate the responses of the school health nurses with those of the pupils and teachers, as the number of only two respondents was too small.
- In view of the fact that only subjects from the Molopo region of the North-West Province participated in this study, the findings cannot be generalised to the pupil population outside of this region.
- Due to the fact that one teacher was not responsible for a class, continuity in record-keeping of absenteeism was a problem and this could have affected the accuracy of the numbers of pupils recorded as absent from school.

7.4 SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

The summary of findings, conclusions and recommendations are based on the responses made by the school nurses, the teachers, and the pupils. These will be discussed according to the conceptual framework on absenteeism and in the discussion address the objectives set out in 7.2.3.

- absenteeism
- the school environment and its influences
- the home environment and its influences

- health problems of pupils and
- peer associations

7.4.1 Absenteeism

For the purpose of this study, absenteeism was defined as the number of days that a pupil was absent from school for three (3) consecutive days or more, including patterned absences when the pupil was always absent on a specific day/days.

The study revealed that most respondents stayed away from school frequently (Sections 5.3.4, 6.5.6, 6.5.7, 6.5.8 and 6.5.9).

Absenteeism was noted to be more prevalent in urban schools than rural schools (Section 6.5.5).

More female pupils were absent from school than male pupils (Section 6.2.2).

Gender and the degree of absenteeism was not found to be statistically significant (Section 6.2.2.1).

The majority of respondents were absent on Mondays and Fridays (Section 6.5.7). Most pupils were absent for the whole day (Sections 5.3.3, 5.3.4, 6.5.7 and 6.5.9).

Absenteeism was recorded in registers by the majority of teachers (Section 5.2.2). However, a significant number of teachers indicated that they did not complete

attendance registers.

These findings are different to a a study conducted by Weitzman e al(1982: 739), who reported school absence rates of about 48% in a Benjamin Franklik High School in New York. More female pupils, two hundred and nineteen (51,77%) to be exact, were absent from school than was the case with male pupils. Teperi and Rimpela (1989: 166) and Whaley and Wong (1987: 216) also reported that girls were more often absent from school due to menstrual pain, in addition to other health problems.

7.4.1.1 Conclusion

The major causes of absenteeism among pupils in the middle schools in the Molopo region were due to health related problems. Absenteeism appeared to be the biggest problem in urban schools. It would appear that record-keeping on absenteeism was not conclusive, as the teachers recording absenteeism were not consistently responsible for a specific class. The fact that no one teacher was responsible for record-keeping in a class may have affected the accuracy of record-keeping.

7.4.1.2 Recommendations

Absenteeism needs to be recorded and monitored. Record-keeping is an important administrative tool in the control of absenteeism and should be introduced or reinforced in schools. Without a proper, accurate and efficient record system, there is no way of correctly identifying pupils with health problems and/or monitoring the health status of pupils.

7.4.2 The school environment

The results of this current study indicates that standard five respondents had a higher degree of absenteeism rate than the absenteeism rate amongst respondents in standard 6 and 7 (Section 6.3.1).

The data also revealed that the majority of the absentees were between the ages of fourteen (14) and fifteen (15) years (Section 6.2.1). According to the results of this study absenteeism rates appeared to become smaller as the pupils got older. The results of a study conducted by Weitzman et al (1985: 380) disagree with the findings of this study. According to Weitzman et al, ascending age is highly correlated with students absent from school.

The findings of this study concurred with the findings of research conducted in public schools in the United States of America, which suggested an increase in school absenteeism, indicated by reports of the National Association of Secondary School Principals, that school absence was the number one problem in the daily administration of public schools (Weitzman et al 1986: 313).

The data collected in this study supports the view that there is a serious problem as far as the control of health related absenteeism is concerned. According to the views expressed by the teacher and pupil respondents, health care services are not provided adequately in the relevant schools and there also appears to be a serious lack of adequate personnel to provide school health services (Sections 4.2.3, 5.2.4, 5.2.5, 5.2.6, 5.2.7, 5.2.8, 6.7.4 and 6.7.5).

There also appears to be a lack of knowledge by both teachers and pupils on policies related to absenteeism and the school attendance school regulations and the steps to be followed in terms of absenteeism (Sections 5.3.5, 5.3.6, 5.3.7, 5.3.8 and 5.3.9).

There appears to be a lack of communication and coordination between parents of the child absent from school, the teachers and the school nurse (Sections 4.2.7, 4.2.8, 4.6.1, 5.5.9, 5.5.10, 6.5.10, 6.5.11, 6.5.14, 6.5.15 and 6.7.8).

The lack of adequate control methods involving teachers and parents was further demonstrated by the fact that home visits appeared not to be done (Sections 4.6.1, 5.5.9 and 6.7.8).

7.4.2.1 Conclusion

The monitoring and control of absenteeism in schools was found to be a major problem and there appeared to be limited school health services available.

7.4.2.2 Recommendations

The establishment of a school health attendance policy, which will specifically address aspects such as health related absenteeism, must be a priority. The policy should address aspects such as the role of the teachers, pupils, parents and the school health nurse, in dealing with health issues at school, in particular when school attendance is going to be affected.

Guidelines which will address measures to be taken in cases of ill-health, should be established. There should be an indication of what follow up procedures should be implemented when a pupil is absent from school. A clear definition of health related absenteeism should be drawn up to rule out all other forms of absenteeism.

It is also recommeded that the individual schools formulate their own internal policies within the broad framework of the policy which is formulated by the Ministry of Education. Registers must be marked at the end of every period so that absences can be checked immediately.

7.4.3 Home environment and influences

It would appear many of the absentees come from socially deprived families (Sections 6.2.7 and 6.2.8). Reid (1984: 67) found that in such families, the parents cannot afford to buy nourishing food for their children, so that their body resistance could be raised to prevent the occurrence of diseases. Such parents are also not able to afford the payment of medical bills when the child is sick. Furthermore, some families are not be able to meet their children's health and educational needs due to poverty, and may even encourage non-attendance as a reaction to unavailability of resources. Children from socially-deprived homes may choose not to attend school because they do not believe that it is a positive addition to their lives (Reid 1984: 68). The identification of pupils with high absenteeism rates can assist with the identification of the families in need of health service intervention. The majority of pupils appear to come from large families. (Section 6.2.6)

The main occupation of the father was labourer and that of the mother was housewife (Sections 6.2.7 and 6.2.8). The occupation of both the father and mother appear to have little statistical relevance to the number of days the pupils were away from school. It would appear that the parents of the pupils were not involved in determining policies and procedures that could control absenteeism (Sections 6.2.6 and 6.2.7).

The majority of pupils appear to come from rural areas (Section 6.2.3).

According to O'Neil (1985: 239), the problem of unemployment also reflects trends where the demand for jobs in an area exceeds the supply, especially for local residents. This affects directly semi-skilled and unskilled workers (domestic workers and labourers). Such families and their children are often also adversely affected by high inflation rates.

7.4.3.1 Conclusion

Home environment especially in relation to family size, occupation and area of residence has a part to play in absenteeism. However, in this study the occupation of both the mother and father appeared to have no statistical significance in terms of the degree of absenteeism among pupils (Sections 6.2.7.1 and 6.2.8.1).

7.4.3.2 Recommendations

Regular school attendance by school children is the responsibility of the parents of the

pupils. Both pupils and parents must be held accountable and responsible for absenteeism. The importance of the total involvement of parents in their children's school health matters will help to facilitate communication related to health matters.

The school should preferably have a policy that will address communication procedures to be followed when a child is sick while at school or at home. This will ensure that health related absenteeism is put under the spot-light, as the parents are directly involved, and the pupil is aware that the parent will be notified of all forms of absenteeism. This effort will keep absenteeism under control.

The parents could be notified of their child's absences by telephone or per letter. The policy should also include what must be done in the case where a pupil is critically ill.

The parents must take responsibility for notifying the school when a pupil becomes ill while at home, as well as the progress made when the child is admitted to hospital. It is recommended that parents are made to take responsibility for their children who do not attend school.

7.4.4 Health problems

In this section questions were asked in relation to the health problems that gave rise to absenteeism and what the pupil did when away from school.

Data from this study indicated that two hundred and sixty (260) respondents, namely 70,7% of the respondents were absent because they went to the clinic, and a small

number (only six pupils) were absent due to having an appointment with a specialist.

The major health problems identified as giving rise to frequent absenteeism in schools related to minor ailments such as flu, headache, eye problems, and abdominal pains. Other health problems mentioned by the pupils included vomiting, allergies, menstrual pain, skin lacerations, sport injuries, and ear problems. According to a study conducted by Weitzman et al (1982: 720), approximately 75% of all school absences were attributed to illnesses suffered by the pupils. The same study suggested that pupils with such high absence rates had lower academic performance and high drop out rates. These findings were supported by Klerkman et al (1987: 427), who stated that physical illness such as cold or diarrhoea constituted 69% of the response received in their study, whilst headaches or stomaches constituted 49% of the causes of absenteeism. Forty five percent of respondents in Klerman et al's study, cited earache or toothache as their reasons for being absent from school.

The health problems that required hospitalisation included diarrhoea, flue, headaches, eye problems and abdominal pains (Sections 4.3.3, 5.4.2, 6.4.4 and 6.4.1).

7.4.4.1 Conclusion

Health problems are identified as the main causes for absenteeism at schools. These problems and the degree of absenteeism need to be monitored and controlled both within the school environment and at home.

7.4.4.2 Recommendations

School health services must be established, to provide efficient and effective school health services. The following aspects relevant to child care, should be addressed in these services:

- the examination of all new pupils at school, and the necessary record-keeping of the findings

- primary health care approach, with emphasis on assessment and early identification of health problems at schools

- preventive and promotive health strategies for the prevention of illness and the promotion and maintenance of good health

- provision made for continuity in the health care provided by making one school nurse responsible for ideally one (1) school or a maximum of three (3) schools

- the provision of knowledge related to the most prevalent health problems at schools to assist the teachers and parents in the prevention and control of diseases which lead to absenteeism

- the provision of in-service education opportunities for the teachers, and health education to the parents and the pupils, on current health problems, particularly those that are related to absenteeism

- education of pupils, teachers and parents on elementary first aid management of frequently occurring medical conditions such as epilepsy, asthma and so forth

- establishment of a communication system to facilitate interaction between the school, the home of the sick pupil and the school health services, as absenteeism is a multi-disciplinary problem

- introduction of regular meetings of the team members, including the parents to discuss health issues relevant to the school-going child

- the introduction of a nursing care programme by the school health nurse, so that causes of ill-health can be identified, treatment given and guidance on personal and family problems offered

- the development by the school nurse of a home visiting programme within the broad framework of the policy on health related absenteeism

- the establishment of a multi-disciplinary approach in schools, which includes the school health nurse, the teachers, parents, pupils and psychologist and other team members, particular emphasis should be placed on parental involvement, to attend to problems of the pupils which could result in absenteeism

7.4.5 Peer associations/environment

The findings of this study revealed that pupils, teachers as well as school health

nurses indicated that smoking and alcohol consumption were the major problems identified amongst pupils (Sections 4.5.1, 5.4.1, 6.6.1, 6.6.2 and 6.6.3). Drugs and glue sniffing did not appear to be a major problem. The incidence of alcohol and smoking was not found to be statistically significant in terms of absenteeism the p value was 5,8% (Section 6.6.1.1).

In relation to these findings Reid (1983: 113) states that children develop among peer groups, and in an attempt to live up to the perceived lifestyle practices and be part of the group, they indulge in habits such as cigarette smoking, alcohol abuse, drug abuse, and so forth.

Furthermore, Gallop (1989: 112) states that these life-style practices are more often practised in the afternoon classes than would be the case in morning classes.

7.4.5.1 Conclusion

There is peer influence in connection with all the health related life-style identified especially in relation to the consumption of alcohol and smoking.

7.4.5.2 Recommendations

Counselling services should be provided by educational counsellors in schools to address issues such as emotional problems of pupils and the problem of peer pressure experienced by pupils in schools.

Health promotion and behaviour modification campaigns should be jointly organised and implemented in schools by the multi-disciplinary health team including the parents and the pupils, to address problems such as cigarette smoking, alcohol abuse, drug abuse and other problems.

The school health nurse should be made responsible for drawing up the above campaigns to ensure that there is adequate information support and control for the pupils, the teachers and the parents.

7.5 SUGGESTIONS FOR FURTHER RESEARCH

Further research studies should be conducted in a number of relevant areas.

This study should be replicated in future, using a larger sample drawn from beyond the borders of the Molopo region and the North-West Province, so that the results could be generalised to the wider school population of Southern Africa.

- There is a real need, for further research using a team approach to determine reasons for absenteeism in schools. It is important that such a study on absenteeism be undertaken as soon as the absences are noted.

- Another study could be done to identify the views of parents in relation to school absences that occur as a result of health problems.

- Self-destructive behaviour of school children, such as cigarette smoking, dagga

smoking, glue sniffing, alcohol consumption and drug taking should be investigated.

- The role of traditional healers in the provision of services to sick school children should be researched.

- A study should be conducted to identify the implementation of the Primary Health Care approach in the provision of school health services.

- The referral system in school health care provision needs to be investigated.

- The supervision of pupils who are on medical treatment for chronic diseases, as well as the extent of the knowledge of teachers and their support in dealing with health problems in schools, are areas that require specific investigation.

- Health education programmes in schools need to be reviewed to determine their relevance to health problems in schools.

- The role of the teachers and parents in the control of health-related absenteeism needs to be researched.

- A team approach in the provision of school health services also warrants further research.

7.6 CLOSING COMMENTS

The reason for embarking on this study was to identify factors which contribute to pupils absenteeism in the Molopo region, North-West Province. The study also looked into the control of health related absenteeism and the role of the school health nurse in school health matters.

The value of this study lies in the fact that it highlights the influence health problems, and a combination of school, peer-related and home environmental factors have on absenteeism in schools.

The findings indicate that health problems are a direct cause of pupils staying away from school. In general, the periods of absenteeism are used to pay a visit to the clinic or hospital, or to consult a general practitioner at his or her consulting rooms. The findings also indicate that there appears to be little control in monitoring health related absenteeism and little knowledge of the school health services available.

The school has a significant role to play in the prevention of absenteeism. In consultation with the school nurse, the parents and the pupils, teachers can help to identify frequently occurring health problems, and to plan health education strategies which will alleviate such problems.

The teacher must develop basic assessment skills to be able to help with the identification of health problems, before complications develop. An effective and efficient referral system will facilitate the implementation of nursing and medical

interventions.

The information and findings that emerged from this study are not encouraging. It would appear that, in spite of the fact that school health service programmes are available, there still is a serious manpower shortage to facilitate the implementation of the plans necessary to address the issue of health problems in schools.

It is hoped that the implementation of the recommendations will place pupils in a better position to acquire good health and improved attendance rates, which will in turn indirectly influence their general school performance.

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ANNEXURE A

LIST OF MIDDLE SCHOOLS

LIST OF MIDDLE SCHOOLS

Batswana

Boingotlo

Boitseanape

Boitshoko

Makgetla

Mmabatho

Molema

Montshiwa Memorial

Redibone

Tetlano

ANNEXURE B

PERMISSION FROM THE DEPARTMENT OF EDUCATION TO CONDUCT RESEARCH

REPABOLEKI YA BOPHUTHATSWANA

REPUBLIC OF BOPHUTHATSWANA

REPUBLIEK VAN BOPHUTHATSWANA

KANTORO YA/OFFICE OF THE/KANTOOR VAN DIE

Nr. Tshup./Ref. No./Verw. Nr.
7/4/1

Botsa Go/Enquiries/Navrae
L.D. MALOPE

Nr. Mog./Tel. No. 29x2363

DEPARTMENT OF EDUCATION

PRIVATE BAG X2044

MMABATHO

8681

M.M. Hlonipho
P.O. Box 7000
MMABATHO
8681

PERMISSION TO CONDUCT RESEARCH ON ABSENTEEISM IN MIDDLE SCHOOLS IN THE MOLOPO CIRCUIT.

1. Your letter dated 12 January 1992 has reference.

2. Approval is hereby granted for you to pursue your study in the Molopo Education Circuit.

3. The Department is eargerly awaiting a copy of your report as this will shed light on contributory factors which underly this thorny issue and ways of how this could be curbed.

SECRETARY FOR EDUCATION

ANNEXURE C

PERMISSION FROM THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES TO CONDUCT RESEARCH

REF. NO. : 7/2/7 (3/93)
ENQ. : M.J. MOLEMA
TEL. NO.: (0140) ~~89 2833~~ 89-9110/2

DEPARTMENT OF HEALTH
AND SOCIAL SERVICES
PRIVATE BAG X2068
M M A B A T H O
8681

16 SEP 1993

Ms. M.M. Hlongwa
P.O. Box 7000
MMABATHO
8681

Dear Sir/Madam

RE : PERMISSION TO CONDUCT RESEARCH IN BOPHUTHATSWANA

1. After a careful consideration of your proposal to embark on a research project, the Departmental Research Committee resolved that your application be approved subject to the following conditions :

   1.1 that you supply the undersigned with progress report on a regular basis,

   1.2 that on completion of the research project, a copy of your findings and or recommendations (research report, disertation or thesis), be submitted to the undersigned,

   1.3 that the use of manpower in institutions, organisations and or establishments to be visited, is the prerogative of the undersigned and,

   1.4 that permission to publish findings is subject to the approval of the undersigned.

2. You are advised to use the reference No.7/2/7(3/93) for easier reference and or enquiries on this matter. Please read with my 7/2/7(M/F) dated ..... .

3. Your usual co-operation is highly appreciated.

M. J. Molema.

SECRETARY FOR HEALTH AND SOCIAL SERVICES
Mokwaledi wa Ilokanelo le Katisatielo va Loago
Sekretaris van Gesondheid en Volkswelsyn
Secretary for Health and Social Welfare

/cbn

Tirelopuso ya Bophuthatswana
Bophuthatswana-Regeringsdiens
Bophuthatswana Government Service

ANNEXURE D

LETTER OF PERMISSION TO THE PRINCIPAL TO CONDUCT RESEARCH

Private Bag X2046 MMABATHO 8681
Republic of Bophuthatswana
Telephone : (0140) 892111
Telex : 3072 BP
Fax No : (0140) 25775

Date 13 September 1993

Your reference

Our reference MMH/pcm

The Principal

_____

_____

_____

Dear Sir/Madam

Permission to conduct a study on health related absenteeism in Middle Schools in the Molopo Circuit.

I hereby request permission to conduct research on the above topic as a partial requirement for my Master's degree. Structured questionnaires will be completed by students who have been identified as absentees from standard 5, 6 and 7, class teachers of those students, as well as the Principal of the school. Participants will complete the questionnaires during break time to prevent interrupting lessons and school administration.

It is hoped that the investigation will reveal important information related to the problem of school absenteeism. Please find enclosed permission from the Secretary of Department of Education.

Thanking you for your cooperation in this regard.

Yours sincerely

M M Hlonipho

ANNEXURE E

LETTER OF PERMISSION TO THE PARENTS

PO Box 7000
MMABATHO
8681

28 October 1993

Dear Parent

PERMISSION TO CONDUCT A STUDY ON ABSENTEEISM OF STUDENTS IN MIDDLE SCHOOL IN THE MOLOPO REGION

Please be kind enough to allow your child to participate in the research study by completing a questionnaire. The aim of the study is to determine the extent of absenteeism in Middle Schools and to establish the reasons given for this behaviour. Recommendations will also be suggested as to how this problem can be prevented or eliminated.

Please note the following:

1. Your child need not write her/his name on the questionnaire.

2. The information given by your child will be treated strictly confidential (nobody will know about it).

3. The results of this study will be made available to you on request.

Your cooperation will be highly appreciated.

Thank you.

Yours faithfully

MM HLONIPHO

Signature of parent: _____ Date: _____

ANNEXURE F

QUESTIONNAIRE FOR SCHOOL HEALTH NURSES

ANNEXURE F

Questionnaire for the School Health Nurse

ABSENTEEISM, AN INDICATOR OF THE HEALTH STATUS OF SCHOOL CHILDREN IN THE MIDDLE SCHOOLS OF THE MOLOPO REGION IN THE NORTH-WEST PROVINCE

Please answer the following questions to the best of your knowledge. In the box provided, please place an 'x'.

(For Office Use)

Pupil's Number

1 - 3

1. Does the school health service in your region have a philosophy?

1.1	Yes	1
1.2	No	2

4

2. What are the goals of the school health programme?

.....

.....

.....

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5

3. Which of the following schools do you visit?

3.1	Redibone	1	6
3.2	Batswana	1	7
3.3	Mmabatho	1	8
3.4	Makgetla	1	9
3.5	Boitsenape	1	10
3.6	Boitshoko	1	11
3.7	Montshiwa Memorial	1	12
3.8	Tetlano	1	13
3.9	Sebopiwa Molema	1	14
3.10	Other (specify)	1	15

.....

4. How often do you visit a particular school?

4.1	Once a month	1	16
4.2	Once in a term	1	17
4.3	Once in six months	1	18
4.4	Once a year	1	19
4.5	Do not visit some schools	1	20

5. How many pupils do you see on an average per visit?

5.1	10-20	1	
5.2	20-30	2	
5.3	30-40	3	21
5.4	40-50	4	
5.5	Other (specify)	5	

.....

6. Which groups of students are examined during your visit to schools?

6.1	New pupils (entrants)	1	22
6.2	Pupils who have reported sick	1	23
6.3	Pupils due for general examination	1	24
6.4	Pupils due for specific tests e.g. hearing test	1	25
6.5	Other (specify)	1	26

.....

7. Which of the following team members are involved in planning and implementation of a school health programme?

7.1	School nurse	1	27
7.2	School administrators	1	28
7.3	Teachers	1	29
7.4	Parents	1	30
7.5	Students	1	31
7.6	Community leaders	1	32
7.7	Social worker	1	33
7.8	Counsellor	1	34
7.9	Psychologist	1	35
7.10	Physical therapist	1	36
7.11	Doctor	1	37
7.12	Head of school health division	1	38
7.13	Other (specify)	1	39

.....

8. How often do you hold meetings with the multi-disciplinary team?

8.1	Once a month	1	
8.2	Once in a term	2	
8.2	Once in six months	2	
8.3	Once a year	3	40
8.4	Never	4	
8.5	Other (specify)	5	

.....

9. Who identifies sick pupils at school?

9.1	The school nurse	1	41
9.2	The school principal	1	42
9.3	The class teacher	1	43
9.4	Other (specify)	1	44

.....

10. What school health records do you keep?

.....

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..... 45

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11. Where do you keep these records?

.....

.....

..... 46

.....

12. Who controls these school health records?

12.1	The school nurse	1	47
12.2	The school principal	1	48
12.3	The class teacher	1	49
12.4	Other (specify)	1	50

.....

13. What is the general practice when you have examined a sick child at school?

13.1	Allow the child to rest	1	51
13.2	Give medications for minor ailments	1	52
13.3	Refer to clinic	1	53
13.4	Refer to doctor	1	54
13.5	Refer to hospital	1	55
13.6	Other (specify)	1	56

.....

14. Do you submit a report after each school visit to your head of department?

14.1	Yes	1	
14.2	No	2	57

15. With whom do you discuss health problems of the sick pupil?

15.1	The sick pupil him(her)self	1		58
15.2	The class teacher	1		59
15.3	The school principal	1		60
15.4	The parents	1		61
15.5	Head of school nursing services	1		62
15.6	Other (specify)	1		63

.....

16. Which of the following health care practices do you carry out?

16.1	Periodic physical examination	1		64
16.2	Periodic history taking	1		65
16.3	Eye testing	1		66
16.4	Hearing testing	1		67
16.5	Immunization	1		68
16.6	Other (specify)	1		69

.....

17. Which of the following health problems result in absenteeism?

17.1	Tooth ache	1	70
17.2	Stomach ache	1	71
17.3	Diarrhoea	1	72
17.4	Vomiting	1	73
17.5	Flue/colds	1	74
17.6	Asthma	1	75
17.7	Allergy	1	76
17.8	Menstrual pains	1	77
17.9	Genital discharge	1	78
17.10	Genital sores	1	79
17.11	Angry outbursts (emotional problem)	1	80
17.12	Headache	1	1
17.13	Epilepsy	1	2
17.14	Skin lacerations	1	3
17.15	Burns	1	4
17.16	Operation	1	5
17.17	Sport injuries	1	6
17.18	Painful ear	1	7
17.19	Appetite problems	1	8
17.20	Eye problems	1	9
17.21	Other (specify)	1	10

.....

18. According to school nursing policy, what do you do when a pupil is absent from school due to health problems?

.....

.....

..... 11

.....

19. Who reports incidences of health related absenteeism to the school health nurse?

19.1	The principal	1	12
19.2	The class teacher	1	13
19.3	The student	1	14
19.4	The parents	1	15
19.5	Student counsellor	1	16
19.6	Other (specify)	1	17

.....

20. In your opinion, do students take part in any of the following activities?

20.1	Cigarette smoking	1	18
20.2	Dagga smoking	1	19
20.3	Drinking alcohol	1	20
20.4	Sniffing glue	1	21
20.5	Taking drugs	1	22
20.6	Other (specify)	1	23

.....

21. Do you visit sick pupils and their families at home?

21.1	Yes	1	
21.2	No	2	24

22. What are the purposes for home visits?

22.1	Sanitary inspection	1	25
22.2	Follow-up of students	1	26
22.3	Health related absenteeism	1	27
22.4	Social problems	1	28
22.5	Interviewing parents	1	29
22.6	Interviewing student at home	1	30
22.7	Administering medications	1	31
22.8	Health education	1	32
22.9	Other (specify)	1	33

.....

23. Which of the following topics are discussed during health education sessions?

23.1	Nutrition	1	34
23.2	Sex education	1	35
23.3	Family planning services	1	36
23.4	Hygiene	1	37
23.5	Exercises/sport injuries	1	38
23.6	Cold/Flu	1	39
23.7	Headache	1	40
23.8	Epilepsy	1	41
23.9	Aids	1	42
23.10	Drug abuse	1	43
23.11	Other (specify)	1	44

.....

24. Do you provide information brochures to teachers and pupils on health issues?

24.1	Yes	1	
24.2	No	2	45

Thank you for completing this questionnaire.

Your cooperation is highly appreciated.

ANNEXURE G

QUESTIONNAIRE FOR THE TEACHERS

ANNEXURE G

Questionnaire for Teachers

ABSENTEEISM, AN INDICATOR OF THE HEALTH STATUS OF SCHOOL CHILDREN IN THE MIDDLE SCHOOLS OF THE MOLOPO REGION IN THE NORTH-WEST PROVINCE

Please answer all questions by placing an 'x' in the box provided.

(For Office Use)

Pupil's Number

1 - 3 | | |

ADMINISTRATION

1. Which standard do you teach?

1.1 Standard 5	1	
1.2 Standard 6	2	4
1.3 Standard 7	3	

2. Do you keep a daily class attendance register?

2.1 Yes	1	
2.3 No	2	5

3. If yes, when do you mark the register?

3.1 Morning	1	
3.2 Afternoon	2	6
3.3 Other (specify)	3	

.....

4. Does the school have written class attendance rules and regulations?

4.1 Yes [1]

4.2 No [2] [ ] 7

If your answer to Question 4 above is yes, please answer Questions 5, 6, 7 and 8:

5. Indicate the title of the school rules:

..... [ ] 8

.....

6. List the contents of the school rules pertaining to attendance and absenteeism:

..... [ ] 9

.....

7. Indicate the title of the regulations from the Department of Education and Training:

..... [ ] 10

.....

8. List the contents of the regulations from the Department of Education and Training pertaining to attendance and absenteeism:

..... [ ] 11

.....

9. In your opinion, does absenteeism promote poor performance among students?

7.1 Yes [1]

7.2 No [2] [ ] 12

10. If your answer to Question 9 above is No, please give your reasons:

.....	1	
.....	2	13
.....	3	

MEASURES TO CONTROL ABSENTEEISM

11. When are most students absent from your class?

11.1 In the morning	1	
11.2 In the afternoon	2	
11.3 The whole day	3	
11.6 Other (specify)	4	14
.....		

12. When are most students absent from your class?

12.1 Mondays	1	15
12.2 Tuesdays	1	16
12.3 Wednesdays	1	17
12.4 Thursdays	1	18
12.5 Fridays	1	19
12.6 All of the above	1	20

13. According to the school health policy, what measures do you take to control health related absenteeism?

13.1	The pupil is required to submit letter from the parents	1	21
13.2	The pupil is required to submit a doctor's certificate	1	22
13.3	The pupil's parents are consulted at home	1	23
13.4	The School health nurse submits a sick note/letter	1	24
13.5	The pupil submits a sick note from the clinic nurse who attended to him/her	1	25
13.6	Other (specify)	1	26

.....

14. What measures are taken if students absent themselves from class due to health problems?

14.1	The parents are notified	1	27
14.2	The student is interviewed	1	28
14.3	A report is given to the headmaster	1	29
14.4	A report is given to the School Health Nurse	1	30
14.5	A report is given to the Guidance and Counselling teacher	1	31
14.6	Other (specify)	1	32

.....

15. In the event of persistent absenteeism, who interviews the parents of the child?

15.1 Nobody	1		33
15.2 The principal	1		34
15.3 The departmental head	1		35
15.4 The class teacher	1		36
15.5 Other (specify)	1		37

.....

16. Who interviews the absent students?

16.1 Nobody	1		38
16.2 The principal	1		39
16.3 The departmental head	1		40
16.4 The class teacher	1		41
16.5 Other (specify)	1		42

.....

17. What rewards do students get when their school attendance is excellent?

17.1 A prize	1		43
17.2 Written individual praise	1		44
17.3 A certificate of recognition	1		45
17.4 No reward	1		46
17.5 Other (specify)	1		47

.....

HEALTH RELATED ISSUES

18. In your opinion, is delinquency associated with absenteeism?

18.1 Yes	1	
18.2 No	2	48

19. Do students in your class engage in:

19.1 Cigarette smoking	1	49
19.2 Dagga smoking	1	50
19.3 Drinking alcohol	1	51
19.4 Sexual activity ("go jola")	1	52
19.5 Sniffing glue	1	53
19.6 Taking drugs	1	54
19.7 Other (specify)	1	55

.....

20. What are the health problems which, in your view, commonly result in absenteeism?

20.1	Tooth ache	1	56
20.2	Stomach ache	1	57
20.3	Diarrhoea	1	58
20.4	Vomiting	1	59
20.5	Flue/Colds	1	60
20.6	Asthma	1	61
20.7	Allergy	1	62
20.8	Menstrual pains	1	63
20.9	Vaginal/penile discharge	1	64
20.10	Genital sores	1	65
20.11	Angry outbursts (emotional)	1	66
20.12	Headache	1	67
20.13	Epilepsy	1	68
20.14	Skin lacerations	1	69
20.15	Burns	1	70
20.16	Operation	1	71
20.17	Sport injury	1	72
20.18	Painful ear	1	73
20.19	Appetite problems	1	74
20.20	Other (specify)	1	75

.....

SCHOOL HEALTH SERVICES

21. Does your school have a school health nurse?

21.1 Yes	1	76
21.2 No	2	

22. How often does the school health nurse visit your school?

22.1 Once a month	1	77
22.2 Once in a term	2	
22.3 Once in six months	3	
22.4 Does not visit the school	4	

23. Does the school health nurse examine pupils who are enrolling at your school for the first time?

23.1 Yes	1	78
23.2 No	2	

24. Are there any health records of pupils kept at your school?

24.1 Yes	1	79
24.2 No	2	

25. Who identifies sick pupils at your school?

25.1	The class teacher	1	80
25.2	The school health nurse	1	1
25.3	The principal	1	2
25.4	Nobody	1	3
25.5	Other (specify)	1	4

.....

26. Does the school health nurse give health education talks?

26.1	Yes	1	
26.2	No	2	5

27. If the answer to question 26 is yes, which topics are discussed?

27.1	Nutrition	1	6
27.2	Sex education	1	7
27.3	Family planning services	1	8
27.4	Hygiene	1	9
27.5	Exercising/Sport injuries	1	10
27.6	Colds/Flu	1	11
27.7	Headache	1	12
27.8	Epilepsy	1	13
27.9	Aids	1	14
27.10	Drug abuse	1	15
27.11	Other (specify)	1	16

.....

28. Does the school health nurse provide the following aspects of health care?

28.1	Periodic physical examination	1	17
28.2	Hearing tests	1	18
28.3	Eye tests	1	19
28.4	Immunizations (Moento)	1	20
28.5	Other (specify)	1	21

.....

29. To your knowledge, does the school health nurse visit the home of a sick pupil?

29.1 Yes	1	
29.2 No	2	22

30. Do you hold meetings to discuss health related problems with the school health nurse?

30.1 Yes	1	
30.2 No	2	23

31. Does the school health nurse provide teachers with informative material on health issues?

31.1 Yes	1	
31.2 No	2	24

Thank you for completing this questionnaire.

Your cooperation is highly appreciated.

ANNEXURE H

QUESTIONNAIRE FOR THE PUPILS

ANNEXURE H

Questionnaire for Pupils

ABSENTEEISM, AN INDICATOR OF THE HEALTH STATUS OF SCHOOL CHILDREN IN THE MIDDLE SCHOOLS OF THE MOLOPO REGION IN THE NORTH-WEST PROVINCE

Please take time when answering the questions. Be as accurate and honest as possible. Do not write your name on the questionnaire so that you cannot be identified.

Please record your answer by placing an x in the box provided, for example:

QUESTION: What is your sex?

Male	1
Female	2

ANSWER : If you are male, place an x in the first box.
If you are female, place an x in the second box.

(For Office Use)

Pupil's Number

1 - 3 | | |

DEMOGRAPHICAL DATA

1. Age

1.1	12-13 years	1
1.2	14-15 years	2
1.3	16-17 years	3
1.4	18-19 years	4
1.5	Other (specify)	5

..... 4

2. Sex

2.1	Male	1	
2.2	Female	2	5

3. Where do you stay?

1.1	Mmabatho	1	
1.2	Montshiwa	2	
1.3	Motlhabeng	3	
1.4	Magogwe	4	
1.5	Majemantsho	5	6
1.6	Lomanyaneng	6	
1.7	Dibate	7	
1.8	Ramosadi	8	
1.9	Other (specify)	9	

.....

4. With whom are you staying at home?

4.1	Both parents	1	7
4.2	Mother	1	8
4.3	Father	1	9
4.4	Aunt	1	10
4.5	Grandmother	1	11
4.6	Friend	1	12
4.7	Other (specify)	1	13

.....

5. What is your parents' marital status?

5.1	Married	1
5.2	Divorced	2
5.3	Widowed	3
5.4	Separated	4
5.5	Single	5
5.6	Other (specify)	6

[ ] 14

6. How many members are there in your family?

6.1	1 - 2	1
6.2	2 - 3	2
6.3	4 - 5	3
6.4	6 - 7	4
6.5	Other (specify)	5

.....

[ ] 15

7. What is your father's occupation?

7.1	School teacher	1
7.2	Lecturer	2
7.3	Administrator	3
7.4	Businessman	4
7.5	Clerk	5
7.6	Labourer	6
7.7	Manager	7
7.8	Other (specify)	8

.....

[ ] 16

8. What is your mother's occupation?

8.1	Housewife	1
8.2	School teacher	2
8.3	Nurse	3
8.4	Typist/Secretary	4
8.5	Domestic helper	5
8.6	Manager	6
8.7	Other (specify)	7

..... [ ] 17

EDUCATIONAL DATA

9. In which standard are you?

9.1	Five	1
9.2	Six	2
9.3	Seven	3

[ ] 18

10. Are you repeating this class?

10.1	Yes	1
10.2	No	2

[ ] 19

HEALTH/MEDICAL RELATED DATA

11. Have you been absent from school due to any of the following health problems?

11.1	Toothache	1	20
11.2	Abdominal pains/Tummy ache	1	21
11.3	Diarrhoea/Running tummy	1	22
11.4	Vomiting	1	23
11.5	Flu/Colds	1	24
11.6	Asthma	1	25
11.7	Allergy, e.g. rash	1	26
11.8	Menstrual pains	1	27
11.9	Discharge from private parts	1	28
11.10	Sores in private parts	1	29
11.11	Angry outbursts (emotional)	1	30
11.12	Headaches	1	31
11.13	Epilepsy (fits)	1	32
11.14	Skin lacerations/Sores	1	33
11.15	Burns	1	34
11.16	Operation	1	35
11.17	Sport injury	1	36
11.18	Painful ear	1	37
11.19	Appetite changes	1	38
11.20	Eye problems	1	39

12. While absent from school, were you examined by:

12.1	A School nurse	1	40
12.2	A Clinic nurse	1	41
12.3	A Private doctor	1	42
12.4	A Dentist	1	43
12.5	Traditional healer	1	44
12.6	Hospital doctor	1	45
12.7	Other (specify)	1	46

.....

13. After being examined, were you referred to:

13.1	A Hospital	1	
13.2	A Clinic	2	47
13.3	Other (specify)	3	

.....

14. If you were referred to hospital, were you admitted?

14.1	Yes	1	
14.2	No	2	48

15. If your answer to Question 14 above is yes, what was the reason(s) for your admission?

.....	1	
.....	2	49
.....	3	

FACTORS RELATED TO ABSENTEEISM

16. What are your school related reasons for being absent from school?

16.1	Do not like school	1		50
16.2	Classes are boring	1		51
16.3	Subjects are difficult	1		52
16.4	Studying for a test	1		53
16.5	Do not like the teacher	1		54
16.6	Afraid of punishment from the teacher	1		55
16.7	Late for school	1		56
16.8	Did not do my homework	1		57
16.9	Other (specify)	1		58

.....

17. What are your family related reasons for being absent from school?

17.1	An ill family member	1		59
17.2	Doing errands	1		60
17.3	Family trips.	1		61
17.4	Death in the family	1		62
17.5	Needed as witness in court	1		63
17.6	Looking after children	1		64
17.7	Looking after elderly people	1		65
17.8	Other (specify)	1		66

.....

18. What are your personal reasons for staying away from school?

18.1	Want to be with friends	1	67
18.2	Working part-time	1	68
18.3	Going for a driving test	1	69
18.4	Athletic meetings	1	70
18.5	Interviews	1	71
18.6	Going to Court	1	72
18.7	Not feeling well	1	73
18.8	Other (specify)	1	74

19. When absent from school, what do you do?

19.1	Go to the clinic	1	75
19.2	Go to a friend's house	1	76
19.3	Stay at home	1	77
19.4	Go to the doctor	1	78
19.5	Go around with a gang (or a group of friends)	1	79
19.6	Other (specify)	1	80

20. Since the opening of this term, how often have you been absent?

20.1	1-2 days	1
20.2	3-4 days	2
20.3	5-6 days	3
20.4	7-8 days	4
20.5	9-10 days	5
20.6	Other (specify)	6

[ ] 1

21. How frequent were you absent from school?

21.1	Once every week	1
21.2	Once every two weeks	2
21.3	Once every month	3
21.4	Other (specify)	4

[ ] 2

22. On which specific day/days were you absent from school?

22.1	Mondays	1	[ ] 3
22.2	Tuesdays	1	[ ] 4
22.3	Wednesdays	1	[ ] 5
22.4	Thursdays	1	[ ] 6
22.5	Fridays	1	[ ] 7
22.6	All of the above	1	[ ] 8

23. In relation to Question 22 above, what was your reason for being absent from school on that particular day or days?

.....	1	
.....	2	9

24. During which part of the day were you absent from school?

24.1 Morning	1	
24.2 Afternoon	2	
24.3 The whole day	3	10
24.4 Other (specify)	4	

25. Were your parents notified of your absence from school?

25.1 Yes	1	
25.2 No	2	11

26. If your answer to Question 25 above is yes, who informed them?

26.1 The principal	1	
26.2 The class teacher	2	
26.3 The departmental head	3	12
26.4 Other (specify)	4	

27. According to school health policy, when you are absent from school, are you required to:

27.1	Submit a letter of explanation from parents?	1	13
27.2	Submit a doctor's medical certificate?	1	14
27.3	Be interviewed with parents at home?	1	15
27.4	Submit a sick note from school health nurse?	1	16
27.5	Submit a sick note from the clinic nurse?	1	17
27.6	Other (specify)	1	18

28. If you are absent from school, who interviews your parents/guardians?

28.1	Nobody	1	19
28.2	The Principal	1	20
28.3	The departmental head	1	21
28.4	The class teacher	1	22
28.5	Other (specify)	1	23

29. Who interviews you if you are absent from school?

29.1	Nobody	1	24
29.2	The Principal	1	25
29.3	The departmental head	1	26
29.4	The class teacher	1	27
29.5	Other (specify)	1	28

30. How do you get to school (transport)?

30.1	In the family car	1	29
30.2	By bus	1	30
30.3	By taxi	1	31
30.4	Walking	1	32
30.5	Lifts with friends	1	33
30.6	Other (specify)	1	34

Please indicate how frequently the following activities take place at your school:

31. Smoking cigarettes

31.1	Very regularly	1	
31.2	Regularly	2	
31.3	Sometimes	3	35
31.4	Seldom	4	
31.5	Never	5	

32. Smoking dagga

32.1	Very regularly	1	
32.2	Regularly	2	
32.3	Sometimes	3	36
32.4	Seldom	4	
32.5	Never	5	

33. Sniffing Glue

33.1	Very regularly	1
33.2	Regularly	2
33.3	Sometimes	3
33.4	Seldom	4
33.5	Never	5

37

34. Involved in taking drugs

34.1	Very regularly	1
34.2	Regularly	2
34.3	Sometimes	3
34.4	Seldom	4
34.5	Never	5

38

35. Drinking alcohol

35.1	Very regularly	1
35.2	Regularly	2
35.3	Sometimes	3
35.4	Seldom	4
35.5	Never	5

39

36. Are you taking any medicines?

36.1	Yes	1
36.2	No	2

40

37. If your answer to question 36 above is yes, give the reason why you are taking this medicine:

..... 1

..... 2 [ ] 41

38. Do you know what to do when you become sick at school?

35.1 Yes 1

35.2 No 2 [ ] 42

39. If your answer to question 38 above is yes, state what you do when you become sick at school:

..... 1

..... 2 [ ] 43

40. Does your school have a school health nurse?

40.1 Yes 1

40.2 No 2 [ ] 44

41. How frequently does the school health nurse visit your school?

41.1 Once a month 1

41.2 Once in a term 2

41.3 Once in six months 3

41.4 Does not visit the school 4 [ ] 45

42. Does the school health nurse give health education talks?

42.1 Yes 1

42.2 No 2 [ ] 46

43. If the answer to Question 42 is yes, which topics are discussed?

43.1	Nutrition	1	47
43.2	Sex education	1	48
43.3	Family planning services	1	49
43.4	Hygiene	1	50
43.5	Exercises/sports injuries	1	51
43.6	Colds/Flu	1	52
43.7	Headache	1	53
43.8	Epilepsy/Fits	1	54
43.9	Aids	1	55
43.10	Drug abuse	1	56
43.11	Other (specify)	1	57
	.....		

44. To your knowledge, does the school health nurse visit the home of a sick pupil?

44.1	Yes	1	
44.2	No	2	58

45. Does the school health nurse provide students with information brochures on health issues?

45.1	Yes	1	
45.2	No	2	59

Thank you for completing this questionnaire.

Your cooperation is highly appreciated.

ANNEXURE I

COPY OF POLICY ON SCHOOL ATTENDANCE FROM THE SCHOOL REGISTER