EXPERIENCES OF REGISTERED NURSES REGARDING MONITORING OF CLINICS BASED AT SPECIAL SCHOOLS IN THE FREE STATE

A dissertation submitted

by

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TABLE OF CONTENTS

LIST OF ABBRIVIATIONS

ADHD - Attention Deficit-Hyperactivity Disorder

ARVs - Antiretrovirals

AYHP - Adolescent and Youth Health Policy

BHF - Board of Healthcare Funders

CDU - Central Dispensing Unit

DoE - Department of Education

DoH - Department of Health

DPME - Department of Performance, Monitoring and Evaluation

FSDoH - Free State Department of Health

FSDoE - Free State Department of Education

GPPSA - Good Pharmacy Practice in South Africa

HIV/AIDS - Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome

HIV-TB - Human Immunodeficiency Virus-Tuberculosis

HoD - Head of Department

HSREC - Health Sciences Research Ethics Committee

IPC - Infection Prevention and Control

ISHP - Integrated School Health Policy

KPAs - Key Performance Areas

KZNDoH - KwaZulu Natal Department of Health

LSEN - Learners with Special Educational Needs

NHI - National Health Insurance

PHC - Primary Health Care

PMDS	-	Performance Management and Development System
POPIA	-	Protection of Personal Information Act
PSC	-	Public Service Commission
RN	-	Registered Nurse
SANC	-	South African Nursing Council
SAPC	-	South African Pharmacy Council
SDG	-	Sustainable Development Goals
SMT	-	School Management Team
TB	-	Tuberculosis
UNDP	-	United Nations Development Programme
WHO	-	World Health Organization

LIST OF TABLES

LIST OF FIGURES

LIST OF ADDENDUMS

ABSTRACT

BACKGROUND:. Clinics in special schools provide vital primary healthcare services to children with special needs and require ongoing monitoring for quality assurance. In special schools, principals act as immediate supervisors of nurses. This misalignment of expertise creates a challenge for clinics based in special schools to be monitored adequately. Additionally, the researcher's experience raises the question that monitoring challenges may arise from a lack of intersectoral collaboration and inadequate adoption of quality guidelines. These issues may hinder the appropriate monitoring of clinics based at special schools.

PURPOSE: The research aimed to describe the experiences of registered nurses working in clinics in special schools in the Free State regarding the monitoring they receive.

METHODS: The research design was qualitative, exploratory, and descriptive, conducted within a specific context. Purposive sampling was employed to select participants from special schools in the Free State. Data were collected through individual in-depth interviews, enabling participants to share their experiences regarding the monitoring of primary healthcare services in clinics at special schools. Thematic data analysis was subsequently used to identify and develop themes from the data.

RESULTS: Three key themes emerged from the data analysis: Theme 1: Challenges Associated with the Lack of Monitoring in Clinics at Special Schools; Theme 2: Effects of Insufficient Monitoring in Clinics at Special Schools; and Theme 3: Support Strategies Employed by Nurses in Clinics at Special Schools. The key findings of the study highlight the challenges and effects faced by nurses due to the lack of monitoring in clinics. This raises the question of how nurses and Departments involved can implement strategies to address these issues.

CONCLUSION: The recommendations arising from this study emphasize the need to raise awareness regarding the deficiencies in monitoring and intersectoral collaboration among relevant departments. Nurses should take the initiative to establish platforms for sharing insights on issues that may impact the monitoring of

clinics at special schools. Such platforms can facilitate collaboration, starting with school personnel and then extending to include other stakeholders from the Department of Education (DoE) and the Department of Health (DoH) to improve monitoring.

CLARIFICATION AND OPERATIONALISING OF CONCEPTS

Clinic

A clinic is a place where primary healthcare services are provided (KwaZulu-Natal DoH, 2001). It renders several specified services that typically fall under the purview of a registered nurse. These services might be used for follow-up care or as the initial point of contact (DoH, 2009:5).

Primary healthcare is a nurse-based health service, and supported by doctors. Primary healthcare services are a package of comprehensive basic services that include maternal, child, and reproductive health, HIV and TB testing and treatment, screening and care for non-communicable diseases, and treatment of common ailments (WHO, 2017:4).

School health services are incorporated into primary healthcare services (DoH & DoE, 2012:9). These services include dental and vision screening and care, hearing and speech testing, dietary and physical evaluations, mental health services, TB and chronic illness management, psychosocial support, vaccines, treatment for minor disorders, as well as sexual and reproductive healthcare (DoH & DoE, 2012:14). They can be either delivered at schools, through mobile services, or through a fixed, on-site clinic (DoH & DoE, 2012:15-16). In this study, clinics refer to nurse-led primary healthcare services rendered on-site at special schools.

Experience

Experience is described as the fact or state of having been affected by or gained knowledge through direct observation or participation (Merriam-Webster, 2023). Gaining knowledge implies that the registered nurses had been exposed to working at a clinic based at a special school. Such experience will enable them to have insight into the monitoring of the clinic. In this study, the experiences of registered nurses regarding the monitoring of the PHC services rendered to children in special schools will be identified through in-depth interviews. The interviews will enable them to share their views of the situation and construct meaning from it.

Free State Province

The Free State is one of the nine provinces in South Africa (Municipalities of South Africa, 2021). The context of the study applies to the special schools located within the Free State province.

Monitoring

Monitoring is the systematic collection and analysis of information through the progression of a project and forms an integral part of day-to-day operational management. Progress is assessed against a set of pre-established objectives and criteria. It is aimed at improving the efficiency and effectiveness of a project or organisation, and is based on targets and activities identified during the planning phase (DoH, 2015:156). Supervision includes using guiding tools such as the Primary Health Care supervision manual, national core standards, integrated clinical services management, the ideal clinic model, and the district health information management system (DoH, 2009:162; 2011:2; 2020:1). In this study, monitoring of primary healthcare services or clinics includes the supervision of services by a clinic supervisor or local area manager, to facilitate quality assurance (DoH, 2009: 26,41).

Registered Nurse

A registered nurse (RN) refers to a person registered in a category under section 31(1) of the South African Nursing Act to practice nursing and/or midwifery (RSA, 2005:6). When the study refers to nurses, it specifically refers to registered nurses working in clinics at special schools, who are registered with the South African Nursing Council. These nurses are qualified to conduct physical assessments, diagnose illnesses, prescribe treatment, provide direct care to healthcare consumers, and refer for further treatment when necessary. (SANC, 2014:1).

Special Schools

Special schools are primary and high schools that are equipped to deliver a specialised education programme to learners requiring access to highly intensive educational support. Each special school is required to specialise in education for children with specific disabilities (Khumalo & Hodgson, 2017:110). A special school has people who possess specialised skills available among its staff, and has developed learning materials to specifically assist learners with barriers to learning and development due to their disabilities or impairments (DoE, 2001:21). Different learning needs that special schools must address arise from a range of factors including physical, mental, sensory, neurological and developmental impairments, psychosocial disturbances, differences in intellectual ability, particular life experiences, or socio-economic deprivation (DoE, 2001:7). Special schools in this study refers to the 19 special schools located in the Free State province, South Africa.

CHAPTER 1 - OVERVIEW OF THE STUDY

1.1 INTRODUCTION

Monitoring is vital in ensuring that healthcare users are provided with quality and safe healthcare services. Monitoring also ensures continuous quality improvement in services provided in primary healthcare clinics. Monitoring strives to address patients' access to basic healthcare facilities, minimising errors in the quality of treatment given to users, and promoting capacity that will improve the delivery of care by identifying and meeting the requirements of primary healthcare providers and users (DoH, 2009:5). The World Health Organization (WHO) advocates for continuous quality monitoring of health establishments, including primary healthcare clinics, to maintain the quality of performance of health providers and the services they deliver, ensuring that nurses receive feedback, which will assist them to perform better (WHO, 2021:55; WHO, OECD, International Bank for Reconstruction and Development, The World Bank, 2018:63).

The above statements underline the critical importance of monitoring in promoting quality healthcare services. The researcher, who previously operated as a professional nurse within a special school in the Free State, has observed and experienced substantial monitoring difficulties. This observation motivated the need to explore the experiences of registered nurses working in these special school clinics. The following background section examines the monitoring of services in Primary Health Care (PHC) clinics in South Africa and focuses on the relevance of special schools within this context

1.2 BACKGROUND

1.2.1 Monitoring

The monitoring of activities at healthcare clinics is essential, internationally as well as in South Africa. According to the World Health Organization (WHO), monitoring offers a chance to improve clinical management and healthcare services in general, as well as to displace the strongly ingrained notion that monitoring of primary healthcare services is merely an administrative duty or an “inspection” (WHO, 2021:55). South Africa is not exempt from monitoring of primary healthcare services. The Department of Health (DoH) maintains that, through monitoring, the South African population will likely be cared for appropriately and safely, which will aid in reducing morbidity and mortality rates (DoH, 2011:2-4).

The World Health Organization argues that it is crucial to routinely monitor the status of implementation initiatives. In a rapidly changing world, health systems need to monitor their performance to learn and adapt, identify and address challenges, and manage unintended consequences of large-scale initiatives (WHO & UNICEF, 2018:36). The Astana Declaration of 2018 and the original Declaration of Alma-Ata are both based on the fundamental value of quality (WHO, 1978; WHO, 2008; WHO, 2018:8).

There is a compelling argument in favour of ensuring primary healthcare quality. High-quality universal health coverage cannot be attained without systematically addressing the quality of primary healthcare, since primary healthcare services make up a significant and growing component of a country’s healthcare services. Primary healthcare needs to be at the centre of efforts to improve quality across health systems because of the significance of quality in primarycare provision as well as the crucial role that primary care clinicians play in the delivery of care (WHO, 2018:8).

The provision of high-quality primary healthcare requires that providers be supported in delivering care following the best available knowledge. A number of actions were put in place to assist the support, supervision, and monitoring of quality primary care (WHO, 2018:16). The first of these is that clinical decision support tools give healthcare professionals patient-specific information and knowledge at the right time during patient interaction to improve the quality of care (WHO, 2018:16). The second is that instruments such as clinical standards, standard operating procedures, and protocols are utilised to direct the adoption of evidence-based healthcare (WHO, 2018:16). In the third place, clinical audit and feedback involve the controlled evaluation of clinical practice over time in comparison to established standards, which has been designed to inform health professionals about clinical performance to facilitate improvement. Monitoring through these instruments provides the data against which quality is measured (WHO, 2018:16).

In South Africa, certain tools are used to monitor of quality assurance, and some of these will now be mentioned. South Africa’s National Core Standards for Health Establishments serve as a standard of quality against which the provision of healthcare services can be monitored (WHO, 2017:22; DoH, 2011:2). A primary healthcare centre must adhere to six requirements that are essential to raising the quality of its services. The six standards include improving staff values and attitudes, the length of waiting times, cleanliness, patient safety and security, infection prevention, and control, and the availability of medicines and supplies (DoH, 2009:3). Clinic supervisors who are clinic managers, and programme coordinators or local area managers within DoH, should ensure that PHC services are delivered effectively and efficiently at the clinic level. To monitor these requirements, the WHO (2017:23) advocates for the following: at least once a month, committed clinic supervisors or local area managers visit fixed Primary Health Care (PHC) facilities, such as community health centres and community day centres, to guarantee high-quality primary healthcare (WHO, 2017:23, DoH, 2009:20). A dedicated clinic supervisor or local area manager conducts the visit according to the clinic supervision manual, which entails the use of regular review tools (WHO, 2017:23; DoH, 2009:65).

A South African study done by Mogakwe *et al.* (2019:1) recommends that clinic managers should be involved in decision-making, senior management at the district level should provide support to clinic managers, and internal communication practices must be improved as part of clinic monitoring. It further states that for senior management to embrace such recommendations, it will need to improve compliance with quality standards at primary healthcare clinics (Mogakwe *et al.*, 2019:1).

The PHC system is supported by a well-established District Health Information System (DoH, 2011:11; WHO, 2017:24). The District Health Information System assesses PHC facility oversight as a signpost (WHO, 2017:23). The transformation and improvement of the standard of primary healthcare services depends on routine health management and information systems. Additional strategies to improve primary healthcare must take into account regional disparities in access to technology (WHO, 2018:21). Also, the primary healthcare system in South Africa has well-established institutions and systems for identifying and quantifying the burden of disease (WHO, 2017:23). For instance, there is a clear notification process for all notifiable diseases that must be followed (WHO, 2017:24). Although districts have recently made significant investments in training, the use of data is still inconsistent and poorly integrated into planning and budgeting procedures.

Regarding the above information, it is clear that much has been done to ensure enough monitoring tools to ensure quality care. A study by Serapelwane and Manyedi (2020:1), however, proved that a lack of supportive monitoring in primary health care is disconcerting, and that monitoring by local area managers, program coordinators, and district management must be enhanced.

On the other hand, a South African study by Tseng *et al.* (2019:1), concluded that supervision and monitoring of services by senior nurses was effective because it provided on-the-job training and debriefing, improved skills, increased motivation, and reduced the marginalisation of lower-category health personnel. This highlights the impact of supervision when effectively implemented. Another study based in South Africa found that a quality improvement intervention was able to direct clinical personnel to create straightforward and effective change interventions while utilizing available resources to enhance HIV-TB integrated service delivery (Gengiah *et al*., 2021:444).

Although monitoring and supervision rates have been increasing, key informants question the quality of supervision provided by monitoring systems. Many people view the supervisory manual as cumbersome and time-consuming; “red flags” are frequently left unaddressed; the monitoring procedure does not provide adequate time for the facilities to raise their own concerns, or engage in problem-solving. Similar criticisms of the National Health Core Standards include their focus on compliance and evaluation, duplication, and insufficient attention to output and outcome indicators (Maphumulo & Bhengu, 2019:6-7; WHO, 2017:23).

The implementation of a National Health Insurance system is one attempt by the Government to improve the quality of care in the PHC system. It is built on the Ideal Clinic model, a more recent (2015) comprehensive intervention that aims to explicitly address the quality of PHC (DoH, 2020:1).

In the National Health Insurance white paper, an ideal clinic is described as follows (DoH, 2020:1):

> *"A clinic with good infrastructure (which is defined as physical condition and spaces, essential equipment and information and communication tools), adequate staff, adequate medicine and supplies, good administrative processes and sufficient bulk supplies that use applicable clinical policies, protocols, guidelines as well as partner and stakeholder support, to ensure the provision of quality health services to the community".*

Integrated Clinical Services Management (ICSM) is a key focus within an ideal clinic (DoH, 2015:19; DoH, 2020:1). ICSM is a health system strengthening model that builds on the strengths of the specific programme to deliver integrated care to patients with chronic and/or acute diseases, or who visit the clinic for preventative services. It promotes a patient-centric view that encompasses the full value chain of the continuum of care and support (DoH, 2020:1). Unfortunately, it was met with much opposition, which caused a long delay in its ultimate implementation.

Regardless of the points made relating to the monitoring of primary healthcare services, it is essential to understand how such monitoring in special schools is structured, according to legislation.

1.2.2 Special schools

The WHO advocates that all schools, where feasible, must have clinics to provide school health services. The WHO recognises that most countries have some form of school health service, but many such programmes are not evidence-based, are not implemented well, are underfunded, and/or delivered with limited reach and scope (WHO, 2021:26).

The South African government took a pledge to put the best interest of children first by being signatories to the United Nations Convention on Children's Rights, and by recognising children in the Bill of Rights in the Constitution of South Africa (DoH, 2012:6). Special schools exist because Section 29 of the *Constitution of the Republic of South Africa* (South Africa, 1996:12) determines that everyone has a right to access education, including learners with special educational needs (LSEN). For various reasons, LSEN needs more assistance and encouragement in their school environment. The government's intent was to ensure that all learners, including learners with special educational needs, are appropriately accommodated by schools, and that all learners have equitable access to high-quality education (SAHRC, 2018:4).

Although the Department of Education (DoE) made such commitments, ensuring that children reach their optimal development has been a significant challenge in South Africa. Children face many health barriers to optimal development and good health, including HIV/AIDS, malnutrition, infectious disease, an increase in non-communicable diseases, substance abuse, violence, and injuries that can cause disabilities (DoH, 2012:6). There are other structural challenges that the South African government faces relating to providing adequate health services, especially in the context of school health services. These challenges include but are not restricted to the following: a lack of transportation and financial resources, the absence of hierarchical structures, the failure to adapt or develop policies relating to monitoring, the Departments of Health and Department of Education's lack of cooperation, insufficient training in supervisory skills, and supervisors' attitudes and approaches (WHO, 2021; Department of Social Development, Department of Women, Children, and People with Disabilities & UNICEF, 2012:82-84).

Above and beyond the challenges already mentioned, children with special needs face further challenges to reach their optimal development, especially when considering learning demands. The Department of Education (DoE) mentions challenges such as physical, mental, sensory, neurological, and developmental impairments, psychosocial disorders, intellectual differences, specific life experiences, and socioeconomic disadvantage, which might contribute to these learning demands (DoE, 2001:7).

To address these challenges, the Department of Education (DoE) utilises guidelines for special schools and resource centres. These guidelines suggest the inclusion of professional specialist support personnel to provide physical, therapeutic, psychological, and social services in special schools, in order to improve students' chances of getting the most out of their educational opportunities (DBE, 2014a:11). One of the steps taken by the DoE was to acquire nursing personnel to provide health services in clinics at special schools. The objective was to ensure that learners in special schools are provided with primary healthcare services. The aim is to ensure the delivery of a more complete package of healthcare that not only addresses learning impediments but also takes into account factors that increase morbidity and mortality among students during both infancy and adulthood. Instead of just focusing on health screening and referrals, more emphasis should be placed on the provision of preventative and promotive health services (DoH, 2012:6-7).

The primary healthcare services at special schools must also be monitored to ensure the quality of care (DoE, 2005:19; DoH, 2012:21). The DoE understands that they must provide monitoring and support to nurses working in special schools (DoE, 2005:17). The Integrated School Health Policy further stipulates the focus points of monitoring school health services, which include its coverage, quality, sustainability, and impact on learners, as well as access to schooling, and the retention and achievement of learners (DoE & DoH, 2012:21). The DoE and DoH agree that intersectoral collaboration is necessary for the provision of primary healthcare services in special schools (DoH, 2012:8).

This intersectoral collaboration may assist the Free State Department of Health in implementing monitoring tools such as the Ideal Clinic model, district health information system, and national core standards to improve the quality of healthcare in clinics in special schools in the Free State (DoE, 2005:19; Department of Health, 2011:10; DoH, 2012:8). Literature reveals that the drive to improve the quality of healthcare in South Africa does not lack interventions or powerful ideas, but there is much still to be done to improve the quality of healthcare (Maphumulo & Bhengu, 2019:6).

1.3 PROBLEM STATEMENT

Twelve clinics based in special schools in the Free State offer primary healthcare services to vulnerable groups, specifically children with different disabilities. However, the effective monitoring of these healthcare services depends on the adherence to guidelines and assessment tools set by the Departments of Education and Health. It seems, however, that a lack of leadership skills continues to cause delays in the achievement of quality healthcare (Maphumulo & Bhengu, 2019:4). Literature indicated that weaknesses in leadership could impede collaboration between sectors

(DoE and D0H), which may lead to subpar healthcare services, also affecting the quality of performance of health providers. This may impact the quality of nursing care for these children with special needs. Therefore, the researcher identified a need to explore and describe the experiences of registered nurses based in clinics at special schools, which might lead to recommendations based on problems identified through the study. The researcher's concern gave rise to the research question.

In the researcher's experience from working in special schools, a lack of intersectoral collaboration and lack of the adoption and implementation of guidelines used for quality assurance, such as the Ideal Clinic, and a lack of data collection and management, created a challenge in the monitoring of the quality of primary healthcare services provided at clinics based in special schools. This is true when considering the elements of the Ideal Clinic that each primary healthcare clinic must comply with, such as good infrastructure, adequate medicines and supplies, good administrative processes, and the application of clinical policies, protocols, and guidelines.

1.4 RESEARCH QUESTION

What are registered nurses' experiences regarding monitoring clinics based at special schools in the Free State?

1.5 RESEARCH PURPOSE

To describe registered nurses' experiences regarding monitoring special school-based clinics in the Free State.

1.6 PARADIGMATIC PERSPECTIVE

A research paradigm is the preferred approach to understanding reality, creating knowledge, and learning about the outside world. A paradigm is a group of discourses that together form the intellectual premises underpinning a certain point of view (Tracy, 2020:49). Kivunja and Kuyini (2017:26) define a paradigm as:

> *“A basic set of beliefs or worldview that guides research action or an investigation; the paradigm defines a researcher’s philosophical orientation, a paradigm tells us how meaning will be constructed from the data we shall gather, based on our individual experiences (i.e. where we are coming from)”.*

A paradigm is built on a specific philosophical framework that the researcher uses to approach qualitative research (Creswell & Poth, 2018:55). This study followed a constructivist philosophical paradigm. Constructivist paradigms believe that individuals seek understanding and knowledge of their world, through experiencing things and then reflecting on those experiences. The constructivist paradigm further states that people construct their own understanding and knowledge through social interaction and communication where particular views and learning can occur (Tracy, 2020:51; Creswell & Poth, 2018:55). In this paradigm, the results of the research depend depended on the participant’s views of the phenomenon under study (Creswell & Creswell, 2018:46). The participants and phenomenon in this research refer to the experiences of registered nurses regarding the monitoring of clinics at special schools in the Free State.

The constructivist paradigm relates to qualitative research and uses open-ended questions to stimulate participants to share their views. The process is inductive as meaning is generated from data gathered from interaction with participants (Creswell & Creswell, 2018:38-39). Inductive reasoning is not about conclusions, or whether the participants are right or wrong. The intent is to understand each participant’s motives, the meaning they ascribe to their experiences, and how they experience their own reality (Creswell & Poth, 2018:55; Tracy, 2020:51).

See Table 1.1 for the application of the philosophical assumptions applying to the constructivist paradigm:

Table 1.1: ***Application of constructivist paradigm in this research***

PHILOSOPHICAL ASSUMPTIONS	**APPLICATION OF CONSTRUCTIVIST PARADIGM**
ONTOLOGY Ontology is a patterned set of assumptions concerning reality (Tracy, 2020:60). It examines the researcher's underlying belief system about the nature of being and existence. Does an objective reality exist, or is it a construction of an individual mind? (Kivunja & Kuyini, 2017:26)	The researcher aimed to create knowledge through dialogue, encouraging the nurse participants to share their perspectives and experiences of monitoring healthcare at the special school clinic.
EPISTEMOLOGY Epistemology refers to how we come to know something, and how we can investigate the truth or reality (Kivunja & Kuyini, 2017:27). How can we obtain knowledge about reality (Tracy, 2020:60)?	The researcher gained knowledge from the nurse participants through dialogue to understand the monitoring practices in the clinic. This underlines the collaborative nature of knowledge insight in an epistemological context.

METHODOLOGY The precise methods of knowing about reality. How should the enquirer obtain knowledge (Creswell & Poth, 2018:68)? Methodology is the broad term used to refer to the well-planned research design, methods, approaches, and procedures used in an investigation to find out something (Kivunja & Kuyini, 2017:27).	Using in-depth interviews, a qualitative research design enabled the researcher to explore and describe the topic, including emotions, opinions, and social interactions.
AXIOLOGY Research should be conducted based on the principles of autonomy, beneficence, and justice (Creswell & Poth, 2018:68). Axiology refers to the ethical issues that must be considered when conducting research. It considers the philosophical approach to making the right decisions (Kivunja & Kuyini, 2017:28).	The research is aligned with the ethical values of the Belmont Report's core principles of autonomy, beneficence, and justice. Respect for the participants was prioritized through informed consent and protecting their autonomy. Beneficence was upheld by minimising harm during the study, while justice was addressed by ensuring fair treatment and rightful access to participation. This alignment strengthened the integrity of the research process and protected the rights of all participants (Botma *et al*., 2022:4).

(Polit & Beck, 2021:9; Creswell & Poth, 2018:68; Tracy, 2020:60).

1.7 RESEARCH DESIGN

The researcher followed a qualitative research design to explore and describe the participants' experiences within a specific context. The constructivist paradigm shaped the qualitative, explorative, and descriptive approach, focusing on understanding the subjective meanings that the registered nurses assigned to their experience within their specific context. The research methodology is described in detail in Chapter 2.

1.8 RESEARCH TECHNIQUE

In-depth interviews were used as a qualitative technique for data collection. The purpose of in-depth interviews is to gain a deeper understanding of participants' thoughts, feelings, and experiences. In-depth interviews allowed the researchers to explore the topic, gather rich qualitative data, and uncover insights. Through the questions asked, the interviews facilitated detailed discussions, enabling participants to express their perspectives in their own words.

1.9 POPULATION

The population is the total group of persons in which the researcher is interested (Dibley *et al*., 2020:53). The complete group of people or other discrete study units are therefore considered the target population (Wilson & Joye, 2017:73). The target population for this research was registered nurses working in clinics based in special schools in the Free State, a province in the Republic of South Africa. Data from the provincial office of the Department of Education in the Free State indicated 13 registered nurses working in clinics in special schools. This information was confirmed by contacting all the special schools in the Free State.

1.10 UNIT OF ANALYSIS

The potential population of participants that could be included in a study based, on particular selection criteria, is referred to as the unit of analysis (Brink *et al*., 2018:116). The unit of analysis is based on the same principle as sampling in quantitative data.

The unit of analysis refers to the process of selecting a subset of individuals or units from a larger population to represent that population (Creswell & Creswell, 2018: 216).

Purposive sampling was utilised to select the unit of analysis. Purposive sampling is also referred to as judgemental or non-probability sampling (Brink *et al*., 2018:126). The method is predicated on the researcher's assessment of which volunteers would best represent the study (Saunders & Townsend, 2018:487; Billups, 2021:26). Purposive sampling was used in this study, as the registered nurses currently working in clinics based in special schools in the Free State were readily available (Billups, 2021:26; Polit & Beck, 2021:499). The following inclusion/exclusion criteria were set to select the unit of analysis:

<u>Inclusion criteria</u>

- Registered nurses working at special schools who are registered with the South African Nursing Council.

<u>Exclusion criteria</u>

- Other categories of nurses are enrolled nurses, enrolled nursing assistants, and auxiliary nurses.

1.11 EXPLORATIVE INTERVIEW

An explorative interview, also referred to as a pilot study in some literature, is an interview conducted before the research study to test the practical aspects of the research (Brink *et al*., 2018:161). The difference between an explorative interview and a pilot study is that the explorative interview is used in qualitative research as a method to refine the research question(s), while a pilot study is used in quantitative research to test the feasibility, time and logistics of a larger research project (Creswell & Creswell, 2018:216). An explorative interview is conducted with an individual who meets the same inclusion criteria as the participants of the research (Polit & Beck, 2021:633). An explorative interview intends to check the feasibility of the study to detect any possible flaws in the data collection process. Such flaws can then be corrected before the actual research study is conducted (Brink *et al.,* 2018:161). Two exploratory interviews were conducted with nurses in special schools in the Free State who were part of the identified population. The researcher arranged a suitable location, date, and time for the interviews. An experienced interviewer joined the researcher to ensure the authenticity of the process. Data from these interviews were included in the findings, as no changes were made in response to the exploratory interviews.

1.12 DATA COLLECTION

Permission to collect data was granted by the Free State Department of Education (Addendum C), the Health Science Research Ethics Committee of the University of the Free State (Addendum E), as well as the principals of the special schools (Addendum D). The principals of the schools acted as the gatekeepers, as the researcher had no direct contact with the participants. Letters were sent to the principals outlining the research project. The principals were asked to disseminate information letters and consent forms to possible participants and to ask participants to confirm their interest in participating in the study with the researcher. The researcher confirmed the logistics of interview dates, times, and venues with the nurses who indicated an interest in participating. In-depth interviews were conducted to collect data from registered nurses. Data were collected until data saturation was attained. It must be noted that the researcher didn't have to seek permission from DoH, as the facilities, resources, and participants are from DoE. Therefore, DoH has no jurisdiction over clinics based in special schools in the Free State.

1.13 TRUSTWORTHINESS

Trustworthiness was upheld by applying relevant principles during data management. Polit and Beck (2021:568) mention four principles for scrutinising the quality and trustworthiness of research, namely credibility, dependability, confirmability, and transferability. These principles also contributed to the rigor of the study and will be discussed in detail in Chapter 2.

1.14 ETHICAL CONSIDERATIONS

The research was guided by four ethical principles, which are the foundation of ethical conduct in healthcare and in research. The four ethical principles are autonomy, beneficence, non-maleficence, and justice, as described by the Belmont Report. An in-depth application of these four ethical principles is discussed in detail in Chapter 2.

1.15 DATA ANALYSIS

Thematic data analysis was applied in this research. The steps for thematic data analysis were adapted from Creswell and Creswell (2018:272), where themes and codes were generated from the collected data. Thematic data analysis will be discussed in further detail in Chapter 2.

1.16 CONCLUSION

This chapter presented an introduction, background, and overview of the study. The next chapter will provide a detailed discussion of the research methodology, including the design and techniques used to collect data, as well as how these relate to the study. Chapter 3 will discuss the data collected and the emerging themes supported verbatim. Lastly, chapter 4 will discuss the recommendations addressing the emerging themes from data.

CHAPTER 2 - RESEARCH METHODOLOGY

2.1 INTRODUCTION

The researcher gave a brief overview of the study in the previous chapter. The purpose of this chapter is to deal with the study's methodology. It describes how the chosen design was appropriate to capture the experiences of registered nurses regarding monitoring in clinics based in special schools in the Free State. Methodology details the research methods used, explaining why they were chosen. Ethical considerations related to the research are also addressed by methodology (Kumar *et al*., 2023:155). Durdella (2019:9) defines methodology as:

> *"A theory of how inquiry should proceed" that "involves analysis of the assumptions, principles, and procedures in a particular approach to inquiry (that, in turn, governs the use of particular methods)."*

The methodology chapter includes the research design and research technique. In-depth interviews were chosen to collect data. The strengths and limitations of this technique indicated its appropriateness for this study. The Methodology also includes the population, how participants are selected, the outcome of the exploratory interview, and data collection.

The section on data collection will be followed by a detailed discussion of the data analysis method, and how trustworthiness was upheld. The ethical considerations, including autonomy, beneficence, and justice, will be discussed, as well as how these were adhered to in order to protect the rights of the participants. The discussion will begin with the paradigmatic perspective of the researcher.

2.2 PARADIGMATIC PERSPECTIVE

Paradigm is of Greek origin, and means "pattern". American philosopher Thomas Kuhn was the first to use the term to signify a philosophical way of thinking (Kivunja & Kuyini, 2017:26). Paradigms are ideal ways of understanding reality, building knowledge, and gathering information about the world. These sets of beliefs are vital to understanding the research problem, question, design, and making sense of research results and findings (Durdella, 2019:90). Paradigms are a worldview that informs the interpretation of data (Kivunja & Kuyini, 2017:26). They underpin the key beliefs that guide researchers' actions, and are usually founded on philosophical assumptions such as ontology, epistemology, methodology, and axiology (Creswell & Poth, 2018:46).

A research paradigm is seen as the preferred approach to grasping reality, creating knowledge, and learning about the outside world. A paradigm is a group of discourses that together form the intellectual premises underpinning a particular point of view (Tracy, 2020:49). Another way of stating it is that a paradigm is a basic set of beliefs or assumptions adopted by a scientific community that defines the nature of the world and the place of individuals within it (O’Reilly & Kiyimba, 2015:3).

A paradigm is built on a specific philosophical framework that the researcher uses as their approach to qualitative research (Creswell & Poth, 2018:55). The paradigm chosen by the researcher is built on specific philosophical assumptions. The constructivism paradigm believes that individuals seek understanding and knowledge of the world they live in, through experiencing things and then reflecting on these experiences. The constructivist paradigm further states that people construct their own understanding and knowledge through social interaction and communication, where certain views and learning can occur (Tracy, 2020:51; Creswell & Poth, 2018:55). Constructivism is concerned with how the world is construed or constructed by the individual mind, a key concern being that actions are not based on the actual reality of the world, but rather on the meaning that those actions have for the individual (O’Reilly & Kiyimba, 2015:18). Thus, constructivism focuses on meaning-making, and emphasises the construction of social and psychological worlds through individual cognitive processes. The focus is on how the individual cognitively engages in the construction of knowledge (Durdella, 2019:91; O’Reilly & Kiyimba, 2015:18).

The philosophical assumptions and their application to the constructivist approach of this study were discussed in Chapter 1.

2.3 RESEARCH DESIGN

Research design is an important aspect of the research process. It serves as the blueprint for how a research study will be conducted. It seeks to strike a balance between its relevance to the research purpose, and its efficiency in terms of data collection and analysis (Kumar *et al*., 2023:75). Research demands careful planning and the execution of procedures that are relevant, appropriate, and justified. Its procedures should be carefully designed to optimise resource utilisation (Kumar *et al*., 2023:6). Research design is a term that refers to the entire process of research, from conceptualising a problem to writing the narrative, not simply the methods, such as data collection, analysis, and report writing (Creswell & Poth, 2018:378-379). In simple terms, the research design articulates the feasibility of the research (Durdella, 2019:10). Therefore, the experiences of registered nurses regarding monitoring in clinics in special schools in the Free State needed to be explored systematically and methodologically for the research to be credible.

A qualitative design, which is explorative and descriptive, was chosen for this research project. A qualitative research design refers to a systematic method used to explain events and situations from a person's point of view (Stenner *et al*., 2017:226). The objective of this qualitative study was to investigate and understand the significance that participants assign to their concerns (Creswell & Creswell, 2018:41). Finding significance in the participants' remarks and providing a description of the information that promotes a deeper comprehension of their experiences were the main objectives of a study (Grove & Gray, 2019:104). The main objective of the research design was to answer the research question:

> *What are the experiences of registered nurses regarding the monitoring of clinics based at special schools in the Free State?*

The purpose of this qualitative research included both exploring and describing phenomena. It aims to gain a deep understanding of people's experiences, meanings, and contexts, allowing for rich, detailed insights (Polit & Beck, 2021:530). Studies conducted utilising this approach are not exclusive to a specific type of research, rather, they are studies conducted for a specific objective that does not fit any other classification (Grove & Gray, 2019:104). Similarly, the researcher was exploring the experiences of registered nurses concerning monitoring in clinics based in special schools in the Free State, which is a topic that does not have much research background.

2.4 QUALITATIVE RESEARCH

Qualitative research is concerned with exploring and understanding the characteristics of the problem or phenomenon that cannot easily be quantified. This type of research is particularly relevant when investigating subjective experiences (Kumar *et al*., 2023:20). It is a systematic, interactive, and subjective approach that allows a researcher to gain insight into people's life experiences, and discover the meaning underlying these experiences (Burns *et al*., 2016:172). Furthermore, it helps to discover knowledge about the underlying meanings and experiences of the participants' viewpoints (Yin, 2016:7; Brink *et al*., 2018:121). Qualitative research mainly deals with real issues in a natural setting by making sense of people's life experiences about the problem under study (Creswell & Creswell, 2018:257). The researcher focused on the participants' viewpoints and relied on their recommendations to obtain the information needed to complete the research.

Qualitative research holistically examines a phenomenon under study to understand it better and discuss its qualities, features, or properties. It gives an in-depth examination and/or explanation of a phenomenon, which might be different from what quantitative research explains and provides (Creswell & Creswell, 2018:258). Qualitative research is concerned with exploring and understanding the problem or phenomenon (Moser & Korstjens, 2017:271), and it assisted in discovering knowledge about the underlying meanings and experiences of the participants' viewpoints (Yin, 2017:7; Brink *et al.*, 2018:121). The researcher focused on the participants' viewpoints and relied on their recommendations to obtain the needed information for the study.

Qualitative researchers are interested in understanding how people interpret their experiences, how they construct their worlds, and what meaning they attribute to their experiences (Sharan & Tisdell, 2016:6). In this study, a qualitative research project was performed because a problem or issue needed to be explored. This exploration was required to study a group or a population, identify variables that cannot be easily measured, or hear silenced voices (Durdella, 2019:5,8). Aother reason for conducting qualitative research was because the researcher needs a complex, detailed understanding of the issue. This could only be established by talking directly with participants, going to their homes or places of work, and allowing them to tell their experiences without expecting specific answers or responses (Creswell & Poth, 2018:77). During the interviews, the researcher provided participants ample time to express their experiences, intending to understand their experiences in their own context.

To conduct qualitative research requires a strong commitment to study a problem, and places demands of time and resources on the researcher. The following are issues that will impact a researcher doing a qualitative study:

The researcher has to commit to long periods in the field (Durdella, 2019:12). The researcher spent many hours in the field, collecting data through in-depth interviews, trying to gain access to schools and participants, and establishing a good relationship between himself, gatekeepers, and the participants. The process of data collection through in-depth interviews will be discussed later.

Engage in the complex, time-consuming process of data analysis (Mwita, 2022:622-23; Rahman, 2016:105). The researcher undertook the ambitious task of transcribing interviews, sorting through large amounts of data, and reducing them to a few themes or categories with the assistance of the supervisor and co-supervisor. This was a lonely time of pondering and making sense of the data for the researcher. The process of thematic data analysis will be discussed later.

Write lengthy and descriptive passages (Billups, 2021:4). The researcher presented the evidence in a way that substantiated the claims and reflected on multiple perspectives. The incorporation of quotes to provide participants’ perspectives also lengthened the study.

Attend to anticipated and developing ethical issues (Creswell & Poth, 2018:79). The researcher considered ethical issues that surfaced during the research and planned how to address these. Some of the participants were concerned with issues of privacy and confidentiality. Ethical considerations will be discussed later.

According to Gray *et al*. (2016:175), qualitative research hinges on subjectivity to understand human experience. This view motivated the researcher to use the subjective data collection method of in-depth interviews. The participants shared their experiences with the researcher, who then described the information through thematic analysis. In summary, the purpose of the qualitative study was to gain a deeper understanding of the subject. This understanding was based on the rich, detailed information gathered during the researcher's active participation in conducting in-depth interviews. The researcher's direct involvement allowed him to capture the full context and nuances of the information (Gray *et al*., 2016:175). In-depth interviews as a data collection method will later be discussed in detail.

2.4.1 Characteristics of Qualitative Research Design

The qualitative design has several characteristics.

Qualitative research studies real-world events in a real world (Burns *et al*., 2016:172). It involves the collection, interpretation, and presentation of data from various sources of evidence (Billups, 2021:3). It is flexible and capable of adjusting to what is found during data collection (Elfil & Negida, 2017:4). Qualitative research represents participants' viewpoints. It is holistic and strives to understand the whole (Billups, 2021:3-4). The researcher is the primary research instrument in qualitative research. This ensures that data is analysed descriptively. Themes are identified by using text analysis and interpreting findings (Polit & Beck, 2021:487).

This study observed the experiences of participants, who are registered nurses, regarding the monitoring they receive in clinics in special schools.

2.4.2 Strengths of Qualitative Research Design

Qualitative research has certain strengths and weaknesses. The strengths of qualitative research include the following, as mentioned by Mwita (2022:621-622), Rahman (2016:104) and (Babbie, 2016:353-357): it explores the research problem and focuses on an in-depth understanding of the central phenomenon, it produces a detailed description of participants' experiences, it is flexible and can be modified anytime, and it is relatively inexpensive compared to other research designs. Qualitative research design yields large volumes of data, compared to quantitative research (Babbie, 2016:353-357).

The research was conducted in a real-life situation, and in-depth interviews helped the researcher to understand the participants' experiences concerning the monitoring of clinics based at special schools (York, 2020:232). The purpose of the research was to understand the findings in the nurses' own context, rather than generalising them. The research design was also in line with the chosen paradigmatic perspective, as qualitative research is inductive in nature (Polit & Beck, 2021:530).

2.4.3 Weaknesses of Qualitative Research Design

In qualitative studies, the researcher usually relies more on participants' views than on literature about the topic. The research focus is also usually on one problem (Mwita, 2022:622; Rahman, 2016:105). Policymakers tend to give low credibility to results from qualitative research studies (Rahman, 2016:105). A smaller sample size raises the issue of generalisability to the whole population (Mwita, 2022:622), and data interpretation and analysis may be more complex and time-consuming (Mwita, 2022:622-23; Rahman, 2016:105). Anonymity cannot be guaranteed entirely, because the researcher comes into contact with the participants. Although participants might not be identified on paper, they might feel uncomfortable divulging sensitive data (Mwita, 2022:622).

Considering the purpose of the study, the researcher also adopted a descriptive and explorative design.

2.4.4 Descriptive Design

Descriptive research is often referred to as "ex post facto" research, which means “after the fact”. Meaning the researcher is looking back at something that has already happened to analyse potential causes and effects (Kumar *et al.*, 2023:17). Descriptive design is concerned with an in-depth description of individuals, groups, situations, events, or activities, providing information related to the research question. This description can provide accurate information related to the individuals' situation or perceptions related to specific activities (Polit & Beck, 2021:763). The researcher wanted to describe the experiences of registered nurses regarding the monitoring of clinics based in special schools.

2.4.5 Explorative Design

Exploratory research aims to fill the knowledge gaps on an unknown topic or to gain insights from different perspectives to generate new perceptions (Polit & Beck, 2021:18). In the early stages of a research study, it helps to establish priorities, operational definitions, and research designs. Explorative research starts with a general idea and adjusts its direction based on new data. This will lead to identifiable solutions (Kumar *et al.*, 2023:9).

By integrating both approaches, the researcher first explored the nurses' experiences to gather a broad understanding of the matter and then provided a detailed description of these experiences, capturing both the nuances and the context. This combination enhanced the depth and credibility of the research findings.

In summary, the chosen design was best suited to answer the research question. Subsequently, the data collection method will be described.

2.5 RESEARCH TECHNIQUE

Ly *et al.* (2020:4) and Hassan (2023:1) define research techniques as the various methods, processes, and tools used to collect, analyse, and interpret data to answer research questions or test hypotheses. Research techniques may include literature review, surveys, interviews, data analysis, and report writing. The researcher made use of individual face-to-face, in-depth interviews to collect data. Hoddy (2019:113) states that an interview is "a conversation with the participants aimed to gather descriptions of the life-world of the interviewee" in an attempt to better understand the described phenomenon.

During an in-depth interview, the interviewer asks specific open-ended questions that can be followed up by more probing questions (Brink *et al*., 2018:144; Kumar *et al*., 2023: 118). The benefit of in-depth interviews is that the researcher can explore a problem/concept in depth through the elicited opinions of the participants (Polit & Beck, 2021:519). In this study, the interviews provided richer information than closed or survey questions, while it afforded the participants the freedom of expression to provide as many responses, explanations, and illustrations as they wished (Polit & Beck, 2021:514).

2.5.1 Advantages of In-Depth Interviews

Various authors have mentioned the advantages of face-to-face interviews. In agreement with Vindrola-Padros and Johnson (2020:1598), in-depth interviews reduce time and cost, increase the amount of collected data, improve efficiency and accuracy, and help the researcher to become familiar with the narrated realities of the research participants. In face-to-face interviews, there is direct interaction between the researcher and the participants, which prevents delays arising from technical disruptions. In this study, the researcher took note of the participants' body language e.g. when they felt uncomfortable answering questions, their facial expressions, and other non-verbal gestures like using their hands, which enriched the researcher's interpretation of the issue under investigation and helped him to explore further through probing questions (Kumar *et al*., 2023: 119). A physical meeting with the participants created a safe and comfortable environment, which was critical in this case due to the nature of the research question (Saarijärvi & Bratt, 2021:394). In support of this view, Rahman *et al.* (2022:43) opine that compared to questionnaires, interviews help the researcher solicit narrative data to investigate people's views in greater depth about issues confronting them.

Hoddy (2019:113) suggests that interviews help the participants to speak freely and express their thoughts and feelings. Interviews allow for greater flexibility for both the interviewer and the participants regarding the planning, implementing, and organising of the interview content and questions (Elfil & Negida, 2017:4). In the researcher's experience, the nature of in-depth interviews allowed participants to be comfortable and express themselves freely. It provided flexibility in engagement with the participants, so much that even when the interviews ended, they still engaged the research question. The researcher that the interviews provided him with enough context of the participants' responses to the research question, as they gave examples in responding to the research question.

2.5.2 Limitations of In-depth Interviews

Fletcher (2016:182) suggests that face-to-face interviews could be time-consuming and expensive, as one must travel to meet the interviewee, increasing costs and risks such as personal safety in data collection. The researcher experienced that it was indeed expensive to conduct in-depth interviews, especially in terms of travel costs. For example, for one of the interviews, the researcher had to travel more than 500 kilometers, which was expensive in terms of petrol. Traveling also proved very time-consuming. Traveling long distances increased the risk of the personal safety of the researcher.

2.6 ROLE OF THE RESEARCHER

The researcher was actively involved in all of the research processes (Billups, 2021:24). This included the research planning process, the formulation of the information leaflet, consent form, and requests to the research ethics committee and gatekeepers, and the development of the budget (Mertens, 2015:326). The researcher was also responsible for organising the research itinerary (Creswell & Creswell, 2018:211). This involved providing the participants with information about the research, inviting them to contact the researcher if they had any queries, scheduling the in-depth interviews, organising sessions for data analysis with the co-coder, and organising the resources required for every step of the research process (Collins & Stockton, 2022:4).

During the data collection process, the researcher organised and facilitated the interviews, managed data collection, took field notes, recorded verbatim, and applied member checking (Mertens, 2015:326). Because the researcher was a former colleague of most of the participants, bracketing was applied to remove bias or undue influence towards the participants (York, 2020:456). Bracketing will be discussed further under the subtitle trustworthiness.

2.7 CONTEXT OF THE STUDY

The research was conducted in clinics in special clinics in the Free State, a province in the Republic of South Africa. The Free State has five districts, Motheo, Lejweleputswa, Xhariep, Thabo Mofutsanyane and Fezile Dabi. All the districts have special schools, but some have more than others. In addition, not all special schools in all districts have clinics in the school that provide health services. Most of the special schools that have clinics within the schools are located in the Motheo and Lejweleputswa districts. The researcher chose to conduct this research in the Free State because he resides in the Lejweleputswa district in the Free State. It was convenient for the researcher to sample the population of nurses working in clinics in special schools. The researcher previously worked in a clinic in a special school in the Free State for three years. Chapter 1 provided some background information regarding special schools.

Below is a map of the Free State and its districts.

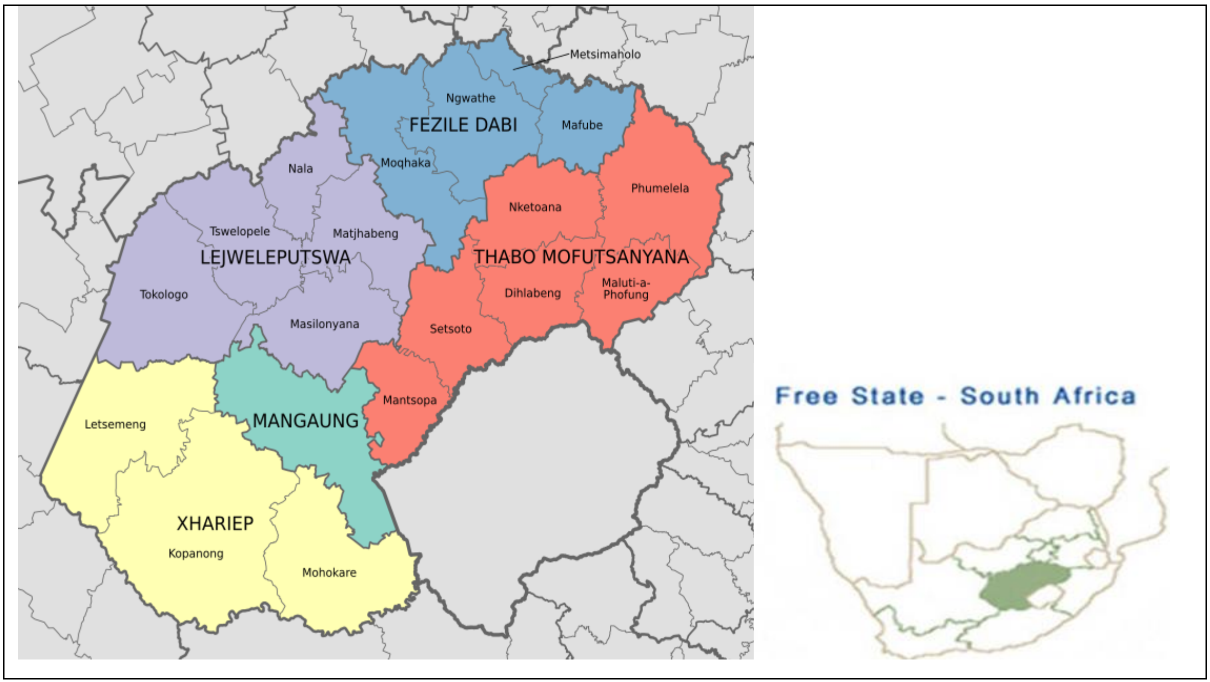

Figure 2.1 ***Map of the Free State*** (WeatherSA, 2016)

The findings of the study may have meaning to others in similar situations (Vindrola-Padros & Johnson, 2020:1598). A detailed discussion of the context and background of the study is discussed in Chapter 1.

2.8 POPULATION

The population is the total group of people in which the researcher is interested (Dibley *et al*., 2020:53). They share the characteristics needed to participate in a study. They can provide information based on their knowledge or experience about the subject under investigation, and should represent the entire population (Polit & Beck, 2021:273; Miller *et al*., 2021:1). The complete group of people or other discrete study units are therefore considered the target population (Wilson & Joye, 2017:73). Nurses working in specialised school-based clinics in the South African province of the Free State formed the population for this study.

Although there are 19 special schools in the Free State, only 12 special schools had registered nurses at the time of data collection. Therefore, the focus was on the 12 special schools with registered nurses. The 12 special schools have 13 registered nurses in total, which formed the target population. Data was collected from nine registered nurses in nine clinics based in special schools in the Free State. Data saturation was reached after interviews with nine participants, so there was no need to continue with data collection.

2.9 UNIT OF ANALYSIS

The potential population of participants that could be included in the study, based on the particular selection criteria, is referred to as the unit of analysis (Brink *et al.*, 2018:116). The unit of analysis refers to the same principle as sampling in quantitative data (Creswell & Creswell, 2018:216). To select the right participants for the research, the researcher set inclusion and exclusion criteria (Polit & Beck, 2021:261). Only registered nurses were included in the study. The inclusion criteria comprised registered nurses working in special schools in the Free State, and who spoke English. The interviews were conducted in English.

2.10 PURPOSIVE SAMPLING

Research often involves dividing a population into smaller samples based on resource availability. These samples are considered representative of the entire population, and findings from them should apply to the broader group (Kumar *et al.*, 2023:5). Sampling doesn’t only refer to choosing people to interview, but also to selecting specific locations and times to conduct interviews (Tracy, 2020:82). Sampling is a fundamental element of research, and the choice of the right sampling method can significantly influence the validity of the research findings (Kumar *et al.*, 2023:145).

Purposive sampling is an approach used to purposefully select individuals who will be able to contribute relevant data to the study (Polit & Beck, 2021:517). A purposive selection includes participants with knowledge and experience related to the problem of interest (Kumar *et al.*, 2023: 149). The selection of participants is guided by the inclusion criteria, and based on their knowledge and experience regarding the topic under study (Botma *et al.*, 2022:201; Polit & Beck, 2021:279; Brink *et al.*, 2018:141). Tracy (2020:82) argues that good qualitative research applies purposive sampling because it purposefully chooses data that fit the parameters of the project's research questions, goals, and purposes. Purposive sampling involves specific criteria for including or excluding participants (Kumar *et al.*, 2023:149-150)

Registered nurses who met the stipulated inclusion criteria were selected to participate in the study. RNs were purposefully chosen to participate as they would be able to supply the necessary information related to the research problem due to their experience working in clinics based in special schools. The selection of the population was suitable because the RNs had experience regarding the topic explored in the study.

2.10.1 Inclusion and Exclusion Criteria

INCLUSION CRITERIA

- All registered nurses working in special schools registered with the South African Nursing Council
- Registered nurses who could speak English

EXCLUSION CRITERIA

- All other categories of nurses.

2.11 EXPLORATIVE INTERVIEW

An explorative interview, also referred to as a pilot study, especially in quantitative research, is an interview conducted before the research study to test the practical aspects of the research (Brink *et al.*, 2018:161). An explorative interview is done by using an individual who meets the same criteria as the participants of the research

(Polit & Beck, 2021:633). Such an interview intends to confirm the feasibility of the research in order to detect any possible flaws in the data collection process. Such flaws should be corrected before the actual research study can be conducted (Brink *et al*., 2018:161).

The interviewer in qualitative research should be competent in this method of data collection (Botma *et al*., 2022:8). The explorative interviews, therefore, took place in the presence of an experienced interviewer with recognised publications, who had personal experience with in-depth interviews and could give feedback on the researcher's interviewing skills. Two explorative interviews were done to assess the research question. Conducting explorative interviews in the presence of an experienced interviewer prepared the researcher for the rest of the interviews, and gave the researcher ample time to correct any possible mistakes identified before continuing with the research project (Polit & Beck, 2021:633). The researcher conducted interviews with two participants who met the inclusion criteria (Brink *et al*., 2018:144). As a result of the explorative interviews, the research question was simplified in layman's language, with the intent of eliminating ambiguity. Cohen *et al.* (2018: 509) suggest that every respondent should understand the research question in the same way. Therefore, the research question was simplified to:

> *What is your experience regarding the monitoring or supervision you received since you have been working in a clinic in a special school?*

No other corrections were made to the interview process in response to the feedback from the explorative interviews. The data from the two explorative interviews formed part of the main study data, as there were no changes to the interview questions following the explorative interviews (Brink *et al*., 2018:161)

2.12 DATA COLLECTION PROCESS

Data collection is the selection and production of material for analysing and understanding collective experiences, and the related meaning-making processes (Polit & Beck, 2021:530). Qualitative data collection is applied to discover and describe issues in the field or structures and processes in routines and practices. Qualitative data collection can be done by talking, listening, observing, or analysing materials.

The aim is often to arrive at information that allows for producing generalisable statements, by analysing and comparing various examples, phenomena, or cases (Flick, 2018:15).

Data was collected in April 2024 through in-depth interviews. Before data could be collected, approval had to be granted by the Free State Department of Education, as a prerequisite for ethical clearance (see Addendum C). Ethical clearance was also provided by the UFS via the Health Sciences Research Ethics Committee (HSREC). A consent form (see Addendum A), information leaflet (see Addendum B), and approval from the DoE (see Addendum C), were attached to a letter written to the principals of the special schools (see Addendum D) as gatekeepers, explaining the research process, the ethical considerations related to the research, and a request to contact the participants. Also attached to the letter was the ethical clearance (Addendum E), which the principals were requested to share with the participants. In a letter written to principals (Addendum D), the researcher provided his telephone number and e-mail address, to enable interested nurses to contact him directly. After confirmation of participation, the researcher called the participants and arranged for the interviews to be done at the convenience of the participants. The researcher discussed the consent form (see Addendum A) and information leaflet (see Addendum B) with the participants while making interview arrangements, and again just before conducting the interviews to explain the research purpose, objective, ethical considerations, and benefits to the participants, as indicated on the participants' information leaflet (see Addendum B). This allowed the participants to understand the reason behind the research, and motivated them to give valuable information about their experiences regarding monitoring in clinics based in special schools, thus enriching the quality of the data. Before the start of the interview, each participant signed an informed consent form (see Addendum A), approved by the HSREC. Participants were made aware that they were free to withdraw from the research at any time without incurring any penalties. The researcher conducted the individual face-to-face in-depth interviews, and audio recorded them using the Otter application. Otter is an artificial intelligence application that can record and transcribe interviews in real time. Although Otter can transcribe in real time, the researcher did quality checks and corrected interview transcriptions.

During the in-depth interviews, the researcher asked the simplified research question to the participants and took field notes while recording the conversation. The open-ended question asked was as follows:

> *What is your experience regarding the monitoring or supervision you received since you started working in a clinic in a special school?*

Probing questions such as "tell me more…" or “can you please explain…”, followed the responses of the participants, which aided the data-gathering process.

On average, each interview took about 30 minutes. Confidentiality was assured by replacing the participants’ names with numbers. No incentives were given to the participants. During interviews, the researcher had the opportunity to listen to the participants describe their experiences. The researcher minimally guided rather than directed or controlled the conversation to explore the areas of interest.

Data saturation occurs when no new information is obtained from interviews (Hennink & Kaiser, 2022:1; Gill, 2020:580). Data saturation was reached after nine in-depth interviews had been conducted. The in-depth interviews assisted the researcher in acquiring valuable information from the participants and in answering the research question, which enhanced the credibility and reliability of the data. The researcher verified the information and clarified any unclear statements made during the interview process.

2.12.1 Field Notes

Polit and Beck (2021:728), as well as Creswell and Poth (2018:228), indicate that field notes are essential to qualitative data collection. They describe it as a researcher's record of what was observed and heard during interviews, in order to secure data for future use. It becomes the backbone for data analysis and serves as a memory tool. Field notes usually capture actual discussions and communication, the participants' attitudes, perceptions, personal feelings, quotes, easily forgotten details, emotional reactions, ideas, impressions, reflections, and conclusions (Polit & Beck, 2021:549). The researcher used a notebook to capture the participants’ emotional reactions that could not be verbally recorded and were not evident from the verbal information. These included incidences seen, experienced, and observed during the interview, which assisted the researcher in the data analysis and description processes. Phillippi and Lauderdale (2018:1) suggest that field notes are essential and widely recommended in qualitative research for documenting essential contextual information, ensuring that rich research data about the context persist beyond the original researcher. It also guides researchers to probe further and to validate information, thus enhancing the credibility and trustworthiness of the study's outcome. The researcher noted down non-verbal reactions as the field notes in English, including eye contact, facial expressions, and mouth, shoulder, and leg movements. Polit and Beck (2021:548) suggest that the researcher should objectively record these non-verbal actions during the interview. The field notes taken during the interview assisted the researcher in describing the non-verbal communication of the findings that could not be part of the recorded data, adding richness, credibility, and trustworthiness to the study's findings. Such non-verbal cues were included in the transcriptions. After including data from the field notes in the transcriptions, the notes were destroyed.

2.13 DATA ANALYSIS

Qualitative data analysis is the process of making sense of the experiences of the participants, and it includes combining, simplifying, and interpreting what the participants said during the in-depth interviews, along with what the researcher saw (Brink *et al*., 2018:180; Polit & Beck, 2021:486; Sharan & Tisdell, 2016:202). According to Polit & Beck (2017:530), analysing data aims to consolidate, arrange, and elicit meaning from data and the process of making meaning produces the findings of the study. Sharan and Tisdell (2016:202) state that the process of analysing data should not be mechanical, but rather "inductive, thinking, and theorizing”. Sharan and Tisdell (2016:202) further suggest that, because the nature of qualitative data analysis is primarily intuitive and inductive, the researcher mostly decides to analyse and code the data himself, with the assistance of the supervisor, co-supervisor, and the expert in-depth interviewer. Brink *et al*. (2018:180), however, suggest that ideally, the techniques to be used for data analysis should be known before the commencement of the project. The volume of data collected can be reduced through the categorisation and consolidation of related themes (Ignatow & Mihalcea, 2018:147). This enables the researcher to interpret the findings of the research (York, 2020:447).

Thematic data analysis was applied in this study. The term thematic data analysis refers to forms of qualitative data analysis that mainly focus on identifying, organising, and interpreting themes in textual data (Brink *et al*., 2018:180). Themes are further defined as 'recurrent and distinctive features of participants' accounts, characterizing particular perceptions and/or experiences, which the researcher sees as relevant to the research question' (Polit & Beck, 2021:536). To further unpack this definition, the first element is that a theme is intrinsically recurrent – something distinctive and characteristic of a particular research text (King & Brooks, 2018). Thematic data analysis is a method that is widely used in qualitative research and is a basic method that is used to identify and analyse patterns (Brink *et al*., 2018:180).

Literature on thematic analysis commonly refers to 'codes' and 'coding' as well as themes. 'Code' refers to short comments or abbreviations linked to passages of text to indicate material of relevance to the research aims (Polit & Beck, 2021:538). Coding is the process of indexing text with codes and, in due course, themes (Kirner & Mills, 2020:159). For instance, when the participants mentioned emotional responses, or where they spoke of issues related to infrastructure, these were assigned a code, highlighted in a colour related to the code, and labelled with segments of text with codes that represented their content. These were either descriptive, for example, "peer support," or interpretive, for example, "relevant bodies involved in monitoring."

As Creswell and Creswell (2018:267) suggest, data analysis occurred concurrently with data collection. The interviews were audio-recorded and were transcribed in English. The researcher recorded the interviews through Otter. Otter is a computer app that records and automatically transcribes recordings. The app was uploaded on a password-protected digital device. Due to some inaccuracies in the Otter transcription, the researcher did quality checks on the transcriptions and corrected them where needed. Thematic data analysis was used to review the transcripts and discourse analysis by following the steps in Creswell and Creswell's (2018:272) method of data analysis, as illustrated in Table 2.1 below.

2.14 STEPS FOLLOWED IN THEMATIC DATA ANALYSIS

Table 2.1: ***Qualitative data analysis***

Steps of data analysis	Actions
1. Organise data for analysis.	This was done by the researcher transcribing interviews, visually scanning notes, capturing field notes, and categorising the data into different types.
2. Read through all the data	The researcher, supervisors, and co-coder made sense of the data to get the general logic of the data, and to understand the general ideas that the participants were sharing.
3. Coding of all the data	The researcher, supervisors, and co-coder compared the coding information to confirm the content. An independent co-coder can assist with peer debriefing or member checking to ensure the codes accurately represent the data.
4. Create a description of the themes and categories for examination using the coding method.	Words that were coded with the same meaning were grouped together under themes. After initial codes were created, they were moved to focused coding, where the researcher refined and categorised these codes into broader themes. This helped in grouping similar concepts together, which guided the analysis and helped to answer the research question.
5. Present conclusions	The researcher presented the conclusions after exhaustive discussion with the supervisor and co-coder, by quoting the participants to transmit the findings of the analysis.
6. Interpret data	The researcher discussed the findings based on the research question and indicated the significance of the findings.

(Creswell & Creswell, 2018:272)

In conclusion, the researcher could gather rich information about the research question from the interviews on the participants' experiences. By doing so, the researcher could check whether the research question was answered. The research findings will be discussed in Chapter 3.

2.15 TRUSTWORTHINESS OF DATA

In qualitative research, the researcher's goal is to uphold the quality of the study and to ensure that the findings accurately reflect the data (Billups, 2021:27). Trustworthiness refers to the attainment of value, genuineness, and honesty in qualitative research findings (Brink *et al*., 2018:157). Rigor in trustworthiness means being careful, precise, and accurate. Rigor is to accurately represent the experiences of the participants (Cypress, 2017).

The interviewer can have a significant influence on the participants in face-to-face interviews. In this case, the researcher, who also acted as an interviewer, used to be a colleague of some of the participants. To remove bias, the researcher applied bracketing. Researchers often use bracketing to hold back their own beliefs about a phenomenon (Polit & Beck, 2021:567). The researcher set aside his own experiences and concentrated on the perspectives of the participants to avoid bias. The personal values of the researcher were clarified, and areas of possible pre-conceived ideas were bracketed by the researcher. This included the recognition of any feelings that the researcher had that might have influenced a lack of neutrality regarding the phenomenon (Brink *et al*., 2018:159; Polit & Beck, 2021:567). This helped the researcher to avoid data contamination (Brink *et al*., 2018:82). The researcher used a reflective journal to give an accurate description of the participants' experiences, which helped the researcher to avoid his own opinions about the phenomenon, and apply bracketing. The researcher described new or surprising discoveries in collecting and analysing data (Vagle, 2018:16). Through the participant's descriptions of their experiences, the researcher was able to acquire a deeper understanding of the participants' experiences regarding the monitoring provided to them in clinics based in special schools.

Polit and Beck (2021:568) specifically created principles for scrutinising the quality and trustworthiness of research. The principles that contribute to rigor include credibility, dependability, confirmability, and transferability.

2.15.1 Credibility

Credibility is the extent to which the analysis of findings can be considered to be trustworthy. Achieving credibility depends on using reliable sources, accurate references, and sound research procedures. Research based on primary data sources is typically more credible than research relying solely on secondary data, as primary data carries higher reliability (Kumar *et al*., 2023:7). Credibility describes the truth-value of research data, using appropriate methods to answer the research question, spending acceptable time investigating the phenomenon in the field, verifying data, and eliminating the researcher’s personal biases (Cypress, 2017:256). Credibility can be described as having confidence in the 'truth' of the findings (Kyngäs *et al*., 2020:1).

Rapport and trust were created between the researcher and the participants. Prolonged engagement and rapport-building contributed to the understanding of the study's context researcher (Polit & Beck, 2021:569).

In this regard, the researcher engaged with the participants from the beginning of the project. By introducing the research topic and the processes to be expected, the researcher gave participants the opportunity to ask questions that they didn’t understand. He further clarified ethical considerations where participants had concerns, particularly regarding issues of confidentiality. This gave the researcher an opportunity to build rapport with participants.

2.15.2 Dependability

Dependability is the long-term stability of the study data. If a similar study is conducted, the results should be the same (Billups, 2021:30). A logical, well-documented, and inspected research procedure should be prioritised by the researcher (Polit & Beck, 2021:569). The researcher entered the collected data and field notes into a password-protected laptop and later on Figshare and meticulously recorded each step of the research process.

Dependability or consistency of qualitative data refers to the extent to which data from a qualitative study will stay true over time. This is done by using replication, where researchers use different data sources to compare the results (Ghafouri & Ofoghi, 2016:1917). Kyngäs *et al*. (2020:1) describe dependability as consistency in the findings that could be replicated when all the research data and documents are subjected to comprehensive evaluation by a supervisory committee or other researchers. Truthfulness was upheld by keeping detailed records and transcriptions, and all information was shared and checked by the supervisor and co-supervisor.

2.15.3 Confirmability

Confirmability is the term used to describe the data's objectivity, accuracy, and ability to accurately reflect the information provided by the participants (Billups, 2021:30; Polit & Beck, 2021:570). For validation, the data gathering procedure, including the field notes, were reviewed more than once (Billups, 2021:31).

Ghafouri and Ofoghi (2016:1917) define confirmability as the extent to which others could confirm the research findings regarding the information gathered in a research process. Toews *et al*. (2017:135), however, describe confirmability as the degree to which the researcher can demonstrate the neutrality of the interpretation of the research findings by doing a confirmability audit. An audit trail refers to the researcher keeping thorough records of the research procedure. This helps to evaluate the accuracy of the results, and the honesty of the participants' views, and allows other parties to evaluate the relevance of the research data. The supervisors' verification of the research process, the recordings, transcripts, and field notes were therefore kept safe on a password-protected laptop for future evaluation by reviewers, if required.

2.15.4 Transferability

Transferability is the degree to which study findings can be used or applied to different people or contexts (Polit & Beck, 2021:570). A thorough description will be used to assure that, should the research be repeated, the same data will probably be gathered and the same findings reached (Billups, 2021:30).

Transferability refers to which research findings are useful and relevant to populations in other settings (Polit & Beck, 2017:122). Ghafouri and Ofoghi (2016:1917) describe transferability as the fact that the current research findings will be the same as a similar study in a similar setting. Transferability also means that research findings are applicable in other contexts (Kyngäs *et al*., 2020:1).

2.16 ETHICAL CONSIDERATIONS

The Singapore Statement (2011) declares that researchers should take responsibility for the validity and trustworthiness of their research. Therefore, research integrity is an ethical requirement (NHREC, 2015). Ethics should be integrated into every phase and aspect of research, from conceptualisation, planning and implementation, up to writing the report and disseminating the results. It is the responsibility of the researcher to ensure the safety of and rights of participants in research studies are preserved (Botma *et al*., 2022:6).

Research involving humans is rarely, if ever, conducted in isolation. Collaboration between the researcher and relevant stakeholders should be considered from the start of the research to minimise the possibility of exploitation or any form of social harm. The researcher should identify possible stakeholders or gatekeepers in the research (Botma *et al*., 2022:7). It is important for the researcher to involve them from the beginning because it would reduce the possible resistance to participate in the research, it will develop harmony between the researcher and stakeholders, and it might increase the possibility of the research findings being implemented (Botma *et al*., 2022:7). Therefore, it was important for the researcher to request approval from Free State Department of Education, principals of the respective schools and the registered nurses who would potentially become research participants.

According to Polit and Beck (2021:137), care must be taken to ensure that the rights of participants are protected, especially when humans are used as study participants. The researcher started by applying for ethical approval from the Health Sciences Research Ethics Committee (HSREC) at the University of Free State (UFS) and only commenced data collection after the ethical approval had been received. The primary function of an ethics committee is to protect both the researcher and the participant. It fulfills this function by reviewing the research proposal for sound scientific methodology, validity, and social value. The Research Ethics Committee also scrutinises the informed consent process. The HSREC also has a monitoring function, and it may stop research when there is misconduct by the researcher or when the potential harm exceeds the potential benefits. Furthermore, ethics committees must hold researchers accountable for their research activities (Botma *et al*., 2022:17).

The extent of the research determines whether permission must be obtained at the district, provincial, or national level. The chief executive officer of the specific institution, as well as the head of the department where the research will be conducted, should give permission (Botma *et al*., 2022:17). As a prerequisite to attain HSREC approval for data collection, approval from the Free State Department of Education was required and provided.

Before the researcher can enrol participants into study, the researcher needs to access the target population. The relevant stakeholders may pave the way for accessing the target population (Botma *et al*., 2022:18). After attaining approval from the HSREC and the Free State Department of Education to collect data, the principals of each individual school were sent all the necessary documents to give to the registered nurses. It has to be mentioned that, unfortunately, the list of emails provided by the provincial Department of Education was incorrect. Therefore, some of the documents had to be hand-delivered to the principals.

Ethical principles including autonomy, beneficence and justice were applied to minimise harm to participants as far as possible throughout the research process (Wilson & Joye, 2017:17).

A researcher needs to ensure that his actions during the research process are ethical (Rubin & Babbie, 2017:83). During the course of this research, the researcher took the necessary measures to protect the participants. These ethical considerations refer to the adherence to moral principles throughout the research process. The Belmont Report describes three primary principles to guide ethical conduct in research (Babbie, 2016:63; Burns *et al*., 2015:98; Polit & Beck, 2021:152). These ethical principles, namely beneficence, autonomy (respect for human dignity), and justice, as well as other specific measures that the researcher adhered to during the research, are discussed in the following sections

According to Polit and Beck (2021:137), care must be taken to ensure that the rights of research participants are protected, especially when humans are used as study participants. The researcher first applied for ethical approval from the Health Sciences Research Ethics Committee (HSREC) at the University of Free State (UFS), and data collection only commenced after the ethical approval was received. As already alluded to, approval to collect data was requested from the relevant gatekeepers in the Department of Education, including the principals of the special schools.

2.16.1 Ethical Approval and Permission to Access Participants

The research proposal was evaluated by a research review committee at the UFS School of Nursing. Approval to conduct the research was obtained from the Head of the School of Nursing. The relevant ethical clearance was obtained. Approval to perform the study was obtained from the Health Sciences Research Ethics Committee (HSREC) of the UFS (Addendum E). Further permission to conduct the research was obtained from the Free State Department of Education (Addendum C). Letters to the principals were sent or given to each special school (Addendum D), which included all necessary documents to participants, including an information leaflet and a consent form.

2.16.2. Informed Consent

An informed consent form was developed, which participants were expected to sign before participating in the research (Addendum A). The purpose of informed consent is to protect the participants from any form of harm and to make participants aware that research participation is voluntary (Polit & Beck, 2021:137). There are three major elements that informed consent should adhere to, namely information about the study, the degree of understanding of the research participants concerning the research before they give informed consent, and that participants have a choice to participate or not in the research, without any fear of penalty (Brink *et al*., 2018:29).

Autonomy or self-determination is the underlying principle of informed consent (Bromwich & Rid, 2015). The associated values are respect and honesty. Obtaining informed consent is not a quick signature on a document; it is a process that starts during recruitment, although procedures and results may necessitate obtaining consent during the study (Petrova *et al*., 2016). Informed consent is an iterative conversational process with consideration of the complexity of the context (Dove *et al*., 2017), and comprises four elements, namely disclosure, comprehension, voluntariness, and documentation (Botma *et al*., 2022:19-20).

In this study, information about the project that was shared with the participants included the title of the research, introduction, and background of the research, purpose of the research, population and sampling rationale, data collection methods, risks involved, anonymity and confidentiality, details of the POPI Act, the voluntary nature of participation in the research project, the offer by the researcher to answer any questions the participants might have concerning the research, contact details of the researcher, and space for the signatures of the researcher, participants, and witnesses (Brink *et al*., 2018:29; RSA 2013; Polit & Beck, 2021:139).

Coercion and undue influence are threats to voluntary participation during the recruitment phase of the research project. Coercion occurs when the researcher threatens to harm the potential participant should they decide not to participate. Undue influence is when the researcher offers the potential participant an excessive, unwarranted reward to obtain compliance (Largent & Lynch, 2017). Consent to participate in this research was given voluntarily. Voluntary informed consent from participants involved them signing a written statement after ensuring that they understood the purpose and nature of the research, and their role in it (Babbie, 2016:64; Yin, 2016:49).

The researcher provided the participants with thorough information about what the study would entail so that they could decide for themselves whether they wanted to participate. An overview of the study and its purpose was offered to the participants to explain what was required from them. The researcher arranged an information session with the principals and registered nurses of the various special schools to inform them of the proposed study and to invite them to participate. Unfortunately, not all principals were able to attend due to their busy schedules. Approval from the HSREC, approval from the Free State Department of Education, an information leaflet, a consent form, and a letter to the principals were provided to the principals for distribution to all registered nurses who met the inclusion criteria. The information leaflet also contained the contact details of the researcher.

The researcher explained to the participants that they could withdraw from the project at any stage should they feel uncomfortable. This could be done without being victimised in any way. They were also informed that there were no monetary benefits related to participation in the study (Polit & Beck, 2021:158).

2.16.3 Confidentiality

Respect for people is demonstrated by maintaining anonymity and confidentiality. Anonymity means that even the researcher cannot link a response to a specific participant. Anonymity cannot wholly be achieved in qualitative studies because qualitative data collection involves face-to-face techniques, such as in-depth interviews. Confidentiality pertains to how the researcher manages personal information to ensure that only the researchers directly involved in the study have access to the information, and that information is not willingly or unintentionally shared with other people unless the participant has consented to share the information (Botma *et al*., 2022:22).

The participants in this study had the right to expect that the data they provided would be kept in the strictest confidence (Babbie, 2016:65). The participants were also assured that they would not have to disclose any information that might make them feel uncomfortable. The researcher committed to not disclosing any information that could lead to the identification of the participants (Yin, 2016:49). The interviews were conducted in such a way that no names could be linked to the collected data (Waggoner *et al*., 2016:664).

Safeguarding measures can be put in place to secure collected data, such as password protection for electronic data and keeping hard copies locked away (Petrova *et al*., 2016). All electronic documents, including transcripts of interviews and signed consent forms, will be kept on a password-protected laptop in the office of the research supervisor, from where the documents will later be uploaded onto the institutional storage space Figshare, which is an encrypted application for safekeeping and maintaining confidentiality.

2.17 THE BELMONT REPORT ETHICAL PRINCIPLES

2.17.1 Autonomy

Participants were made aware that their participation in the study was voluntary, and that their information would be treated with confidentiality (Farmer & Farmer, 2021:26; Wilson & Joye, 2017:21). No names appeared anywhere, and no information was linked to a specific participant. The participants were free to leave at any moment without incurring any penalties (Polit & Beck, 2021:141). The participants received an information leaflet. The research and its purpose were explained to participants to their full understanding. Participants were allowed to ask questions before they consented to participate in the interviews (Brink *et al.*, 2018:29). Some participants were concerned that the information they provided would identify them, which caused some anxiety to some participants. The researcher continuously engaged with the participants to allay their fears in this regard.

2.17.2 Beneficence

The research process should be structured in such a way that no harm should be done to participants (Farmer & Farmer, 2021:25; Polit & Beck, 2021:133). The anticipated benefits should also outweigh the potential harm (NHREC, 2015).

The research process was structured in a way that would prevent any harm to the participants. The benefit and risk ratio concerning the participants in this study is detailed in the table below. The purpose of the risk/benefit assessment was to determine whether the benefits of the study outweighed the risks (Polit & Beck, 2021:136-137; Brink *et al.*, 2018:35). Benefits in research can take different forms.

Although the benefit/risk ratio is more applicable in quantitative research because the qualitative research process is relatively unpredictable, the researcher anticipated that the benefits would outweigh the risks in this study (Farmer & Farmer, 2021:25). The researcher anticipated that the benefits and risks would be personal, and they were addressed by the researcher as proposed (Polit & Beck, 2021:136).

Table 2.2: ***Benefit/Risk Ratio Table***

Benefit	Risk
Benefits to society: the results of the research could assist in improving the quality of healthcare received by the community, especially vulnerable groups in special schools, such as disabled children. **Psychosocial benefit:** the results of the research could assist in improving the monitoring of clinics based in special schools. **Institutional benefit:** the study could assist in increasing the research capacity of the DoE and DoH. **Benefit to the researcher:** the researcher might be recognised as a competent researcher by peers.	There was low trivial harm, which was possibly temporary emotional discomfort to participants.

(Polit & Beck, 2021:136-137; Brink *et al.*, 2018:35).

There was minimal risk concerning the research, as there were no vulnerable groups involved, and no sensitive information was divulged (Bracken-Roche *et al.,* 2017:6; Gehlert & Mozersky, 2018:31-32, Wilson & Joye, 2017:17). The participants were briefed on what to expect during interviews (Farmer & Farmer, 2021:25) before the commencement of data collection.

Any health needs of the participants should be anticipated, and treatment options must be made available (CIOMS, 2016). An arrangement was made with the social workers of all the involved schools to be on hand for counseling if the need arose. No participant became uncomfortable to the point that they could not continue with the interview, and none of the participants requested the services of the social worker (Brink *et al.*, 2018:29; Polit & Beck, 2021:143).

2.17.3 Justice

The selection of the participants should be done fairly, without any form of bias (Brink *et al.*, 2018:30). The principle of distributive justice requires, on the one hand, that a specific group should not be 'over-researched' and, on the other hand, that other groups should not be deprived of the opportunity to participate in research (CIOMS, 2016). Privacy and confidentiality should always be maintained, and only the research team should have access to the data (Farmer & Farmer, 2021:26; Wilson & Joye, 2017:21). Anonymity is not guaranteed in a qualitative study. Code names should therefore be assigned to participants, and their real names should never be used in the study, to prevent identification (Farmer & Farmer, 2021:26; Polit & Beck, 2021:141; Wilson & Joye, 2017:21).

In this research, participants were purposefully selected because of their experience of working in clinics in special schools. They were selected fairly without any bias. An invitation to participate in the research was extended to all registered nurses who matched the inclusion and exclusion criteria. Data were kept private and confidential. Data were kept in a password-protected laptop and later uploaded onto Figshare. The participants' names were never mentioned in the data, not even in the recordings.

2.18 CONCLUSION

Chapter 2 outlined the methodology of the study, starting with the paradigm that guided the research design, followed by the research techniques, the context of the study, the chosen population, and the processes of data collection and analysis. The Chapter concluded by discussing data trustworthiness and the ethical considerations applied during the research. Chapter 3 will focus on the study's findings and the discussion of those findings.

CHAPTER 3 : RESEARCH FINDINGS

The previous chapter discussed the design and methods applied to explore the experiences of registered nurses regarding the monitoring of clinics based at special schools in the Free State. The findings of the exploration will be described in this chapter. Data were collected using individual face-to-face, in-depth interviews. All the participants were individually asked the following question:

> *What is your experience regarding the monitoring or supervision you received while working in a clinic in a special school?*

This chapter includes the general overview and demographics of participants, as well as the description of the findings according to the final list of themes and sub-themes presented in Table 3.1. The themes emanated from the data from the individual in-depth interviews conducted with registered nurses working in clinics based in special schools in the Free State. The nine participants shared their stories, and these were utilised, along with relevant literature and personal quotes, to enhance the comprehensive analysis of the themes and sub-themes. Direct quotes will be italicised. To uphold confidentiality, each participant was assigned a number to be used instead of their name.

3.1 GENERAL OVERVIEW OF DATA

The research findings involved nine professional nurses who emphasised poor collaboration between governing bodies and departments overseeing health services in special school clinics in the Free State. Some nurses were excited to share their experiences, but others were initially hesitant and anxious. Their reluctance was due to fears that their information might lead to repercussions in the workplace. However, the researcher's assurance of confidentiality allowed them to speak freely and to feel listened to. They shared the lack of monitoring of services in the clinics, and although some of the school principals supported them regarding physical needs, their perspective focused on the educational environment. They had little knowledge about the scope of nursing and the nurses' role within the school. Inclusion in the School Management Team was also limited, and they felt disowned and not supported by the Department of Health. They seldomly received training on new guidelines implemented in healthcare, so they felt as if they experienced litte professional development. Feelings of being neglected and uninformed obliged them to establish their own support strategies. These strategies included peer support groups, and seeking help from Primary Health Care clinics in their districts as well as from private practitioners. The summary follows the same sequence as the data-finding table, while a description of the demographic data of the participants follows below.

3.2 DEMOGRAPHIC DATA OF THE PARTICIPANTS

Table 3.1 represents the demographic data of the participants.

By the time ethical clearance was granted, one registered nurse had retired, and the invitation to participate was extended to 12 special schools in the Free State. Data was collected from nine (9) registered nurses. The other three registered nurses were excluded because data saturation was achieved after nine in-depth interviews. The registered nurses that were interviewed were from the Motheo and Lejweleputswa districts in the Free State. The demographic data included age, race, sex, and years of work experience in the clinic at a special school in the Motheo and Lejweleputswa districts of the Free State. The years of experience working as a nurse in a clinic in special schools ranged from five months to 26 years.

Table 3.1: ***Demographic data of participants***

PARTICIPANT	SEX	YEARS OF EXPERIENCE AS A REGISTERED NURSE	YEARS OF EXPERIENCE WORKING IN CLINICS IN SPECIAL SCHOOLS
Participant 1	Female	11 years	5 years
Participant 2	Female	28 years	18 years
Participant 3	Female	32 years	11 years
Participant 4	Female	42 years	24 years
Participant 5	Female	43 years	23 years
Participant 6	Female	34 years	26 years
Participant 7	Female	13 years	10 years

Participant 8	Female	28 years	5 months
Participant 9	Male	20 years	9 years

3.3 RESEARCH FINDINGS

Table 3.2 reflects the themes and sub-themes of the research findings as they emerged from participant interviews.

Table 3.2: ***Research themes and sub-themes***

Themes	Sub-themes
Theme 1: Departmental challenges associated with a lack of monitoring in clinics based at special schools.	1.1 Monitoring challenges related to DoE
	1.2 Monitoring challenges related to DoH
Theme 2: Effects of a lack of monitoring in clinics based at special schools.	2.1 Effects of lack of monitoring on the availability of resources
	2.2 Effect of lack of monitoring on emotional and psychological well-being of nurses
	2.3 Effect of lack of monitoring on regulatory requirements
	2.4 Effect of lack of monitoring on professional development
Theme 3: Support strategies of nurses working in clinics based at special schools.	3.1. Peer support 3.2. Local clinics 3.3. Private practitioners

The data represented in Table 3.2 will be discussed in detail. The discussion will include the themes and sub-themes, with verbatim examples in support.

3.3.1 Theme 1: Departmental Challenges Associated with the Lack of Monitoring of Clinics in Special Schools

A lack of monitoring seemed to be a significant challenge for participants, as one participant stated:

"*That is the thing, that is a problem. They won't come and monitor us here*…".

Therefore, the researcher will first offer additional background on monitoring. This will include an explanation of the importance of monitoring while detailing the roles of all involved parties.

Monitoring is defined by Gosling and Edwards (2003:12) as *"the systematic and continuous collecting and analyzing of information about the progress of a piece of work over time"* (Gosling & Edwards 2003:12). It is described by the United Nations Development Programme (UNDP 2019:43) as the continuous tracking and recording of actions and developments to ensure the success of public policies or initiatives. It includes collecting data at regular intervals, starting from the inception of a programme, and assessing its performance over time. This ongoing process provides information to make informed decisions about resource use and program effectiveness, and it helps determine if adjustments are needed to achieve the desired outcomes (EvalCommunity, 2024). The WHO confirms how essential monitoring is for tracking progress, identifying implementation challenges, assessing intervention effectiveness, documenting success stories, and ensuring accountability through transparent reporting. Monitoring also requires an enabling policy environment, good governance, a skilled and motivated workforce, effective finance and information systems, safe and regulated medicines and technologies, and accessible, well-equipped facilities (WHO, 2020).

Although monitoring is the primary focus of the research findings, it is essential to recognise that it plays an integral part in evaluation. Data from previous monitoring efforts are instrumental in understanding how a project or program has evolved, and in driving improvements (Sportanddev, 2024).

A monitoring activity must address several basic questions (Simister, 2017:3): What work has been completed, and what was planned but not done? Why was the work not completed? What problems were encountered, and how were they addressed? If problems were not addressed, why not? What opportunities have emerged? Have there been changes in target populations? Is the program on track to meet its objectives, and are those objectives still relevant? What lessons have been learned, and how can they inform future work? Have there been any changes in the external political or socio-economic situation? What immediate and longer-term adjustments might be necessary?

Monitoring is necessary to drive the improvement of quality. This relies on accurate, timely, and actionable data. The integration of global and national measurement efforts is critical to ensuring that countries collect data that matters, and use that data to transform and improve their service delivery systems (WHO, 2020).

In the context of quality healthcare in South Africa, key concepts are described as follows: quality planning, which is a structured approach to developing services that effectively meet population needs; quality assurance, which indicates the process of ensuring adherence to standards and guidelines to maintain and promote quality of care; quality improvement, which deals with the sequence of evidence-based steps aimed at enhancing patient outcomes, system performance, and professional development (Begg *et al*., 2018:78).

Regarding quality assurance, the Public Service Commission (PSC) and the Department for Performance (later Planning) Monitoring and Evaluation (DPME) are statutory institutions charged with the task of monitoring and evaluating government service delivery and performance. Since 2000, all government departments in South Africa have established their own monitoring and evaluation units, mainly focusing on monitoring (Abrahams, 2015:1). The DPME also emphasises that monitoring is a management role that all managers must include in their performance agreements (DPME, 2014:3).

In terms of frontline service delivery monitoring, the DPME states that departments that deliver services directly to the public must have frontline service delivery programs for facilities such as clinics (DPME, 2014:7). Provincial departments play a critical role in mobilising support and resources for service delivery sites that have capacity constraints, such as rural clinics and schools (DPME, 2014:7). It is therefore imperative that the findings of monitoring visits are used to inform improvements at site level. Periodic visits must be done to monitor any improvements made since previous visits (DPME, 2014:7).

The Primary Healthcare Supervisory Manual, a key tool for monitoring quality healthcare, identifies several role players in clinic oversight. These include local area managers, clinic managers, program coordinators, clinic staff, infrastructure maintenance staff, and suppliers (DoH, 2009:3).

Monitoring serves several key purposes: it tracks progress toward goals and objectives, identifies implementation challenges, assesses the effectiveness of interventions, documents success stories and best practices, and enhances accountability. By providing insights into achievements and areas for improvement, it helps adjust approaches, share valuable lessons, and ensure transparency in progress reporting (EvalCommunity, 2024; Simister, 2017:2).

From the challenges experienced by the participants across various departments and role players, it seems as if there is insufficient intersectoral collaboration between the DoH and the DoE. One participant despondently said:

> "*sometimes it's very difficult for me, because remember I have to follow hierarchy or something, if I need to complain, Be it from district point, provincial or national…*" (P1).

Intersectoral collaboration refers to the promotion and coordination of the activities of different sectors (DoH, 2014:1). Health planners have often identified education as one of the sectors that can, and should, collaborate in helping to reduce inequities in health (DoH, 2014:1). Since the major determinants of health lie outside the healthcare system, it stands to reason that efforts to address inequities in health must incorporate sectors whose activities have a bearing (both directly or indirectly) on the health and well-being of people, especially children and youth with disabilities (Samuels *et al.*, 2020:173). One of the most important sectors is education. The reported fragmentation and lack of collaboration between health and education can represent a failure to recognise the intersection of probably the two most important sustainable development goals (SDGs) for children and youth, namely SDG 3 (Good Health and Well Being) and SDG 4 (Quality Education) (Samuels *et al.*, 2020:173). Hahn and Truman further explained this relationship between health and education. Firstly, health is seen as a prerequisite for education. A second principle is that education on health and providing health services in schools are regarded as important public health interventions (Hahn & Truman, 2015).

Four policy documents between the DoH and the DoE highlight the importance of intersectoral collaboration between the two (DoH, 2012:17; DoE, 2005:19; DoE, 2005:19; DoE, 2007:6). In addition to this, a study by Samuels *et al*. (2018:171) conclude that intersectoral collaboration between the DoH and the DoE would strengthen intervention services and facilitate the improvement of health and developmental outcomes for children and youth with disabilities. However, there is a disjuncture in how these policies are implemented at the provincial, district, hospital, and school levels (Samuels *et al*., 2020:171).

The roles of relevant governing structures influencing the shortcomings in monitoring and the lack of effective inter-sectoral collaboration by the participants will be described. The consequences of governance on these issues will also be elaborated on.

3.3.1.1 Sub-theme 1.1: Monitoring challenges related to DoE

The importance of addressing health barriers and structural challenges for the optimal development of learners with special needs is emphasised (DoH, 2012:10; DoE, 2007:9). Guidelines for special schools and resource centers also highlight the significance of special schools employing nursing personnel to address these challenges (DBE, 2014a :11). As important as it is to provide health services in special schools, it is also emphasised that such services must be monitored to ensure quality health services. As part of ensuring effective monitoring to ensure quality health services, an intersectoral collaboration between DoH and DoE was recommended (DoH, 2012:17; DBE, 2005:19; DoE, 2005:19; DoE, 2007:6).

Regarding the role of the Department of Education in special schools, the guidelines to ensure quality education and support in special schools and special resource centers, state the following:

> *“The Department of Education at national, provincial and district levels has an obligation to monitor all special schools on a regular basis, and to provide the necessary support to protect the rights of the most vulnerable learners in the system.”* (DoE, 2007:5).

This statement emphasises the fact that the monitoring of clinics in special schools must be supported by all levels of management, especially within the Department of

Education. This point is emphasised by the DPME (DPME, 2014:3). The collected data suggest that managers at all levels within the DoE play an important role in monitoring, including the principals of special schools.

> *"We have to work under the supervision of the principal" (P1)*
>
> *"The principal is the sole person whom we, request anything from" (P6)*

The direct management of schools within the DoE is the responsibility of principals. Principals automatically become the immediate managers of any staff working in schools (DBE, 2014b:7). In the context of clinics in special schools, the principals are the immediate managers of support services personnel.

The Policy on the South African Standard for Principalship, developed from the National Education Policy Act of 1996, determines the role and objectives of the principal in the school. It mentions eight key performance areas (KPAs) (DBE, 2014b:9). The policy mentions the role of the principal in strategic leadership, and states that the principal must develop a framework for continuous improvement of all systems in the school (DBE, 2014b:13). It further stipulates that the principal must have an understanding of the intersectoral relationships with district and external stakeholders and their impact on the school system (DBE, 2014b:20).

Furthermore, it is the role of the principal to develop and support all staff in the school (DBE, 2014b:22), as well as to be familiar with monitoring and evaluation strategies (DBE, 2014b:12). Some participants shared that their experiences in this regard:

> *"…doesn't give me any support" (P1)*
>
> *"…they don't monitor, they don't evaluate, they just let me do everything by myself" (P7)*

Even though it is expected of the principal to support the registered nurses in the school, that doesn't equate to interfering with nurses' roles within the school. Good communication between the nursing personnel and the principal is required for the principal to understand the role of the nurse within the school.

Regarding organisational leadership, the Policy on the South African Standard for Principalship mentions that the principal must have a communication system in place to share good practices, create processes to identify and solve problems and challenges, communicate with all stakeholders regularly, and comply with and implement national policies and provincial directives and mandates (DBE, 2014b:13).

The participants shared their experiences about challenges they encountered regarding communication with the principal, the management of the school, and the school in general. Communication is defined as t action of imparting or exchanging information from one person or group to another by speaking, writing, or using any other medium that provides a means of understanding (Fatimayin, 2018:1). Communication, in this instance, refers to principals communicating with the participants, information that will affect their role as registered nurses managing a clinic, or how the registered nurses' role contributes towards the functioning of the multi-disciplinary team and the school, and vice versa.

The challenges mentioned by the participants regarding communication in the school are related to key activities that the participants feel they should be involved in as part of their work. One such activity is the admission of new learners. The admission of learners in special schools requires a multi-disciplinary consultation process (DoE, 2007:7). Some participants shared experiences where they felt they were excluded from communication related to the admission process of learners in the school, particularly on issues related to medical conditions of the learners that the participants would be expected to manage.

> *"The communication also here in the school is bad for me. Sometimes, they admitted the new learners without me I'm not part of admitting learners here in the school." (P2)*
>
> *"I think sometimes we are frustrated because, we are all left out in the communication system." (P5)*
>
> *"…as nurses, we are not being included in the admission of learners at our schools. I don't know why. . . .if we could be given a chance to be the part of admission committee, we can also give views regarding the psychiatric conditions, chronic conditions, or anything that can help the school not to admit the child wrongly. Maybe if we can also give views the admission can run smoothly. But we are not being included. But when they encounter problems, they refer the kids to us in order for us to refer them to the district hospitals, or the local clinics." (P8)*

The participants experience negative emotions in this regard and feel as if they are excluded from a team effort that could require their input to provide quality health services for the learners. The communication challenge between principals and nurses has led to ambiguity regarding the nurses' roles within the school. Due to that ambiguity, the participants experience interference from teaching staff and principals regarding what the nurses are supposed to do within the school, as explained by one participant:

> *“You'll be having a problem with a child, or the teachers will be having a problem with the child. The principal will be the one who's telling you how to treat the child” (P1)*

Interference by the principal is confirmed by the following statements:

> *“The headmasters, I don't think they always understand, that they do not have any say over medication, because I've had the headmaster tells me, how can I let my patient do a mouth rinse with saltwater? It's not good enough.” (P5)*

The following statements address the issue of teachers being unclear about the role of the nurses, who work according to a specific scope of practice:

> *“Even the teachers they don't understand what the nurse is doing.” (P4)*
>
> *“The teachers sometimes interfere with the nurses’ job description.” (P8)*
>
> *“When a child have a headache they will give medication, their prescribed medication from somewhere. And they are not allowed to do that. The other thing, they will tell the nurse, they will assess the child on their own and tell that, call the nurse and say please put this child in bed, is sick. Without being assessed by a nurse.” (P7)*

The nurses don’t know why teachers act in the way stated above:

> *“…is like she does not trust me or I feel she feels she knows better than me in my profession.” (P1)*

From a human resources perspective, the lack of communication and insight into the role of the nurse seemed to cause confusion and feelings of resentment:

> *“I'm often expected to do things that I don't think should be done by a professional nurse.” (P5)*

> *“Like I've got to do the injury on duties. And that is supposed to be human resources. It's not supposed to be a nurses work to do their administration of injury on duty.” (P5)*

> *“Over time you realise communication is very, very, very important with everyone, the teacher, the parents.” (P4)*

As the previously mentioned policy guidelines suggest, it is also important for the principal to communicate with the registered nurses, involving them in the strategic decision-making process for the school. It seems that the registered nurses are not involved in general school processes such as learner admissions, and the participants stated that they feel left out of the communication in the schools.

The nurses indicated unhappiness with the principals being their immediate managers. They feel that the principals have limited understanding of healthcare management, and therefore won’t be able to appropriately monitor clinics in special schools. Some of the participants mentioned:

> *“. . .you have to report to a person who doesn't know anything, about your profession.” (P1)*

> *“. . .my supervisor is a principal and … doesn't know health issues. . .” (P3)*

> *“We know they don't monitor, they don't evaluate, they just let me do everything by myself.” (P7)*

There was also a concern about principals’ understanding of the nurses’ scope of practice and job description. Some nurses said:

> *“They don't know … about our scope of practice…there are lots of things that fall out of the job description” (P7)*

> *“I'm often expected to do things that I don't think …should be done by a professional nurse.” (P5)*

The nurses specifically mentioned the Performance Management and Development System (PMDS) as an appraisal tool. The PMDS is a performance appraisal system that provides a framework to enhance individual employees' performance, thereby contributing to improved organisational performance. To be effective, the PMDS is supposed to be integrated with all other organisational planning, monitoring, improvement, and reporting processes and systems. One of the principles underpinning the effectiveness and efficiency of the PMDS is developmental orientation (PSC, 2018:1). There is a concern by the Public Service Commission (PSC) about poor work performance within public services. The concern emanates from the outcomes of the research and monitoring done by the PSC, which proved that PMDS is poorly managed (PSC, 2018:1). One of the participants mentioned unhappiness because the performance appraisal and evaluation of nurses are done by principals or teaching staff.

> *"The PMDS is done by the person with no nursing experience e.g. the principal or the HOD." (P7)*

From the statement above, it seems that some of the nurses feel that principals are unable to manage the performance appraisal of nurses because they don't have adequate knowledge about the nurses' job descriptions and scope of practice.

Most of the nurses do not think that the principals are incompetent, or malicious. It is rather the reality that principals come from an educational rather than a healthcare background. acting maliciously towards them. Some participants were empathetic towards the principals by saying:

> *"Well, it's totally a different sector. They think like teachers, which is right… But I think, they're not negative about the nurse. I just think they don't know exactly what the nurse is doing." (P4)*

Regardless of the challenges regarding monitoring by principals, some participants felt they have a good relationship with their principals and that principals are willing to help wherever they can:

> *"I can say it's very good. And then sometimes there's an SMT. If I got some issues regarding the health of the learners or anything that affects me, I usually go to the SMT. They are principals, deputy principals, and the HODs. We usually sit together and discuss some issues. So the relationship is very good. The principal, and also other members that are working in the school." (P9)*

> *"And let's say if we need some things that we need to have in the clinic. We report to the principal, fill the requisition, and get what we want to." (P6)*
>
> *"The current principal is not interfering in the medical side. He leaves that to us." (P5)*

From the collected data, it seems as if there is a lack of monitoring by principals of the registered nurses and clinics in special schools. Any monitoring being done is probably more administrative than clinical.

District-based support teams should assist principals in developing the right skills and knowledge to monitor clinics in special schools (DoE, 2005: 9).

Conceptual and operational guidelines for the implementation of inclusive education, defines district-based support teams as integrated professional support services at the district level (DoE, 2005:6). The primary role of district-based support teams is to provide integrated support to education institutions (DoE, 2005:6). Local needs and resources influence the composition of the district-based support team (DoE, 2005:16). The composition of the district-based support team can include health professionals like nurses (DoE, 2005:17). The policy confirms that there are districts where support is not readily available and that there is a need for developing a framework of 'collaboration', or teamwork, where the different support providers plan and work together to comprehensively address local needs and challenges.

Another key role of the district-based support team is to liaise with sister Government Departments, such as Health and Social Development, to provide support to schools through the services of health professionals. Linking up specifically special schools with DoE includes resources such as primary healthcare clinics (DoE, 2005:22). This view is shared by some of the participants, who felt that this is not happening. One particular participant mentioned the following:

> *"If there's someone who's liaising with the Department of Education in Health, at least we can be helped." (P9)*

Considering the comment above, some participants felt that if the district-based support team were to liaise with other government departments, particularly the Department of Health, it would assist with monitoring clinics in special schools.

Local needs and resources must influence the composition of the district-based support team, and this team can include health professionals.

A general experience by the participants is that the district-based support team supports the schools, but not the clinics specifically. Some said:

> *“There is no coordinator for nurses at the district. Visits by school-based support teams are limited” (P4)*
>
> *“We don't have support from the coordinator from the department whereby maybe there can be a clarity of roles on issuing of medications. . .” (P7)*
>
> *“We don't have support they don't send the school-based support teams to us for monitoring and evaluation. . .” (P7)*

It also seemed like the participants had inadequate orientation about the composition of district-based support teams.

> *“I don't even know and maybe who to call at a district level. . .” (P1)*

The DPME already alluded that all levels of management must be involved in monitoring, and Provincial Department of Education is no exception (DPME, 2014:3). One of the roles of the Provincial Department of Education is that it must develop district-based support teams to support the implementation of White Paper 6 (DoE, 2005:20). Therefore, the Provincial Department of Education has an interest in the composition and assurance that the district-based support teams deliver on their objectives (DoE, 2005:20).

The Provincial Department of Education must also conduct periodic monitoring visits (DoE, 2005:14). The participants had varying experiences regarding their interaction with the Provincial Department of Education. The following statement by one of the participants seems to be shared by the other participants.

> *“The Department of Education does not have a structure. The nursing structure at the department who can come and evaluate the work…at special schools.” (P6)*

The above statement indicates that nurses working in special schools feel that they don’t have guiding policies and structures to address some of their challenges. Consequently, they have to find alternative ways to manage their challenges. There are also no standardised services provided in clinics in special schools, which could impact the quality of health services provided to learners. Some participants stated that although the provincial DoE supports schools, there seems to be little to no contact with the provincial DoE, specifically on monitoring clinics in special schools. They mentioned that they feel the focus of provincial DoE is on academic issues rather than nurses. Some said:

> *“I don't think we've had any contact with the Department of Education concerning the nurses.” (P6)*
>
> *“Then there is a special needs directorate. That’s where we have to liaise with them, but …none of them do come to us and check what we need, what are our shortcomings.” (P5)*

The experience of the participants emphasise the importance that the different levels of management within DoE play in monitoring clinics based in special schools. What seems to be central to participants’ experiences regarding the monitoring of clinics, is the lack of monitoring by DoE to clinics in special schools. This seems to be against the expectations of the participants and the guiding documents relating to monitoring within DoE, as mentioned in Chapter 1. Statements by the participants emphasise this point.

> *“We don't have a representative from the Department of Education….The other thing also they don't monitor us here…I think if there was monitoring, if there was somebody who is presenting us there, it was gonna be better for us, as special school nurses.” (P3)*
>
> *“…district, national, provincial, they're not giving us any support. provincial or district….Department of Education should do something, I don't know what, so that they can help with the supervision because right now where I'm seated, We are not being supervised at all.” (P1)*
>
> *“I don't think we've had any contact with the Department of Education concerning the nurses.” (P5)*
>
> *“The Department of Education does not have a structure. The nursing structure at the department who can come and evaluate the work of special, at special schools….Then, there is a special needs directorate. That’s where we have to*

> *liaise with them, but now none of them do come to us and check what we need, what are our shortcomings.” (P6)*
>
> *“We don't have support they don't send the school-based support teams to us for monitoring and evaluation.” (P7)*

The monitoring of health services in special schools does not solely rely on the DoE, but the DoH, as a custodian of health services, also has a significant role to play. The next sub-theme will discuss the experiences of participants as they interacted with the DoH regarding monitoring.

3.3.1.2 Sub-theme 1.2: Monitoring challenges related to DoH

Chapter 1 referred to policies that guide the DoH in providing primary healthcare services, of which school health services form part of. The same guiding documents assist the DoH in monitoring the quality of healthcare services. The national core standards state deliverables against which primary healthcare is measured (DoH, 2011:2). Using national core standards; clinic supervisors must conduct periodic visits, guided by the clinic supervision manual, during which they monitor, support, and supervise clinics to ensure that the quality of care is maintained (DoH, 2009:65). The Ideal Clinic is a model that intends to ensure that clinics have good infrastructure, adequate staffing, and appropriate policies and systems to ensure the provision of quality healthcare (DoH, 2020:1). In addition, there are policies like the District Health Information System and Integrated Clinical Services Management, which entail the monitoring of health services to ensure quality (DoH, 2020:1; DoH, 2011:11).

Furthermore, the DoH has a crucial role to play in the district-based support team functions (DoE, 2005:19). In this instance, the district-based support team refers to the district-based support team within the DoE, as mentioned in Theme 1. By developing the school health policy, the DoH showed an interest in the DoE ensuring that health services are delivered in schools, particularly to address health barriers to learning (DoH, 2012:13).

Additional to the school health policy, as discussed in Chapter 1, the Adolescent and Youth Health Policy (AYHP) is a document that seeks to provide a practical approach to the provision of health services to the youth (DoH, 2017:1). AYHP identifies stakeholders that are important in delivering health services to the youth, including the DoH (DoH, 2017:1). The policy is aligned with a number of DoH policies and interventions related to the provision of adolescent and youth-centered health services, including adolescent and youth-friendly services, the Ideal Clinic, the Integrated School Health Program, B-wise and the She Conquers campaign (DoH, 2017:1)

The key objectives of the AYHP include the promotion of the health and well-being of youth and adolescents, the provision of comprehensive and integrated sexual and reproductive health services, the prevention, testing, and treatment for HIV/AIDS, TB, and non-communicable diseases, reducing substance abuse and violence, promoting healthy nutrition and the reduction of obesity, and the empowerment of youth and adolescents to take care of their health, including youth with disabilities (DoH, 2017:5).

The policy concedes that health promotion programs must be part of health services provided in schools (DoH, 2017:7). Collaborative efforts between the DoH and DoE should be strengthened at the local, district, provincial, and national levels, to ensure that the delivery of health services to adolescents and youth are realised (DoH, 2017:6). The policy further states that the DoH, DoE and other stakeholders must establish a monitoring and evaluation committee to monitor and evaluate the implementation of AYHP, and to assess its progress against set key performance indicators on a regular basis (DoH, 2017:10). This recommendation is in line with recommendations made by the School Health Policy, the Guidelines for The District-Based Support Teams and Guidelines to Ensure Quality Education And Support In Special Schools And Special School Resource Centers (Department of Health, 2012:17; DoE, 2005:19; DoE, 2007:6).

This sub-theme will discuss some of the role players within the DoH with whom the participants have, and that have a role to play in monitoring clinics based in special schools.

The supply of medication is one of the issues mentioned by the participants. The Good Pharmacy Practice in South Africa (GPPSA) policy states the role of the pharmacist in the supply of medication (SAPC, 2004:3-4). GPPSA determines that a pharmacist must exercise control over the medication they supply (SAPC, 2004:26). A pharmacist must not supply medication where there is doubt of the safety of the medication

(SAPC, 2004:26). Also, a pharmacist may not supply medication to a person not authorised to be in possession of such medicines (SAPC, 2004:26). The district pharmacist must therefore ensure that the registered nurses working in special schools to whom they supply medication to on behalf of the clinic, must have a dispensing license and the appropriate qualifications to do so (RSA, 1965:Sec. 22A).

Regarding monitoring, the Good Pharmacy Practice in South Africa further states the general objectives and requirements of pharmaceutical services, which include a sound management structure that emphasises professional and managerial accountability, quality assurance practices, a prescription monitoring service that must ensure that prescribing and administration of medicines are monitored regularly to ensure compliance with accepted practice and safe systems of work and encourage effective prescribing, and that pharmacists must be available to contribute actively to health education programs in schools where compliance is important (SAPC, 2004:34).

In general, the Good Pharmacy Practice of South Africa emphasises the importance of district pharmacists in monitoring. This includes ensuring that supplied medication supplied is kept safe, that there is a rationale behind prescribing by whomever they supply medication to, and that there is waste management of medicines (SAPC, 2004:26). In the context of registered nurses working in clinics in special schools, this can only be done if the district pharmacist periodically visits clinics in special schools.

There is evidence that one of the key cost drivers in the provision of health services is medication (BHF, 2014:2). The participants mentioned different ways in which they acquire medication. In some instances, it is bought from the school budget.

> *"I usually buy them from outside pharmacy. I communicate with them. There is a budget for the nurse. So I usually buy medication from outside pharmacy." (P9)*

> *"For medication we don't get from the clinics, local clinics, from Department of Health. So I also get … from the school budget." (P3)*

> *"We are at the school where we've got kids who come coughing; the Department of Health doesn't provide cough mixture. So we buy, the school provide for such things that we do not get from the Department of Health." (P6)*

Some are assisted by local clinics:

> *“we take our kids to Fauna clinic and to Fichardt Park clinic because I don't have the training in ARVs.” (P2)*
>
> *“I rely on Riebeeckstad clinic to give medication.” (P3)*
>
> *“and also get chronic from one stop clinic in Dewetsdorp.” (P7)*

There are variations in how the nurses acquire medication:

> *“We have another a pediatrician who helps at the moment. She doesn't come to the school physically, but she helps us with prescriptions and repeats because there are a lot of children that is on medication, especially for autism, ADHD, epilepsy, and other behavior problems as well. …we take children to Bloemfontein, the psychiatric hospital, the clinic there as well.” (P4)*
>
> *“We received our scripts from, Universitas Hospital.” (P8)*
>
> *“But also, they also get from Free State Psychiatric Complex… We also get from Universitas Tertiary Hospital.”* (P7)

The participants also mentioned getting medication from the district pharmacies within the DoH. It is particularly important to remember that most of the participants were from the Lejweleputswa and Motheo districts in the Free State province, so the mentioned district pharmacies are in Lejweleputswa and Motheo.

> *“We registered…as a clinic at the Department of Health. So I received basic medication from the government pharmacy, as well as medication for the children that are on chronic medication.”* (P4)
>
> *“We get it from the Department of Health. . .at Orange Hospital there is a chemist there, we are registered there to fetch medication. We are allowed once a month, to get medication.”* (P5)
>
> *“I created a relationship, and we are now getting medication from CDU, which is Department of Health. Sub pharmacist. We are getting medication we order once a month.”* (P7)

The participants shared their experiences regarding the monitoring they received relating to the district pharmacies where they received medication.

> *“For the past 20 years I would say I have not seen anybody from the district doing an inspection like, how I keep my medicine.”* (P5)
>
> *“Because I also have medicine here. I order them from the Department of Health, but nobody comes and inspect.” (P2)*
>
> *“But from the Department of Health itself, no. In these 24 years nobody ever visited us nobody! When I am asked for help, I didn't receive.” (P4)*

Two participants who have been working in clinics in special schools for more than 20 years, mentioned that during that time, no monitoring was done by the relevant district pharmacies. This could imply that the issue of not monitoring clinics in special schools is a long-standing problem.

Regardless of the remarks, the participants felt that they have good ethical practices to do what is right regarding how they manage medication.

> *“I can work on my own and I am responsible, but everyone need someone just to check you up”. (P4)*
>
> *“I think, I'm a very responsible person. So I feel very strong about work ethics”. (P5)*

However, one of the participants highlighted the danger of not monitoring clinics in special schools:

> *“But if I, if I choose not to obey the rules, nobody will know.” (P5)*

One of the participants mentioned some of the effects of no monitoring:

> *“There's no accountability. They don’t come, and look at the stock cards….And we don't submit the stock cards to them.” (P7)*

Even with the mentioned experiences, participants still felt it was important to have a responsible body supporting and monitoring their work regarding the management of medication. Here is one participant’s opinion on having someone to support them with the management of medication:

> *“I think you've got someone to ask questions, you got someone to…lead you or to help you. With what to know, that what you do is the correct way. Because, if you are never followed up, you do what you think is right. And it's nice to know*

> *that someone is looking after you and that you are supported and you… like to know that what you're doing is right. So it's nice if someone expects and find it, that your things are right. It's just that backup that you have." (P5)*

The participants' experiences seem to reflect that although district pharmacies support them by providing the medication they use in clinics in special schools, there seems to be minimal to no monitoring of clinics in special schools by the management of district pharmacies, particularly regarding the medication they provide to clinics in special schools.

District pharmacies are not the only role players in the DoH that should be involved in the monitoring of clinics based in special schools. Another essential body is the Directorate of School Health Services.

The World Health Organization (WHO) defines a school health program as a combination of services ensuring the physical, mental, and social well-being of learners to maximise their learning capabilities (DoH, 2012:6). Although the Integrated School Health Policy (ISHP) was mentioned in Chapter 1, it is necessary to mention that it is an important policy which clarifies the interest and the role of the DoH in providing and monitoring health services in special schools. Although there are many guiding tools, ISHP is the most important guideline in the school health program.

ISHP mentions its key objectives as providing preventative and promotive health services to school-going children, identifying and addressing barriers to learning, and improving access to health by school-going children (DoH, 2012:11). ISHP further mentions of the health services it intends to provide to school-going children (DoH, 2012:14). ISHP further states the importance of collaborative efforts between the DoH and DoE to ensure such services are deliverable (DoH, 2012:11). One of the important outcomes of collaboration between the DoH and DoE is an effective referral system between the two departments (DoH, 2012:15). ISHP also mentions the roles of different management levels from national, provincial, district and facility level in the implementation of ISHP objectives (DoH, 2012:17-19). More importantly, ISHP mentions the importance of monitoring and evaluation. ISHP states that there must be a national task team that ensures the interfacing of DoH provincial and district information systems with that of the DoE, to monitor coverage of school health services, the impact of the service on the health of learners, and access to schooling, retention and achievement of learners, the quality of school health services, and the sustainability of school health services in all districts (DoH, 2012:21).

Health services provided in clinics in special schools are part of school health services. Therefore, the monitoring of clinics in special schools applies as above. The school health directorate is a custodian of ISHP. Therefore, the DoH has an important role to play in ensuring that ISHP is implemented well (DoH, 2012:10, 22).

Participants shared their experiences of interacting with school health services. Some of the participants who have been working in special schools for more than 20 years mentioned that previously, there were representatives from the school health directorate who used to come and monitor clinics in special schools, but this has ceased. One of the participants had this to say:

> *"There used to come a representative from the Department of Health to come and evaluate or monitor our work as professional nurses. But as time went by, there was no such person who used to come, even now there is no person, who evaluates our work." (P6)*

Some participants mentioned that the only contact they have with school health services is when there is a human papilloma virus campaign, but no monitoring is done. Some participants say that school health services used to support schools with the human papillomavirus campaign, but they no longer do. Some of the participants have previously asked for assistance from school health services with programs like dental services, but their requests were ignored. Here are some comments by participants:

> *"From school health services, no, not a lot of help." (P4)*
>
> *"Our school does not benefit from school health system of the Department of Health." (P7)*
>
> *"School health services…No actually, no. There is a mess here." (P9)*

Some of the participants felt that the non-existent relationship between themselves and school health services is deliberate. School health services might assume that special schools don't need them because special schools have nurses. Therefore, school health services are focused on mainstream schools. One of the participants shared their experience with school health as follows:

> *"We don't have a relationship, we don't even know who are they because they never come to our school, ba re kgesolla (they discriminate against us)." (P7)*

Through the school health directorate, the DoH has a role to play in strengthening health services provided by clinics in special schools, as already mentioned. The importance of intersectoral collaboration between the DoH and DoE cannot be over-emphasised. The DoH could potentially be taking a leading role in the intersectoral committee, as suggested by the Integrated School Health Policy and other policies already discussed (DoH, 2012:17; DoE, 2005:19; DoE, 2005:19; DoE, 2007:6). Furthermore, as the ISHP mentions, the DoH has a significant role to play in monitoring school health services (DoH, 2012:21), especially those the provided in the clinics of special schools. However, it seems as if there is a lack of monitoring of special schools' clinics by the school health directorate. This lack of monitoring may stem from a potential lack of intersectoral collaboration between the DoH and DoE. One of the participants mentioned the challenge that this brings.

> *"The thing is we because we belong to the Department of Education, and then there's the Department of Health. That is the thing, that is a problem. They won't come and monitor us here. Yes, there is this integrated school health program, but we are on the same level." (P3)*

In conclusion, this theme discussed the quality of monitoring or lack thereof as described by participants. The following theme will discuss the effects of the quality of monitoring they have received.

3.3.2 Theme 2: Effects of Lack of Monitoring of Clinics in Special Schools

In the Christian Bible, Galatians 6:7 says you reap what you sow (Bible, 1984). This biblical verse is an example of the cause-and-effect relationship. In the cause-and-effect relationship, one or more things happen as a result of something else (Bressmer, 2022:1). The level of monitoring provided to clinics in special schools, or lack thereof, has resulted in several effects. These effects, as derived from the participants' experiences, affect resources, the emotional and psychological well-being of nurses, regulations that nurses must adhere to, and the professional development of nurses. This will be discussed in detail.

3.3.2.1 Sub-theme 2.1: Effects of lack of monitoring on the availability of resources

Workplace resources are any factors necessary to accomplish a goal or carry out an activity. They are the components that an institution needs to conduct its daily business (Koehler, 2019:1). According to the Occupational Health and Safety Act (RSA, 1993:7) it is the responsibility of the employer to provide and maintain all necessary resources to perform work. Resources include employees, working space, and equipment (Koehler, 2019:1), which is in line with how the Ideal Clinic is defined (DoH, 2020a:1). The participants mainly focused on resource challenges related to human resources, equipment, and infrastructure, which will be discussed below.

- **Material resources**

Material resources refer to equipment that employees need to perform their work (Koehler, 2019:1; DoH, 2006:14). The participants mentioned some of the resources that they require to do their work, but that they are not provided with.

> *"Right now, you can even go to my office, and I am seated on a chair that's broken." (P1)*
>
> *"The other thing that is also bothering me is that I don't even have a laptop here in my office. All the other professionals in the school has a laptop I don't have if I want to do something I must do it on my cell phone, I must use my own data." (P2)*

Some participants expressed that they were expected to wear uniforms at work, but they were not compensated for the cost of the uniforms.

> *"We're not even provided the money for the uniform." (P1)*

Material resources are not the only resources that the participants struggle with. They also mentioned the shortage of human resources.

- **Human resources**

Another challenge expressed by the participants is that due to a shortage of nursing personnel, most of the clinics in special schools work with only one nurse per clinic. This creates challenges when they are sick or when they need to attend to other matters.

> *“We are mostly working on our own.” (P5)*
>
> *“For the mere fact that I'm working alone is very difficult to can check everything... if I'm not well, I am on sick leave, there's no one who's going to care after the learners.” (P9)*
>
> *“And the nurse will also leave with that child to go take the child home. And then you leave 250 learners behind, the clinic is closed just to take that one.” (P3)*

The participants feel that staff shortages compromise the provision of quality healthcare. Nurses are unable to perform their work adequately, and it compromises the learners because if a nurse is not there, no health services can be rendered.

Infection Prevention and Control (IPC) is another factor raised by the participants. IPC is a scientific, evidence-based approach and practical solution designed to prevent harm caused by infection to patients and health workers. It is grounded in infectious diseases, epidemiology, social science, and health system strengthening (DoH, 2020b:4). IPC is part of the management of a clinic (DoH, 2009:18; DoH, 2020:23). Environmental cleaning is an integral part of the prevention of institution-acquired infections (DoH, 2020b:23). One participant mentioned non-compliance to infection prevention and control requirements:

> *“The department don't employ cleaners.” (P3)*

Due to the non-availability of cleaners, clinics are not properly cleaned, and infrastructure is poorly maintained.

- **Infrastructure**

Some of the participants complained of their challenges regarding infrastructure. According to the participants, the infrastructure of the clinics in special schools doesn’t meet the requirements of a clinic.

> *“We just improvised just to provide primary health care for the learners. We needed space; there's no privacy as you can see….. is just to improvise, it's not well-equipped clinic.” (P3)*

> *“Infrastructure is a huge problem. Our sick bays don’t have an exit for emergency like when is a fire or there's no exit for wheelchair or a stretcher. When the ambulance come to fetch the child who is supposed to go to the hospital. There's only one door, and our medication room doesn't have the correct cold monitoring tools. We just put medication in there; it is not being monitored.” (P7)*

On the other hand, as some participants already expressed, they have good relationships with their principals, and the principals or the school management assist them by buying medication or even uniforms, as mentioned by one participant.

> *“I never struggle with uniform; every year, I get my own uniform. I've got my own budget.” (P3)*

According to the participants, the clinics in special schools may not meet the criteria of an Ideal Clinic, as discussed in Chapter 1. The definition of the Ideal Clinic refers to good infrastructure, adequate staffing, and the availability of resources (DoH, 2020a:1). The lack of resources, as discussed, appears to have an emotional and psychological impact on the participants, which will be explored in the following sub-theme.

3.3.2.2 Sub-theme 2.2: Effects of lack of monitoring on the emotional and psychological well-being of nurses

Emotional effects, which represent fundamental feelings, are characterised by two dimensions, valence, ranging from pleasant to unpleasant, and arousal, ranging from calm to activated (Johnson & Boyd, 2023). The participants’ feelings ranged from feeling frustrated to feeling unworthy.

> *“It's really frustrating….It's like we are we have been dumped here…feel like we are being neglected….we are not being taken seriously.” (P1)*

> *“I did have my frustrations, and I think if you sometimes unsure, then it's really something that steals your emotional energy.” (P5)*
>
> *“It makes me feel like I'm unworthy… not appreciated….it also like, makes me feel like I'm not part of them, not part of the school…I'm also not appreciated. And it's like I don't exist here.” (P2)*
>
> *“It seems as if we are, the neglected one… we are the forgotten one.” (P9)*
>
> *“It makes me doubt myself because how can a person who doesn't have a nursing, nursing diploma or degree, assess a person who's a clinical nurse practitioner?” (P7)*

As part of emotional responses, psychological effects relate to the influence of psychological trauma on mental health, affecting individuals and communities alike. This encompasses the consequences of exposure to traumatic events (Silove *et al*., 2008). Psychological well-being is a vital aspect of general well-being, and correlates with physical health, emotional satisfaction, and happiness (Harshitha & Senthil, 2021:30). Some of the participants mentioned how their negative emotional responses caused psychological problems.

> *“But it make us feel useless, and it also give us a psychological problems like stress, depression because we have to think about the things that we are not supposed to think about that.” (P7)*

An employer has the responsibility to create a work environment that is conducive to the emotional, physical, and social well-being of staff, which will be to the benefit of the organisation as it will increase productivity (Harshitha & Senthil, 2021:28). The range of emotions and psychological responses expressed by participants can affect them professionally, and eventually affect their ability to provide quality healthcare. The application of policies and guidelines then becomes necessary to ensure that standardised and quality healthcare is provided. The next sub-theme will detail the participants' concerns regarding legislation that regulates their work.

3.3.2.3 Sub-theme 2.3: Effects of lack of monitoring on regulatory requirements

Nursing is a highly regulated profession (RSA, 2005:5), where each category of nurse has its scope of practice and job description (RSA, 2005:6). In addition to the scope of practice and job description that nurses must adhere to when performing their duties, they must also comply with the latest guidelines. These are based on the most recent scientific evidence in their field of work. Policies and guidelines in general, are either reviewed and/or updated regularly to be aligned with new scientific evidence. New policies might also be introduced, or old ones could be discontinued (Cerna, 2013:4). If nurses are not updated regularly about new developments regarding policies, it might create confusion about which policies and guidelines to follow. To ethically practice their scope, nurses need new guidelines and training that the participants don't feel they are getting.

> *"I never know if we are still on the standard of the policies." (P2)*
>
> *"Maybe I did something wrong that I didn't even realize I did wrong, especially when it comes to regulations and laws and all these things." (P4)*
>
> *"Because, if you are never followed up, you do what you think is right." (P5)*

One of the participants experienced confusion regarding which policies and guidelines to follow.

> *"I suppose we work under the Department of Education and we are paid by them, but we follow the rules, regulations, and well policies at the Department of Health." (P5)*

The need for intersectoral collaboration between the DoE and DoH is again mentioned. It could address what seems to be a lack of knowledge, and the misinterpretation of the nurses' scope of practice and job descriptions. It will also assist in ensuring that nurses are updated with recent developments in policies and that the latest policies are followed.

The importance of supervisory visits in supporting good practices and correcting undesirable behaviour has been previously highlighted (DoH, 2009:34). Data suggest that some participants may engage in unprofessional and unethical behaviour due to non-adherence to regulatory requirements.

> *"You know what it impacts in such a way that I sometimes, I don't record… we usually cheat and don't record because there's no monitoring and evaluation." (P7)*

Adhering to regulatory requirements enhances professional development, which will be described subsequently.

3.3.2.4 Sub-theme 2.4: Effects of lack of monitoring on professional development

Employees are one of the most significant assets of any organisation. The value of employees as assets can be increased by investing in their professional development (Harshitha & Senthil, 2021:28). Parsons (2022:1) explains professional development as gaining new skills through continuing education and career training after entering the workforce. It can include taking classes or workshops, attending professional or industry conferences, or earning a certificate to expand knowledge in a chosen field. Although it is mainly the individual's responsibility to develop themselves professionally, most employers offer in-house opportunities like in-service training, mentoring programs, and courses (Parsons, 2022:1). The purpose of professional development is to sharpen existing skills, learning new skills, boosting confidence and credibility, helping employees to stay up to date with industry trends, and providing opportunities for career advancement (Parsons, 2022:1). This is also mentioned in the PHC supervision manual.

The PHC supervision manual highlights one of the key objectives of monitoring visits as identifying skills gaps, improving skills, building credibility, creating career advancement opportunities, managing risks, fostering continuous learning, and positively influencing performance evaluations (DoH, 2009:10). What seems to come out strongly from the data is that the frustrations of nurses, the ambiguity and confusion relating to regulatory requirements as mentioned in the two sub-themes above, stem from a lack of opportunity for professional development.

> *"2013 I started with special school, but I've never really attended formal training since I came to special school." (P3)*
>
> *"The in-service training opportunities are really scarce." (P5)*

> *“We felt, that we are no longer skilled… The school could not provide us with the funds to do such course. The only funds, the bursaries that they have, it's for educators and clerks.” (P6)*
>
> *“They seem to forget us when there is a training… they should at least provide us with bursaries so that we can study” (P9)*

Training for nurses is necessary so that they are upskilled and can provide quality healthcare based on scientific knowledge. This will ensure the accessibility of healthcare to learners in special schools, and will help nurses to timeously address any medical barriers to learning, which is the goal of both the DoE and DoH (DoH, 2012:10).

This again shines the spotlight on the need for intersectoral collaboration. The DoH has a regional training centre, which has the capacity to train nurses, although the DoE employs the nurses in this case. Intersectoral collaboration would further correct the confusion regarding who is responsible for the training of the nurses working in clinics in special schools, between the DoE and the DoH.

> *“I don't get support, training, in-service training… the special schools nurses are not developed like the Department of Health nurses.” (P3)*
>
> *“We don't know where to take our challenges or frustrations because we don't have a representative from the Department of Education. Because sometimes when I, I request training from Department of Health, they will tell us that you belong to Department of Education so that is the challenge I’ve got.” (P3)*

The participants feel that a lack of monitoring, inadequate resources, poor infrastructure, inadequate staffing, and non-clarity of policies are contributing to their frustration and their inadequacies in knowledge and skills. This is counter to what is indicated in the integrated PHC monitoring model (DoH, 2009:31). But the participants didn’t sit on their laurels, because one of the participants said:

> *“I have to fend for myself.” (P1)*

Participants have developed innovative methods to secure support for themselves and to try to keep up with new information. Subsequently, some of the strategies employed by participants to obtain professional support from other professionals will be described.

3.3.3 Theme 3: Support strategies of nurses derived from a lack of monitoring

Strategies in nursing are methodical plans or techniques intended to accomplish particular goals in patient care, enhance operational effectiveness, improve clinical results, or further professional growth. These tactics frequently entail applying evidence-based procedures, allocating resources as efficiently as possible, and applying creative thinking to tackle difficult healthcare problems (Ben Natan, 2020). Due to a lack of monitoring, some participants employed novel strategies to ensure that they received the necessary professional support to execute their functions equipped with the latest knowledge. The strategies include acquiring peer support, aligning with local clinics, and using private practitioners for support.

3.3.3.1 Sub-theme 3.1: Peer support

Peer support can be defined as a process through which people who share common experiences or face similar challenges come together as equals to give and receive help based on the knowledge that comes from shared experiences (National Guideline Alliance, 2021; Riessman, 1989).

Peer support programs can range from informal to formal, and from programs self-organised by peers to meet their own needs to highly structured programs that include training. Some peer support programs start as self-organised but evolve into more formal programs (Canadian Agency for Drugs and Technologies in Health, 2022).

The benefits of peer support include the provision of emotional, informational, and appraisal support, and can mean peer affirmation of the appropriateness of one's emotions, cognitions, and behaviors. Peer support benefits both those who provide it and those who receive it. Using peer support to improve self-management is particularly promising because peer supporters have credibility as people “who understand, have been there, and done that” (Aboumatar *et al*., 2021).

The DoE does agree that developing ‘clusters’ of schools and other education institutions to support each other, mainly through sharing their different skills and knowledge, is an effective strategy for providing peer support and can prove to be cost-effective and empowering’ (DoE, 2005:18). The participants spoke about the importance of nurses’ meetings, that assist them with managing the challenges they face at work. These meetings are organised by the nurses themselves, through the support of the principals, who provide time and resources such as transport to attend the meetings. When speaking about these meetings, one of the participants said:

> *“Nurses’ meetings from all the nurses, especially special school nurses in the Free State. And I think that was a good place to communicate and to talk about our frustrations.” (P5)*

The participants mentioned that these meetings were disrupted by COVID-19, during which time they could not meet to discuss their challenges. They mentioned that they would like to revive that platform. In addition to the nurses’ meetings, participants mentioned the nurses’ congress. They mentioned this as a platform where all nurses working in special schools from different provinces meet and discuss their challenges. It is also used as a skills development platform, where nurses organise presenters on different topics, particularly topics that would provide solutions to their challenges. In mentioning the nurses’ congress, one of the participants said:

> *“The Congress is for us special schools to meet with other nurses... we discuss our challenges … and how to take care of the challenges…to support each other…because we are very few…” (P3)*

The peer support platforms seem to be some of the few reliable sources of support, where the participants can self-monitor if they are on the right track regarding their knowledge, and how they manage the clinics in special schools. A number of DoE policies advocate for strengthening peer support strategies for benchmarking, which is a strategy that could be used to adopt good practices from peers (DoE, 2005:18). The participants were not exposed to any formal peer support strategies, however:

> *“Because it was the nurses organising it, on our own, not, not the department.” (P5)*

The DoE should consider taking reasonable steps to strengthen peer support activities (DoE, 2005:18). The participants also found support from local clinics.

3.3.3.2 Sub-theme 3.2: Local clinics

A local clinic is a primary DoH healthcare clinic within the vicinity of the special school, providing health services to the community surrounding the special school. Nurses working in special schools would refer learners to these clinics in cases where they are unable to provide services, either because they don't have the knowledge or skill to do so, or they don't have the appropriate resources to do so (DoH, 2012:15). For instance, participants mentioned that they would refer a learner to a local clinic if a learner needed ARVs, TB treatment or antenatal services. Some participants mentioned that the nurses working in local clinics feel this overburdens them. The local clinic nurses feel that the special school nurses should be competent enough to provide the same services that they provide. Unfortunately, from the data it does not seem as if there is a formal referral system through which nurses in special schools can refer learners to local clinics. One of the participants said:

> *"The clinics outside… they are helping us but with a heavy heart." (P2)*

As part of local clinic management, local area managers have a role to play in monitoring clinics in special schools that fall under their jurisdiction. The primary healthcare supervision manual mentions that local clinics must have a strong link with health-oriented workplaces that fall under their catchment area, and this would include clinics in special schools (DoH, 2009:15). This would provide the local area manager the opportunity to conduct a skills audit of nurses working in special schools, to ensure that they receive appropriate training so that they can provide quality health services in clinics in special schools (DoH, 2009:28).

To the participants, local clinics are not only clinics close to the special school. It could be a clinic where the participant has previously worked or has built a personal relationship with the nurses who work there. According to the participants, they use these local clinic contacts to seek advice when they don't know how to handle a specific issue. These contacts serve as clinical support structures when special school nurses need them. One of the participants said:

> *"What we now do is we phone maybe a friend at the clinic, at the municipal clinics or what used to be the municipal clinics, you will phone a friend and say okay in this situation, what do you do" (P5)*
>
> *"I have to make sure that I develop myself by just phoning around, or just visiting the hospital, the clinics just to get new methods of treating the learners." (P3)*

According to participants, some local clinics support clinics in special schools by providing resources like medication or allowing special school clinics to dispose of medical waste at the local clinics. The arrangement depends on the relationship between the special school clinic nurse and the local clinic. There are no formal agreements between the DoE and DoH, or between the school and the clinic. One of the participants shared an experience regarding a local clinic:

> *"There was a clinic I'm working with …I usually got the medication from them. But when the management of that clinic changed, things got much worse. I couldn't even get a simple thing, maybe panado, to provide for the learners." (P9)*

According to the collected data, nurses working in clinics in special schools had to find innovative ways to develop relationships with local clinics. Such relationships help them to obtain resources, or to, for example, dispose of medical waste, as some participants mentioned. These arrangements remain informal.

It is not only the local clinics that nurses develop relationships with but also with local doctors. In some instances these are their own family doctors, which will be subsequently discussed.

3.3.3.3 Sub-theme 3.3 Private practitioners

What came out of the data is that sometimes, nurses would urgently need assistance. They would then reach out to their contacts in the health fraternity about how to should manage certain medical conditions. Some of the participants mentioned that they rely on private general practitioners for support.

> *"Like my house doctor, she said I can ask her anything. So I would say, see something at school. Maybe skin dermatologist or dermatology or something*

> *that I really don't know. Then I'll send a photo and she would report back to me and say she would do this and this and this. So I get like that kind of support professional support and giving medication." (P5)*

In terms of national norms and standards for PHC facilities, the PHC supervisory manual mentions that doctors and other specialised professionals should be accessible for consultation, support and referral, and provide periodic visits (DoH, 2009:12). This is however not happening. Nurses have to find other ways to get support, which stems from a lack of monitoring.

3.4 CONCLUSION

This chapter discussed the data gathered from the in-depth interviews, exploring the experiences of registered nurses in clinics in special schools regarding the monitoring they receive.

The overview of the research and the demographics of the participants were discussed. From the data, themes and sub-themes were identified. The first theme emerged as challenges associated with the lack of monitoring in clinics based at special schools. This theme discussed sub-themes of the DoE and DoH, respectively, as key role players in the monitoring of clinics in special schools. Due to the lack of monitoring by the identified role players, the second theme was identified as the effects of this lack of monitoring, with the sub-themes of resources, the emotional and psychological effects on nurses, regulatory requirements, and professional development. The third theme emerged as the support strategies of nurses working in clinics based at special schools. The sub-themes of peer support, local clinics, and private practitioners discussed the innovative strategies participants employed due to the lack of monitoring and support for nurses. The discussion of the themes and sub-themes was supported by verbatim extracts from the interviews, which were presented in italics, and relevant literature to substantiate and interpret the research results.

The next chapter (Chapter 4) will discuss, amongst other things, the conclusion, recommendations, limitations, and value of the study.

CHAPTER 4 : SUMMARY OF RESEARCH FINDINGS, RECOMMENDATIONS, LIMITATIONS AND CONCLUSION

4.1 INTRODUCTION

The previous chapter presented a discussion of the research findings. The discussion included three themes: departmental challenges associated with the lack of monitoring in clinics, the effects of a lack of monitoring, and support strategies utilised by nurses working in clinics based at special schools. The themes were further divided into sub-themes, presented and supported by literature and verbatim quotes of the participants from the in-depth interviews. The first theme, departmental challenges with monitoring, discussed the role of the Departments of Education and Health in monitoring, magnifying their specific monitoring within the specific departments. A central theme in this regard was a lack of monitoring from the mentioned departments towards clinics in special schools in the Free State. The second theme discussed the effects of the lack of monitoring on the supply of resources, the emotional and psychological impact on nurses, regulatory requirements, and the professional development of nurses working in special schools. Theme 3 discussed the innovative ideas regarding support strategies that nurses developed.

This chapter will provide a summary of the study's findings and recommendations. The discussion will also include limitations related to the study, the value of the study, the personal reflections of the researcher, and, lastly, the conclusion.

4.2 SUMMARY OF RESEARCH FINDINGS

The research findings are outlined below. It reflects the themes and sub-themes from the research question regarding the experience of registered nurses relating to the monitoring of clinics in special schools. The researcher is of the opinion that despite the availability of guidelines, the central theme of the lack of monitoring and collaboration between departments may be corrected by coordinating, as indicated in the recommendations.

4.2.1 Departmental challenges associated with the lack of monitoring in clinics based at special schools

What seems to be the central theme from the data is that there is a lack of monitoring from the relevant bodies that are expected to play a role in monitoring clinics in special schools. As much as monitoring is the responsibility of each role player, what also seemed evident was the lack of intersectoral collaboration between the role players, particularly between the DoE and the DoH, which are the central figures identified by the data.

4.2.1.1 Monitoring challenges related to DoE

The literature reviewed in Chapters 1 and 3 mentions that the Directorate of Inclusive Education at the provincial level is responsible for ensuring that the district-based support team is effectively composed to serve the local needs. The Directorate should further ensure that the support team supports special schools, particularly principals and support services personnel, including nursing personnel. From the gathered data, it seems as if the district-based support team is unable to support principals, which makes it challenging for principals and school management teams to provide the appropriate support and monitoring to nurses.

The participants mentioned the challenge of being supervised by education-orientated supervisors, who felt they were not adequately supported. In some schools, nurses form part of the school management team, while in other schools, they do not. Some participants mentioned that they do not form part of the admission committee in their schools, causing them to feel left out of the school’s communication and administrative system. Some participants also mentioned that their job descriptions are at the discretion of the principals. They are, therefore, at times expected to do what is beyond their scope of practice. Additionally, opportunities for skills development are scarce for nurses, according to the participants. All these challenges mentioned by the participants increased their frustration, and could potentially be detrimental in terms of them providing quality comprehensive primary healthcare services for learners in special schools.

Certain participants felt that the DoH should collaborate with the DoE to address monitoring challenges.

4.2.1.2 Monitoring challenges related to DoH

The DoH, as the custodian of health services in South Africa, has a role to play in monitoring all institutions that offer health services to the public, and the clinics in special schools are no exception. The data indicate that some special school clinics get their medication from district pharmacies, while school health services are supposed to support clinics in special schools. Unfortunately, the data reveal that the managers in district pharmacies don’t monitor and support clinics in special schools, and neither do school health services. Often, nurses in special schools have to refer children to local clinics due to their inability to provide certain services. Some participants mentioned that although local clinics provide assistance, this is done with some degree of reluctance, with the impression that nurses in special schools should themselves be able to provide the services. The fact that nurses in special schools are unable to provide comprehensive primary healthcare services is due to their lack of professional development. This again highlights the confusion of who is supposed to monitor, support, and provide training for these nurses, between the DoH and the DoE.

ISHP suggests that there is a need for intersectoral collaboration between the DoE and DoH to effectively implement school health services-related policies and to appropriately monitor school health services, of which primary health care services offered in clinics in special schools are part. From the data, it seems that there is a lack of intersectoral collaboration between the DoE and the DoH, which causes a lack of monitoring of clinics in special schools.

4.2.2 Effects of a lack of monitoring in clinics based at special schools

The lack of monitoring by the above-mentioned departments in special schools clinics negatively affects the nurses working in these clinics.

Material resources such as laptops, chairs, and the provision of uniforms seem to be lacking. Participants identified a shortage of nursing personnel and cleaners, affecting the services rendered. In many cases, the participants said that the infrastructure did not meet the standards of a clinic. Working in a resource-limited environment seemed to lead to frustration and low morale, as staff felt as if they could not provide the quality of care they aspired to deliver. In reaction, a few of the participants mentioned that they felt isolated and excluded from the team. These emotional triggers seem to affect the nurses negatively, even having an impact on their confidence in their ability to deliver quality primary healthcare. Staff are required to take on additional responsibilities due to insufficient resources, leading to depression and decreased job satisfaction. Constantly facing resource constraints may lead to emotional stress and feelings of helplessness among staff, affecting their mental health and job performance.

The participants also mentioned confusion in terms of which policies to follow. Most of the policies they follow fall under the DoH, although they are employed by the DoE. The issue of the nurses' job descriptions also came to light. The participants mentioned that their job descriptions differ, as principals apply personal interpretations to what they are supposed to be doing. Some roles they are expected to play may fall outside of their scope of practice. This creates confusion for the nurses, as they don't know if they should follow their prescribed job descriptions/scope of practice or the principals' instructions. This eventually creates frustration among nurses, affecting their confidence in executing their duties.

The participants mentioned the lack of professional development as a challenge. There are no opportunities for them to participate in in-service training, and they feel left behind regarding new developments in their field. Without adequate resources, personnel miss out on essential training and professional development opportunities, impacting their skills and knowledge. They have to rely on their limited and outdated knowledge in how they conduct their daily business. Very few bursaries are suited for nurses, which makes it difficult for them to study further.

4.2.3 Support strategies of the nurses working in clinics based at special schools

Due to the challenges faced by the nurses, they found some innovative ways to gain support for themselves. One of these was the development of a special forum, where all nurses from special schools in the Free State could come together and share ideas and knowledge on managing specific medical conditions and their clinics. Some participants mentioned a national conference of special school nurses, which serves the same purpose as the nurses' forum but on a larger scale. Attending this conference enables them to share knowledge and skills, and to exchange information on how special schools function in different provinces.

The participants further mentioned using local clinics for information and resources that they cannot get from the DoE. It was mentioned that nurses would call a local clinic for advice if they didn’t know how to manage a condition. The participants further mentioned that although local clinics help them, some are reluctant as they feel that nurses in special schools overburden them because they are supposed to be able to manage by themselves.

Because the nurses working in clinics in special schools have no formal access to doctors, some participants call on their private doctors for help. The doctors seem eager to assist with telephonic advice or if the nurses need a prescription.

Certain recommendations can be made to try to mitigate the challenges faced by the participants. These should, however, be considered to be specific to the context of this study.

4.3 RECOMMENDATIONS

It must be noted that the researcher's recommendations did not follow the same sequence as the themes that emerged in chapter three. The sequence of the recommendations was made with consideration of their logical implementation.

4.1. Table of recommendations

Theme 1: Departmental challenges associated with a lack of monitoring in clinics based at special schools	1.1. The researcher proposes that further studies are necessary to identify if the lack of monitoring and collaboration impacts learners' health care, as this was not the focus of the current study. 1.2. Approval of the study by the Department of Education (DoE) was conditional upon doing a presentation to the relevant departments. The researcher, therefore, expects to [Sub-themes 1.1 and 1.2]: create awareness amongst the departments regarding the shortcomings as were described by the participants of the study. This awareness could lead to: • the establishment of an intersectoral committee between the DoH and DoE, spearheaded by the School Health Directorate in DoH and the Inclusive Education Directorate in DoE • a memorandum of understanding between the two departments on the role of each in the intersectoral committee, and the establishment of a communication system • addressing the referral system between special school clinics and the institutions in DoH, including local primary health care clinics, level 1 hospitals, and outpatient departments • prioritising successful monitoring between the departments

Theme 3: Support strategies of the nurses working in clinics based at special schools

3.1. Nurses can take the initiative to reactivate the nurses' forum, giving it a specific name for Nurses Working in Special Schools. This platform can be used to share insights on issues that may affect the health of the learners, as well as the working environment of the nursing staff.

- Elect a chairperson and a secretary to maintain the structure of meetings and document all discussions. Initial discussions may include the following:
    - Define the common goals and objectives for the forum.
    - Identify stakeholders from each department involved in clinics to form part of the forum.

DoE representatives [Sub-theme 1.1]:	**DoH representatives [Sub-theme 1.2]:**
• Principal • Chairperson of the school governing body • Occupational therapist/physiotherapist • Social worker	• District support team • School Health • Local area managers of clinics • Pharmacy

    - Develop a joint action plan
- The forum's secretary can initiate meetings with stakeholders, beginning with the principal of the school as the primary Department of Education (DoE) contact, followed by meetings with other stakeholders in the school.
- Establish committees at every special school to have regular discussions with non-teaching staff.

	Objectives for meetings with DoH representatives: 1. Invite the pharmacist of the specific district to discuss the supervision of medication storage, usage, and supply. 2. Collaborate with the designated person of school health teams and outreach programs in the district, to determine their role in supporting the nurse in the special school clinic. 3. Identify the representative in the district-based support team to discuss the referral to local clinics and outpatient services, and to clarify the role of private practitioners [Sub-theme 3.3] in clinics of special schools. 4. Invite the local area managers of the local clinics and discuss the referral of learners and mutual support to each other [Sub-theme 3.2].
Theme 2: Effect of the lack of monitoring in clinics based at special schools	**Objectives for meetings with principals:** 1. Identify clear outcomes related to the needed resources and the impact of this on the quality of care delivered by the nurses [Sub-theme 2.1]. 2. Propose that nurses attend at least one quarterly webinar to enhance their knowledge regarding new guidelines and the medical treatment of learners [Sub-theme 2.4]. 3. Highlight the importance of being part of the School Management Team (SMT) to address learners' needs and implement a holistic approach to their overall treatment. Use this opportunity to discuss the scope of practice of the nurse [Sub-theme 2.3].

- Once nurses had the opportunity to communicate their needs to the principal, explore the possibility of arranging a collaborative meeting with all the principals, inviting them to a joint session at the nurses' forum once clear objectives for the meeting have been established.
- During follow-up meetings with the principal, discuss the emotional needs of the nursing staff and explore potential initiatives that the principal can implement to address these concerns [Sub-theme 2.2].

Regarding regulatory requirements and professional development, nurses can promote their own development [Sub-themes 2.3 and 2.4]:

- Use forum meetings to identify the most pressing knowledge gaps of the nurses.
- Register on Knowledge Hub and select a realistic timeframe to complete a specific topic. Organise an end-of-year function where nurses can showcase the certificates they have earned through Knowledge.

4.4 LIMITATIONS OF THE STUDY

The research focus in this study was not on the entire value chain of primary healthcare services provided in clinics in special schools in South Africa. The focus of the research was on the Free State as a geographical area and the experiences of registered nurses in the monitoring of clinics. The study was further limited to registered nurses only, and no data were collected from other categories of nurses, the recipients of health services in the special schools, or possible stakeholders in the Departments of Health and Education. The viewpoints of principals, school management teams, school governing bodies, school health nurses, local area managers, and local clinic unit managers would also have been valuable. The research had 12 possible participants, but data saturation was reached after nine interviews, which could have been another limitation of the research. It has to be mentioned that it didn't have a negative impact on the research, as the focus of the qualitative research is the depth of data, not representation. Another possible limitation was that the researcher was a former colleague of the participants, which might have caused unintentional bias.

4.5 VALUE OF THE STUDY

DoE: The research could highlight the challenges of nurses working in clinics in special schools, allowing the DoE to better understand these challenges. It could improve how different levels of management within DoE, including the Directorate of Inclusive Education at the provincial level, district-based support teams at the district level, and principals and school management teams, monitor and support the nurses working in clinics in special schools. Principals could have a better understanding of the challenges faced by nurses, and how to best support them.

DoH: The Directorates of School Health and Pharmaceutical Services would better understand the loopholes in monitoring and supporting the nurses and clinics in special schools. This would allow the DoH to effectively implement ISHP and AYFS policies in special schools.

The intersectoral collaboration between the two mentioned departments at all management levels could improve the quality of monitoring and support received by the clinics in special schools. A referral system between special school clinics and the DoH could be established.

The effective application of recommendations for the development of monitoring systems may positively impact monitoring in other non-DoH institutions that are providing health services, such as the Department of Correctional Services, the Department of Social Development, and old age homes.

Participants: The implementation of the recommendations could positively impact the participants, as their inputs would be validated. It could further improve the support and monitoring that they receive, and they might be exposed to more learning opportunities to improve their skills and knowledge. Their confidence regarding their own knowledge and skills to provide quality primary healthcare could be enhanced. They would also be in a better position to adhere to the appropriate regulations governing their work.

Recipients of primary healthcare services in special schools: An improvement in the quality of monitoring of clinics in special schools could improve the quality of primary healthcare received by special school learners.

Future researchers: This research could be of value to future qualitative researchers, particularly in the primary healthcare and school health sector, and could be used as an example to build on for future qualitative studies in primary healthcare and school health.

4.6 RECOMMENDATIONS FOR FUTURE STUDY

The researcher recommends that future research relating to primary health services/school health services should investigate the following issues:

- National research on nurses' experiences regarding the monitoring and supervision of clinics in special schools.
- The quality of supervision and monitoring in primary healthcare clinics in preparation for the NHI.

- Challenges faced by managers in monitoring and supporting clinics in special schools, including principals, school management teams, district-based support teams, and educational specialists within the Department of Education.
- Studies to determine the impact of a lack of monitoring and collaboration on the healthcare of the learners.
- Assessment of the value chain of health services provided in special schools and their contribution towards national health strategic goals.

4.7 RESEARCHER’S REFLECTION ON THE RESEARCH

Reflection creates an opportunity to look back and re-live an event and, in this case, the researcher's reflection related to this research. The research empowered the researcher with the rigorous skills needed for qualitative research. The qualitative methodology of this study interested the researcher, as the approaches inherent in qualitative research challenged the personality, skills, and knowledge of the researcher, who is an analytical, systems thinker who likes the challenge of solving problems. The data collection process engaged the researcher intellectually. His own experiences resonated with those of the participants, as he has previously worked in clinics in special schools. However, he applied bracketing to sensitise himself regarding possible biases, prejudices, and emotions during the data collection and analysis process. The data analysis process of transcribing, reading, coding, and creating themes kept the researcher engrossed in the data.

The researcher embraced technological tools in the data collection and analysis process. Using an application like Otter made recording of the in-depth interviews and transcribing much easier, which could have been a much more time-consuming process. The findings of the study resulted in the researcher's understanding of what an exploratory, descriptive design means, as the findings reflected the situation in the Free State. Personally, the journey through this Master’s degree program resulted in growth for the researcher through enhancing coordination skills, improving the searching and interrogation of literature, and improving writing skills exponentially. The researcher, who was a full-time employee, needed a balance between the requirements of the employer, personal family commitments, and academic pressure.

4.8 CONCLUSION

This chapter presented a summary of the study's findings, recommendations, and limitations, including the value of the study and personal reflections. The researcher was interested in the experiences of registered nurses regarding the monitoring of clinics in special schools. The researcher hopes to address the challenges emanating from these experiences through the recommendations. The recommendations were made by taking into account the role of the DoE and DoH in the monitoring of clinics in special schools.

Chapter 1 provided the background of the research, and the pragmatic perspective followed. Chapter 2 engaged in the research methodology. It was explained why a qualitative, descriptive, and explorative research design was chosen. The chapter further clarified the population and sampling of the participants. It was also in this chapter that the data collection process of in-depth interviews was discussed in detail. The thematic data analysis process was also discussed in this chapter. Chapter 3 discussed the research findings, diving deeper into the details of the collected data.

From the collected data, a lack of monitoring clinics in special schools, from all levels of management from the DoE and DoH, seems evident. The recommendations include intersectoral collaboration at the provincial and district levels between the DoE and DoH to strengthen the monitoring activities and support management and clinics in special schools. The intersectoral collaboration would have a domino effect in addressing the effects caused by the lack of monitoring. Strengthening peer support activities by nurses it is another recommendation to ensure that there are support systems in place for nurses working in special schools.

The intent of all the recommendations is to strengthen the monitoring systems, to effectively coordinate available resources, and to improve the quality of primary healthcare provided in clinics in special schools.

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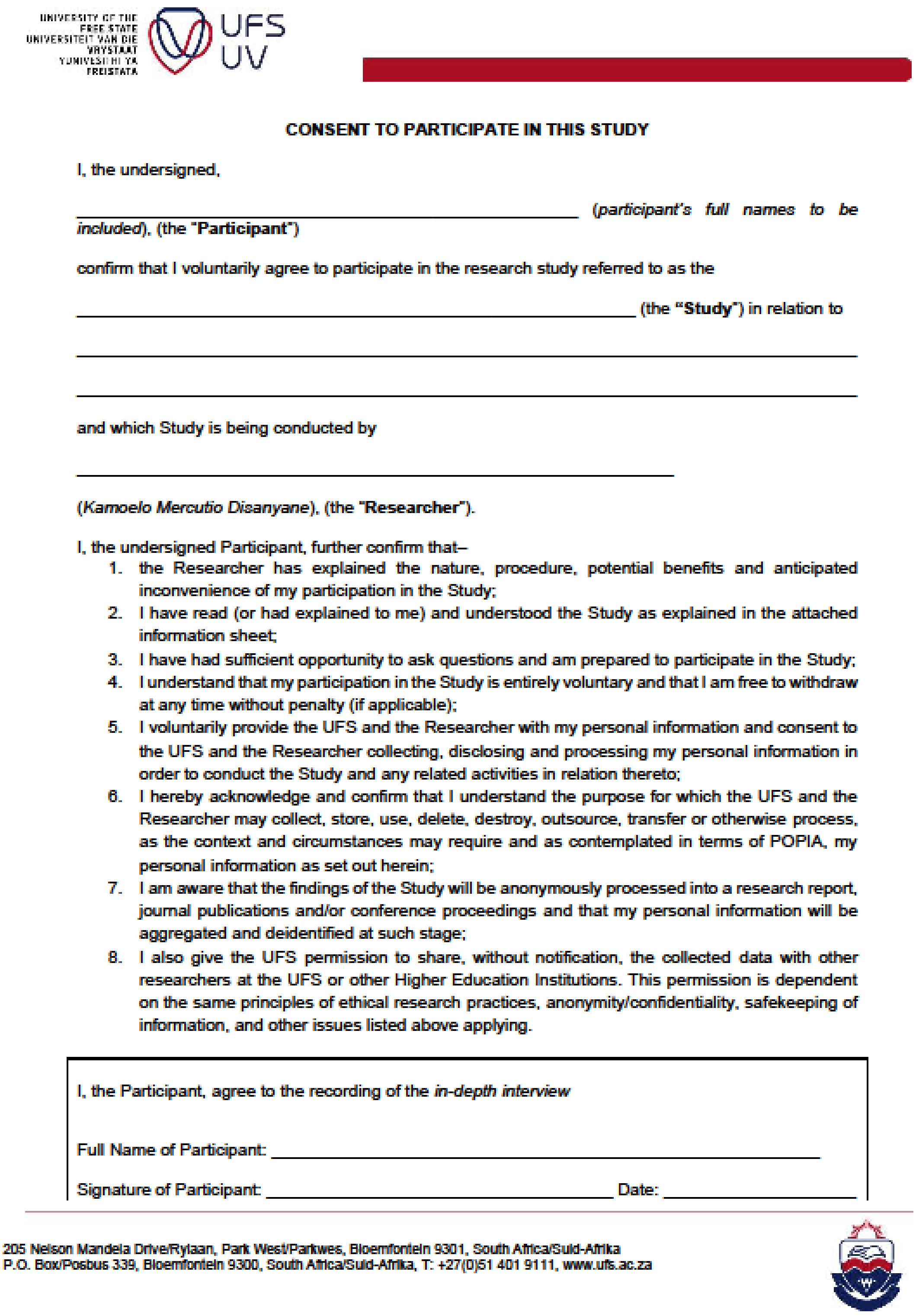
ADDENDUM A - CONSENT FORM



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FREISTATA

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CONSENT TO PARTICIPATE IN THIS STUDY

I, the undersigned,

____ (*participant's full names to be included*), (the "**Participant**")

confirm that I voluntarily agree to participate in the research study referred to as the

____ (the "**Study**") in relation to

____

____

and which Study is being conducted by

____

(*Kamoelo Mercutio Disanyane*), (the "**Researcher**").

I, the undersigned Participant, further confirm that–

1. the Researcher has explained the nature, procedure, potential benefits and anticipated inconvenience of my participation in the Study;
2. I have read (or had explained to me) and understood the Study as explained in the attached information sheet;
3. I have had sufficient opportunity to ask questions and am prepared to participate in the Study;
4. I understand that my participation in the Study is entirely voluntary and that I am free to withdraw at any time without penalty (if applicable);
5. I voluntarily provide the UFS and the Researcher with my personal information and consent to the UFS and the Researcher collecting, disclosing and processing my personal information in order to conduct the Study and any related activities in relation thereto;
6. I hereby acknowledge and confirm that I understand the purpose for which the UFS and the Researcher may collect, store, use, delete, destroy, outsource, transfer or otherwise process, as the context and circumstances may require and as contemplated in terms of POPIA, my personal information as set out herein;
7. I am aware that the findings of the Study will be anonymously processed into a research report, journal publications and/or conference proceedings and that my personal information will be aggregated and deidentified at such stage;
8. I also give the UFS permission to share, without notification, the collected data with other researchers at the UFS or other Higher Education Institutions. This permission is dependent on the same principles of ethical research practices, anonymity/confidentiality, safekeeping of information, and other issues listed above applying.

I, the Participant, agree to the recording of the *in-depth interview*

Full Name of Participant: ____

Signature of Participant: ______________________________ Date: _______________

205 Nelson Mandela Drive/Rylaan, Park West/Parkwes, Bloemfontein 9301, South Africa/Suid-Afrika
P.O. Box/Posbus 339, Bloemfontein 9300, South Africa/Suid-Afrika, T: +27(0)51 401 9111, www.ufs.ac.za

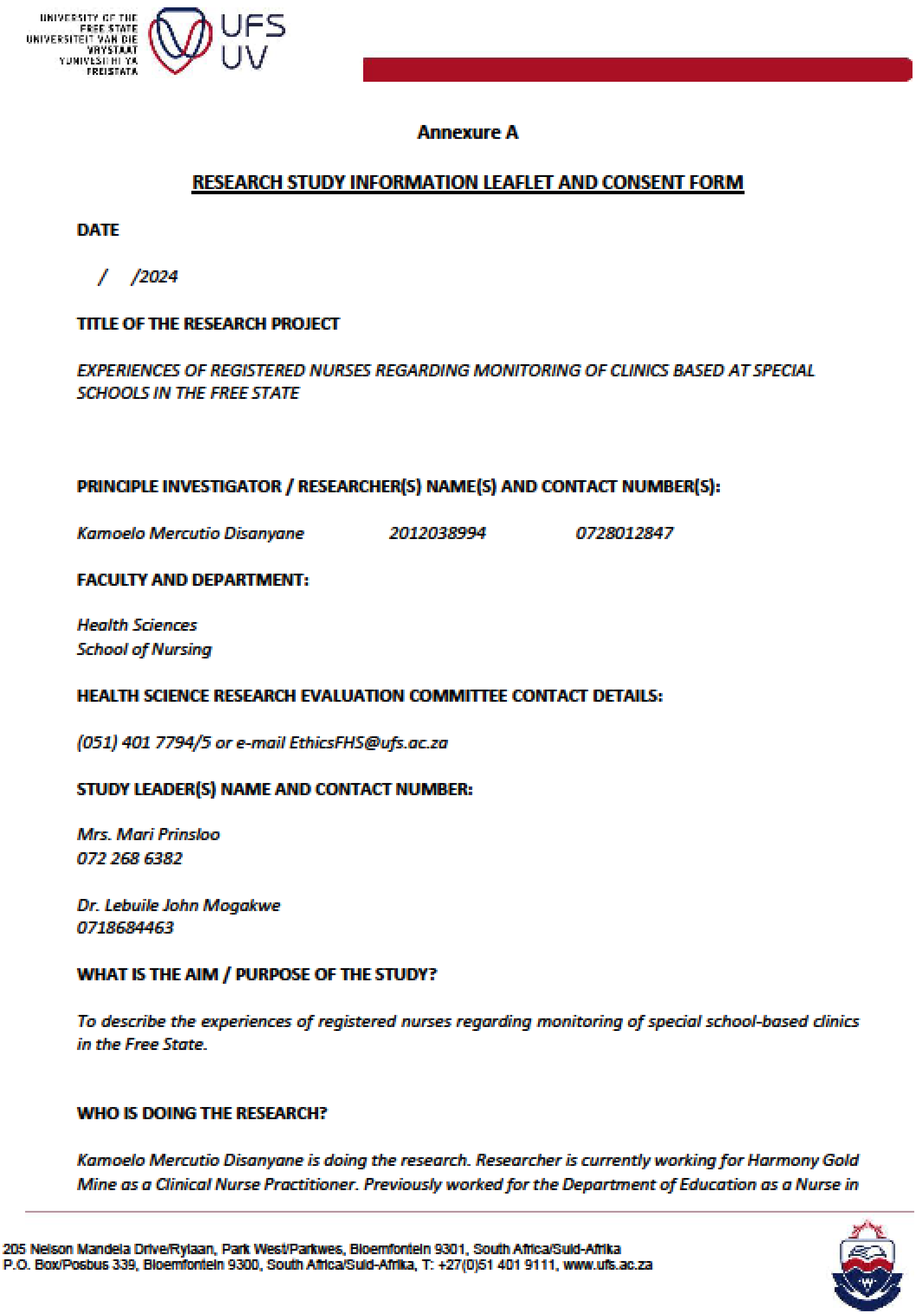
Full Name(s) of Researcher(s): ______________________________

Signature of Researcher: ______________________ Date: ______________

Witness' Signature: ______________________ Date: ______________

Witness' Name: ______________________ Time: ______________
(please print name)

ADDENDUM B - INFORMATION LEAFLET



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Annexure A

RESEARCH STUDY INFORMATION LEAFLET AND CONSENT FORM

DATE

/ /2024

TITLE OF THE RESEARCH PROJECT

EXPERIENCES OF REGISTERED NURSES REGARDING MONITORING OF CLINICS BASED AT SPECIAL SCHOOLS IN THE FREE STATE

PRINCIPLE INVESTIGATOR / RESEARCHER(S) NAME(S) AND CONTACT NUMBER(S):

Kamoelo Mercutio Disanyane	*2012038994*	*0728012847*

FACULTY AND DEPARTMENT:

Health Sciences
School of Nursing

HEALTH SCIENCE RESEARCH EVALUATION COMMITTEE CONTACT DETAILS:

(051) 401 7794/5 or e-mail EthicsFHS@ufs.ac.za

STUDY LEADER(S) NAME AND CONTACT NUMBER:

Mrs. Mari Prinsloo
072 268 6382

Dr. Lebuile John Mogakwe
0718684463

WHAT IS THE AIM / PURPOSE OF THE STUDY?

To describe the experiences of registered nurses regarding monitoring of special school-based clinics in the Free State.

WHO IS DOING THE RESEARCH?

Kamoelo Mercutio Disanyane is doing the research. Researcher is currently working for Harmony Gold Mine as a Clinical Nurse Practitioner. Previously worked for the Department of Education as a Nurse in *one of the special schools and observed some of the challenges nurses face in their daily operations in special school-based clinics.*

HAS THE STUDY RECEIVED ETHICAL APPROVAL?

This study has received approval from the Research Ethics Committee of UFS. A copy of the approval letter can be obtained from the researcher.

APPROVAL NUMBER:

WHY ARE YOU INVITED TO TAKE PART IN THIS RESEARCH PROJECT?

You are a professional nurse working at a special school-based clinic in the Free State, which the focus of the research is on.

WHAT IS THE NATURE OF PARTICIPATION IN THIS STUDY?

A one-on-one in-depth interview will be conducted between yourself as a participant and the researcher. Four central questions will be asked, followed by probes where necessary. The interview will be audio recorded. The researcher, will keep records of people who participated in the research, the audio recordings, the field notes, and transcripts of those audio recordings. Each in-depth interview will last approximately 45 minutes, dependent on the direction of the interview, the data provided and the precipitation of the data provided. As a participant, you will be required to provide the date, time, and place convenient to conduct the interview.

CAN THE PARTICIPANT WITHDRAW FROM THE STUDY?

Your participation in this research is voluntary, and you will not be penalized if you refuse to participate or decide to terminate participation during the study. If you agree to participate, you will be given a signed copy of this document as well as the participant information sheet, which is a written summary of the research.

WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THIS STUDY?

There are no personal benefits for involvement in the study, but there is a potential benefit of improvement on how special school-based clinics could be supervised.

WHAT IS THE ANTICIPATED INCONVENIENCE OF TAKING PART IN THIS STUDY?

To the best of the researcher's knowledge, there are no physical, emotional, or psychological risks involved in participating in the research.

WILL WHAT I SAY BE KEPT CONFIDENTIAL?

Your answers will be given a fictitious code number or a pseudonym, and you will be referred to in this way in the data, any publications, or other research reporting methods such as conference proceedings. Your answers may be reviewed by people responsible for making sure that research is done properly, including the transcriber, supervisors, data analyst, language editor, external coder, and members of the Research Ethics Committee. Otherwise, records that identify you will be available only to people working on the study, unless you give permission for other people to see the records. Privacy will be protected in any publication of the information. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report. Your identity will not be revealed when the study is reported or published without your consent, as is provided in the POPI act.

HOW WILL THE INFORMATION BE STORED AND ULTIMATELY DESTROYED?

All your transcribed answers and all electronic information will be stored on Figshare for 5 years and will be password-protected. Future use of the stored data will be subject to further Research Ethics Review and approval if applicable. Information will be destroyed by deleting all electronic information from Figshare, all audio recordings will be deleted, and all hard copies will be shredded.

WILL I RECEIVE PAYMENT OR ANY INCENTIVES FOR PARTICPATING IN THIS STUDY?

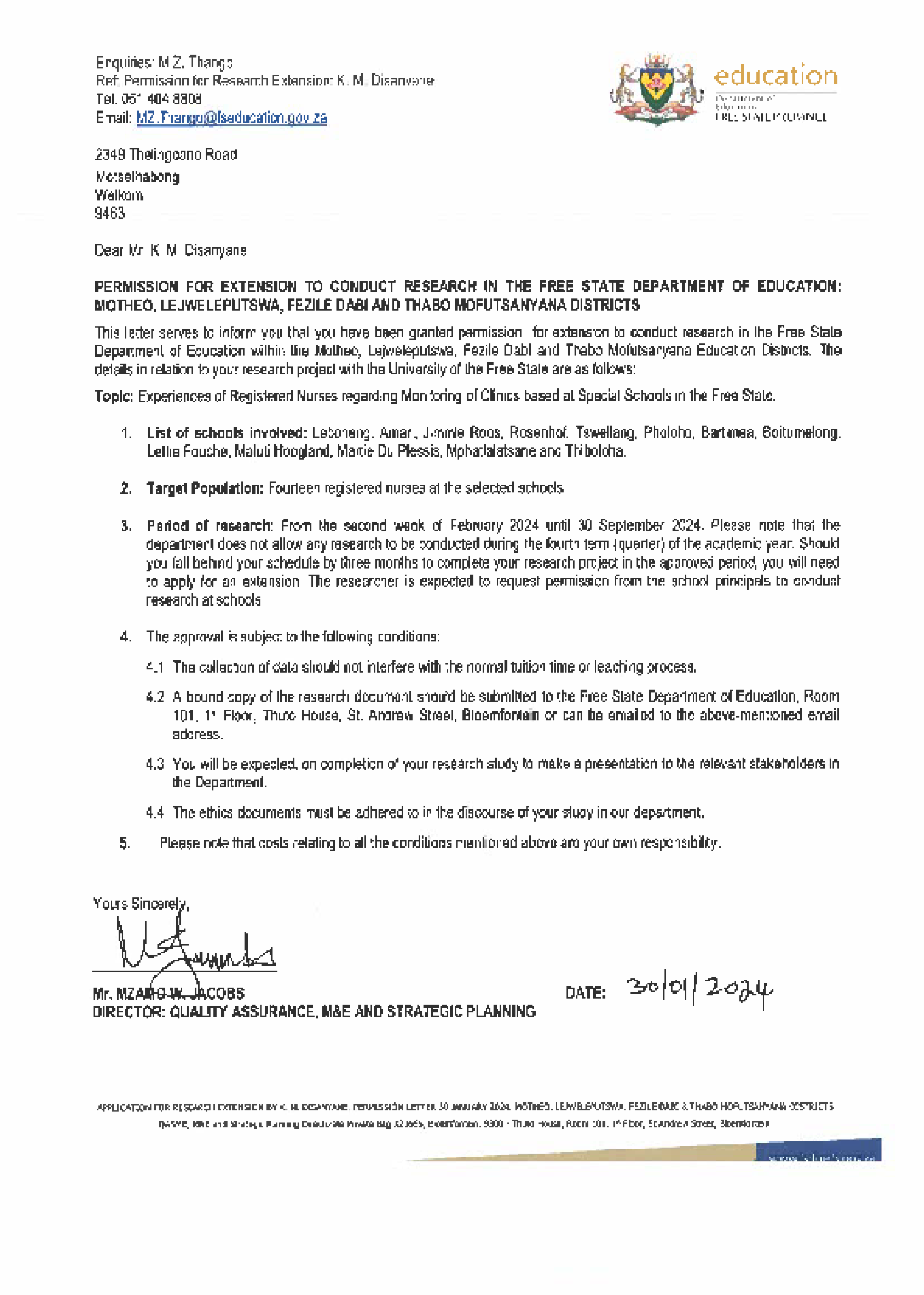
There will be no reimbursements or any incentives for participants, for participating in the research.

HOW WILL THE PARTICIPANT BE INFORMED OF THE FINDINGS / RESULTS OF THE STUDY?

If you would like to know about the research findings, publication of the research findings, to be provided with a digital link to read the research findings, or you have any questions regarding the research or about participating in the research, please feel free to ask me, Kamoelo Mercutio Disanyane. You can call or whats app on 072 801 2847, or e-mail me at mercutiod@gmail.com. If you have concerns to raise about the researcher's conduct during the research, any unethical conduct observed, or any other query concerning the researcher, please contact Mrs. Mari Prinsloo at 072 268 6382 or email at PrinslMM@ufs.ac.za.

Thank you for taking the time to read this information sheet and for participating in this study.

ADDEDNUM C - APPROVAL FROM THE FREE STATE DEPARTMENT OF EDUCATION



Enquiries: M Z. Thango
Ref: Permission for Research Extension: K. M. Disanyane
Tel. 051 404 8808
Email: MZ.Thango@fseducation.gov.za

education
Department of Education
FREE STATE PROVINCE

2349 Thelingoano Road
Motselhabong
Welkom
9463

Dear Mr K. M. Disanyane

PERMISSION FOR EXTENSION TO CONDUCT RESEARCH IN THE FREE STATE DEPARTMENT OF EDUCATION: MOTHEO, LEJWELEPUTSWA, FEZILE DABI AND THABO MOFUTSANYANA DISTRICTS

This letter serves to inform you that you have been granted permission for extension to conduct research in the Free State Department of Education within the Motheo, Lejweleputswa, Fezile Dabi and Thabo Mofutsanyana Education Districts. The details in relation to your research project with the University of the Free State are as follows:

Topic: Experiences of Registered Nurses regarding Monitoring of Clinics based at Special Schools in the Free State.

1. **List of schools involved:** Lebohang, Amar, Jannie Roos, Rosenhof, Tswellang, Phaloho, Bartimea, Boitumelong, Lettie Fouche, Maluti Hoogland, Marie Du Plessis, Mphatlalatsane and Thiboloha.
2. **Target Population:** Fourteen registered nurses at the selected schools.
3. **Period of research:** From the second week of February 2024 until 30 September 2024. Please note that the department does not allow any research to be conducted during the fourth term (quarter) of the academic year. Should you fall behind your schedule by three months to complete your research project in the approved period, you will need to apply for an extension. The researcher is expected to request permission from the school principals to conduct research at schools.
4. The approval is subject to the following conditions:
    - 4.1 The collection of data should not interfere with the normal tuition time or teaching process.
    - 4.2 A bound copy of the research document should be submitted to the Free State Department of Education, Room 101, 1st Floor, Thuto House, St. Andrew Street, Bloemfontein or can be emailed to the above-mentioned email address.
    - 4.3 You will be expected, on completion of your research study to make a presentation to the relevant stakeholders in the Department.
    - 4.4 The ethics documents must be adhered to in the discourse of your study in our department.
5. Please note that costs relating to all the conditions mentioned above are your own responsibility.

Yours Sincerely,

Mr. MZAMO W. JACOBS
DIRECTOR: QUALITY ASSURANCE, M&E AND STRATEGIC PLANNING

DATE: 30/01/2024

ADDENDUM D - LETTER TO PRINCIPALS

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HEALTH SCIENCES
GESONDHEIDSWETENSKAPPE

Disanyane Kamoelo Mercutio

2349 Thelingoane Road

P.O. Motsethabong

Welkom

9463

R.E.: REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY: EXPERIENCES OF REGISTERED NURSES REGARDING MONITORING OF CLINICS BASED AT SPECIAL SCHOOLS IN THE FREE STATE.

Dear Principal

I am a student at the University of Free State student pursuing a Master of nursing science degree. I am an employee at Harmony gold mine but previously worked at a special school for the Free State Department of Education. I am humbly requesting permission to conduct this study at special schools in the Free State and gather data from the registered nurse.

The purpose of the research study is to describe the experiences of registered nurses regarding the monitoring of clinics based at special schools in the Free State. In-depth, interviews will be conducted between the nurses and the researcher.

Registered nurses' participation in this research is voluntary, there are no personal benefits for registered nurses (e.g. monetary remuneration) for involvement in the study. Confidentiality of participants and the information gathered during the research will be maintained at all times.

If you need any other information, please feel free to ask Kamoelo Mercutio Disanyane. You can call or whats app on 072 801 2847, or e-mail questions at mercutiod@gmail.com. If there are any concerns to raise about the researcher's conduct during the research, any unethical conduct observed, or any other query concerning the researcher, please contact Mrs. Mari Prinsloo at 072 268 6382 or email at PrinslMM@ufs.ac.za or you can contact the Health Sciences Research Evaluation Committee at 051-4017794/5 and email: EthicsFHS@ufs.ac.za.

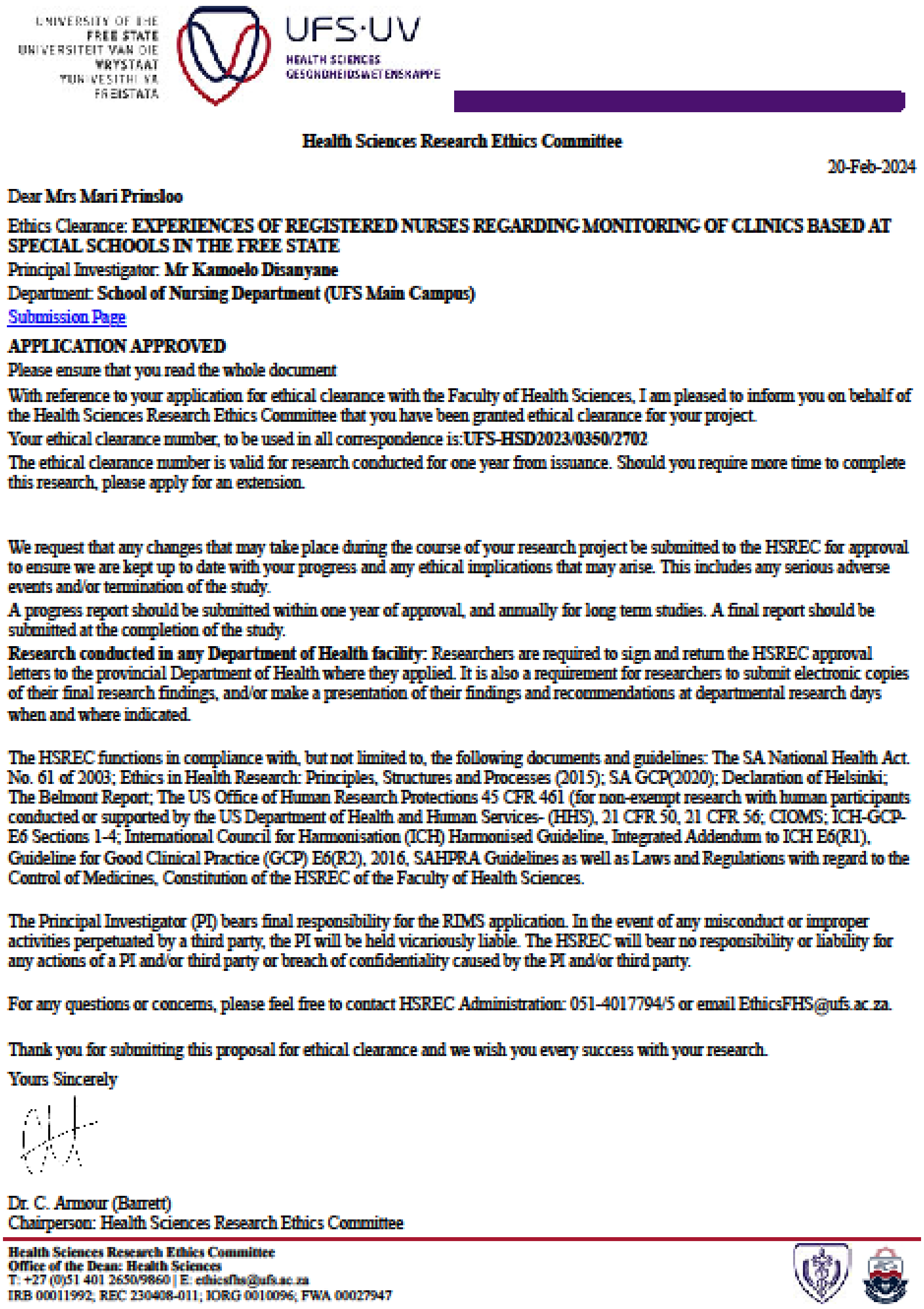
Please see the attached research proposal and approval from the University of Free State Health Science Research Ethics Committee.

____

Kamoelo Mercutio Disanyane

Master in Nursing Science student

ADDENDUM E - ETHICAL CLEARANCE



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GESONDHEIDSWETENSKAPPE

Health Sciences Research Ethics Committee

20-Feb-2024

Dear Mrs Mari Prinsloo

Ethics Clearance: **EXPERIENCES OF REGISTERED NURSES REGARDING MONITORING OF CLINICS BASED AT SPECIAL SCHOOLS IN THE FREE STATE**
Principal Investigator: **Mr Kamoelo Disanyane**
Department: **School of Nursing Department (UFS Main Campus)**
Submission Page

APPLICATION APPROVED

Please ensure that you read the whole document

With reference to your application for ethical clearance with the Faculty of Health Sciences, I am pleased to inform you on behalf of the Health Sciences Research Ethics Committee that you have been granted ethical clearance for your project.

Your ethical clearance number, to be used in all correspondence is:**UFS-HSD2023/0350/2702**

The ethical clearance number is valid for research conducted for one year from issuance. Should you require more time to complete this research, please apply for an extension.

We request that any changes that may take place during the course of your research project be submitted to the HSREC for approval to ensure we are kept up to date with your progress and any ethical implications that may arise. This includes any serious adverse events and/or termination of the study.

A progress report should be submitted within one year of approval, and annually for long term studies. A final report should be submitted at the completion of the study.

Research conducted in any Department of Health facility: Researchers are required to sign and return the HSREC approval letters to the provincial Department of Health where they applied. It is also a requirement for researchers to submit electronic copies of their final research findings, and/or make a presentation of their findings and recommendations at departmental research days when and where indicated.

The HSREC functions in compliance with, but not limited to, the following documents and guidelines: The SA National Health Act. No. 61 of 2003; Ethics in Health Research: Principles, Structures and Processes (2015); SA GCP(2020); Declaration of Helsinki; The Belmont Report; The US Office of Human Research Protections 45 CFR 461 (for non-exempt research with human participants conducted or supported by the US Department of Health and Human Services- (HHS), 21 CFR 50, 21 CFR 56; CIOMS; ICH-GCP-E6 Sections 1-4; International Council for Harmonisation (ICH) Harmonised Guideline, Integrated Addendum to ICH E6(R1), Guideline for Good Clinical Practice (GCP) E6(R2), 2016, SAHPRA Guidelines as well as Laws and Regulations with regard to the Control of Medicines, Constitution of the HSREC of the Faculty of Health Sciences.

The Principal Investigator (PI) bears final responsibility for the RIMS application. In the event of any misconduct or improper activities perpetuated by a third party, the PI will be held vicariously liable. The HSREC will bear no responsibility or liability for any actions of a PI and/or third party or breach of confidentiality caused by the PI and/or third party.

For any questions or concerns, please feel free to contact HSREC Administration: 051-4017794/5 or email EthicsFHS@ufs.ac.za.

Thank you for submitting this proposal for ethical clearance and we wish you every success with your research.

Yours Sincerely

Dr. C. Armour (Barrett)
Chairperson: Health Sciences Research Ethics Committee

Health Sciences Research Ethics Committee
Office of the Dean: Health Sciences
T: +27 (0)51 401 2650/9860 | E: ethicsfhs@ufs.ac.za
IRB 00011992; REC 230408-011; IORG 0010096; FWA 00027947

ADDENDUM F - DECLARATION BY A LANGUAGE EDITOR

To whom it may concern

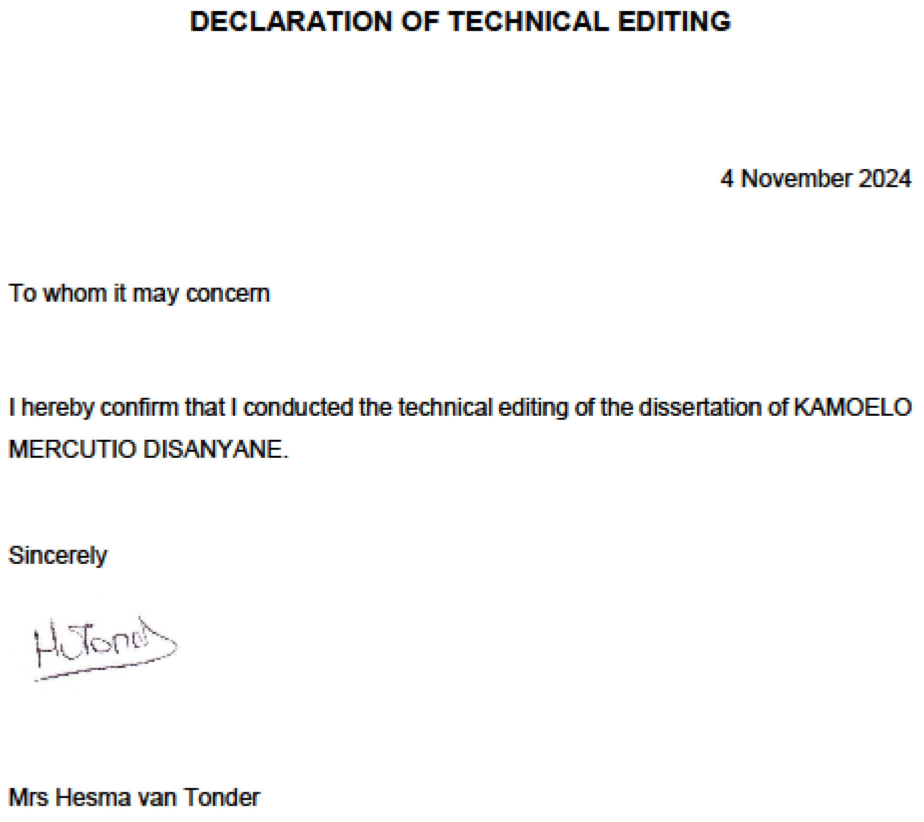
This is to state that the thesis titled EXPERIENCES OF REGISTERED NURSES REGARDING MONITORING OF CLINICS BASED AT SPECIAL SCHOOLS IN THE FREE STATE by Kamoelo Mercutio Disanyane has been language edited by me, according to the tenets of academic discourse. The final responsibility for applying any proposed corrections lies with the authors.

AduPreez

Annamarie du Preez
B.Bibl.; B.A. Hons. (English)
0837641864

27-10-2024

ADDENDUM G - DECLARATION BY TECHNICAL EDITOR



DECLARATION OF TECHNICAL EDITING

4 November 2024

To whom it may concern

I hereby confirm that I conducted the technical editing of the dissertation of KAMOELO MERCUTIO DISANYANE.

Sincerely

Mrs Hesma van Tonder