# Assessing healthcare accessibility and quality for Namibian learners under the National School Health Programme

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***Abstract***
*This study delved into the intricate landscape of analysing the National School Health Policy in Namibia. By gathering data from the Khomas, Oshana, and Kavango regions, this research analysed the perspectives of various stakeholders on the execution of the policy. Foucault's theory of Power Relations and Talcott Parson's Social Action provided the appropriate theoretical conceptual tools to unearth inequalities in the health policy implementation in Namibia. Power was considered a system that was used to suppress learners from accessing quality health care. Methodologically, a mixed approach was employed to unearth gaps in the challenges and successes of implementing the National School Health Policy. Through interviews and focus group discussions, the study highlighted the scarcity of essential resources and personnel dedicated to school health programmes, leading to potential gaps in health service provision. The prevalent inequalities in the health sector emerged when learners were insufficiently informed about their entitlements to medical care accessibility within the school premises. Generally, there was a positive attitude toward the policy's implementation evidence among stakeholders. Nevertheless, despite this attitude, inadequate accessibility of health care services among learners was rampant in Namibia. Nonetheless, areas necessitating increased attention became apparent, such as enhancing awareness across all groups involved in school health initiatives and to pave the way for enhanced effectiveness, strategic recommendations were proposed such as addressing the communication ambiguities. These included the enhancement of communication channels between educators, administrators, and parents, ensuring ample availability of resources and personnel, including an adequate number of trained nurses, with requisite governmental support. Moreover, tackling barriers stemming from geographical distances or financial constraints that limit healthcare access emerged as a crucial facet of policy improvement.*

**Keywords:** *National School Health Policy, stakeholders, implementation, healthcare accessibility, resource constraints*

## Introduction

The National School Health Policy (NSHP) is a comprehensive programme launched in Namibia in 2008. The primary objective of this programme is to provide quality healthcare services to all learners at primary and secondary school institutions. The programme encompasses a range of preventive measures such as regular check-ups, vaccinations, nutrition education programmes, mental health counselling sessions, and necessary medical interventions if required. The programme aims to promote healthy habits and lifestyles among primary and secondary school learners, which helps them grow into healthy adults. This is believed to be a significant step towards ensuring that every school learner and child in Namibia has access to quality healthcare services regardless of their socio-economic background (World Health Organization, 2021). Of concern are the challenges in the implementation of the NSHP meant to improve the overall health and well-being of school children in Namibia. Key factors that raise concerns are the accessibility of the policies for the learners and their implementation strategies in Namibia.

## Statement of the problem

The National School Health Programme aims to address historical health inequalities and enhance healthcare provision in schools. It works alongside initiatives such as the Integrated Nutrition Programme, which implements school feeding programmes for underprivileged children, and social grants that cater to children provided by the government. The programme plays a crucial role in improving overall health standards among school-going youth across Namibia with its comprehensive approach towards better

education outcomes. The National Food Consumption Survey conducted in South Africa revealed that a significant 8% of children were stunted, while 1% suffered from severe underweight conditions (Rossouw et al., 2016). The underprivileged communities face several health challenges that are compounded by poor nutrition and inadequate access to healthcare. This situation is made worse when there is a lack of support for these groups, exacerbating their health problems. When implemented effectively, the School Health Programme (SHP) can offer much-needed relief to communities by improving overall health outcomes through proper nutrition and increased access to medical care. It is crucial to acknowledge the significance of investing in school health programmes as a means of promoting better overall health outcomes. According to the World Health Organization, the statement could be a significant element in a more extensive framework for education or health policy. Furthermore, it can also exist as an independent entity (World Health Organization, 2021). Therefore, the purpose of this study was to explore the perspectives of various stakeholders on the execution of the National School Health Programme in Namibia.

**Objectives of the study**

The study aimed to achieve the following objectives:

1. To evaluate the availability of the essential resources that affect how the National School Health Programme is implemented.
2. To offer suggestions for approaches to the constraints preventing the National School Health Programme from being implemented successfully.

**Theoretical framework**

The theoretical framework assists in understanding, describing, and explaining behaviour (Phiri et al., 2023). For this study, Foucault's theory of Power Relations was found useful owing to matters, questions, and issues arising about the actors in the health sector demonstrating as a network of policy actors and the various approaches it provides for thinking about the materiality, ordering, distribution, and hierarchy (Phiri, 2021) with which policymakers interact. Therefore, Michel Foucault's theory of Power Relations (Phiri, 2017) and Parson's (2009) Social Action provided the appropriate theoretical thinking tools to unearth inequalities in the implementation of health policy in Namibia. A social system has been defined by Mitchell (1979) as 'consisting of a plurality of all actors interacting directly or indirectly with each other in a bounded situation' (p. 203). The theories are particularly important because they allowed the researchers to delve into individual and institutional practices, which embody power (Phiri, 2017) and social action. Further, for this study, these theories proved useful as a theoretical lens in gaining a better understanding of the life-worlds of the learners. The term "life experiences" was conceived by Habermas (1987, p. 124) as the "culturally transmitted and linguistically organized stock of interpretive patterns" that guide the individual's interaction with others and social institutions.

The primary concern of life experience research is to arrive at a point where a learner in social institutions reaches a common understanding regarding the reasons and functional nature of power relations in health institutions. What is particularly relevant for this study is the Parsonian positivists' social action where the learners believe that social actors have complete knowledge of their social situation. This leaves no room for error on the part of policymakers or variation among actors regarding the Namibian health policies. Unfortunately, what is missing in policy implementation to access quality health for the learners is that it is the exclusivism of the learner's perspectives. This implies that the Social Action theory considers the rational nature of the individual or the collectives, which most health experts in Namibia gross over.

**Literature review**

The Namibian school health services were established in 1972. They were organised and delivered at a regional level by health workers, but the delivery was inconsistent and fragmented due to the legacy of the country's colonial background (Ministry of Health Social Services, 2008). Furthermore, the Namibian government envisioned that all people of Namibia shall have equitable access to high-quality and affordable health care by the year 2030 (National Planning Commission, 2013). According to the World Health Organization (2021), the government of the Republic of Namibia established the School Health Programme in 1990. The purpose is to promote the health of school-going children. In addition, following Namibia's independence on the 21st March 1990, the Ministry of Health and Social Services (MoHSS), in partnership with other

line ministries, developed the National School and Adolescent Health Programme to address the country's school health conditions. A study by Darling-Hammond et al. (2020) revealed that school health programmes were needed to promote children's well-being, healthy development, and transferable learning. Unfortunately, in agreement with Phiri (2017; 2021), there is a lack of social cohesion on the part of the policymakers which he coined as: "an act of social solidarity and cohesion which is not always reciprocated and in monetary value" (p. 25). According to Phiri (2022) what emerges on similar issues is the exchange of social rewards, economic rewards, and emotional support rather than promoting adolescent health programmes for the youth during the process.

Currently, Namibia's School and Adolescent Health Programme focuses primarily on three 'traditional' areas: school health care, environmental protection, and health education. However, an integrated strategy for school health must be planned and developed. School health services as an ongoing process of child healthcare beginning from early childhood through adulthood, provide a safety net wherein early childhood care was missed and ensure that health issues that could contribute to learning barriers are detected and dealt with early. Shung-King et al. (2013) further assert that the process prepares children for healthier adulthood by encouraging healthy lifestyle choices and addressing psychosocial and chronic physical health issues. Thus, improving the quality of health of school-aged children and allowing them to maximise their learning potential.

The provision of health services to various schools in the Engela district of Namibia is noticeably declining; this was also found in the study conducted by Ashipala and Shapopi (2022). According to Ashipala and Shapopi's findings, there are possibilities that elements such as lack of training and transport are influencing the delivery of school health services that pose a serious threat to the actual implementation of the School Health Programme. Numerous key components of school health services, according to Shung-King et al. (2013) the data include; (i) exclusive health assessments of children that are screened for various health conditions such as vision and hearing; (ii) age-appropriate health education and promotion; (iii) psychosocial and mental health assessments; (iv) identifying and supporting children with chronic health conditions; (v) supporting safe and healthy school environments; and (vi) providing preventive services, primarily immunizations and dozing for deworming. Importantly, school health services are provided by the National Department of Health (NDoH), and learners' social issues are addressed by the Department of Social Development. This necessitates coordinated integration among these government agencies (Shung-King et al., 2013).

South Africa's lower-grade school registration illustrated that school health inventiveness has the potential to reach many learners. However, the nurse-to-school ratio was 1:20 to 1:30 on average in 2008 (Shung-King et al., 2013). The situation was made worse by nurses' lack of transportation to schools. Due to a lack of transport, remote locations, and exorbitant transportation fees, many children were allegedly unable to obtain referral services to, for instance, optometrists and dentists. Nurses were also unable to follow up on children who were identified as having health issues (Shung-King et al., 2013). According to Phiri et al. (2023) and Schultz and Ruel-Bergeron (2021), school health and nutrition interventions include routine school health services, which should be supplemented with improved water, sanitation, and hygiene (WASH) infrastructure and messaging integrated into the current curriculum. Providing school health services, on the other hand, will not improve health or learning outcomes. Rather, the quality, consistency, and relevance of services and delivery modes are critical to achieving their goals.

According to Shung-King et al. (2013), school health implementation in South Africa depends on district managers, who provide primary healthcare, and facility managers, who oversee the development, direction, and support of school health teams. Conversely, poor managerial support hampered successful implementation due to a widespread lack of thought and obligation to school health. Individual nurses' enthusiasm and devotion were largely responsible for pockets of good practice as stated by Darling-Hammond et al. (2020). In addition, implementation issues were exacerbated because most regions' district health systems were still in their infancy. A school health policy aims to create a shared vision, strategy, and set of recommended interventions for all schools and implementing partners across the country. Moreover, UNESCO (2021), there is a need to address all four pillars of school health programme such as

equitable school health policies, a safe learning environment, skills-based health education, and school-based health and nutrition services. Furthermore, to ensure that it addresses the health priorities of all school-aged children, an effective policy must be founded on thorough situational analyses and multi-stakeholder consultations (girls and boys, minority groups, urban and rural, pre-school through secondary schools). According to UNESCO (2021), it must also address all four pillars: equitable school health policies, a safe learning environment, skills-based health education, and school-based health and nutrition services.

**Methods and methodology**

For the purpose of gathering and examining data, a blend of both qualitative and quantitative techniques was implemented by utilizing various methodologies to produce comprehensive results (Creswell & Clark, 2017). This study utilized a qualitative research approach (Aguboshim, 2021; Ames et al., 2019), conducting semi-structured interviews with 20 representatives from diverse stakeholder groups, purposive sampling was used to select national-level programme officers from the ministries of health and education; school health programme administrators at the district level; school principals; and school governing bodies. A quantitative approach using questionnaires distributed to 300 respondents who are mainly teachers and nurses used to gather data on the availability of resources and their impact on the NSHP's implementation (Brannen, 2017). The study was conducted in the Khomas, Oshana, and Kavango regions, on the implementation of the National School Health Policy in Namibian schools.

**Ethical considerations**

Ethical considerations involve issues such as informed consent, risk of harm, confidentiality and anonymity, and conflict of interest (Fleming, 2018). This is by ensuring that no participant suffers any physical, emotional, or psychological harm as a result of a study. To ensure ethical compliance, the study obtained clearance from the relevant Ethical Committee or Institutional Review Board such as the UNISA ethical committee, the Ministry of Health and Social Services (MoHSS), and the Ministry of Education, Arts and Culture in Namibia. Before participating in the study, all individuals involved provided informed consent by voluntarily agreeing to take part. The participants were adequately briefed on the objectives of the research as well as their right to voluntary participation and confidentiality regarding their responses.

**Findings**

This study aimed to assess the availability of resources necessary for the effective implementation of the National School Health Programme (NSHP) and to provide recommendations for overcoming challenges faced during implementation. These qualitative findings highlight the significant challenges facing the implementation of the NSHP, particularly regarding resource limitations, geographic disparities, and insufficient stakeholder awareness.

***Lack of resources and infrastructure***

One of the most prominent findings was the widespread concern about inadequate resources, particularly in rural areas. Many schools lacked basic facilities such as trained medical staff and first aid kits. A health programme administrator from the Oshana region stated that: *"We simply do not have enough nurses to visit every school regularly. Some schools go months without any health personnel stepping foot on the premises*". A school principal from the Kavango region echoed this, by saying that: *"Even getting basic first aid supplies is a challenge. We have learners with minor injuries, and we have no proper way of treating them*".

***Inconsistent access to health services***

Stakeholders pointed out that although the NSHP aims to provide equitable health services to all schools, access varies widely depending on the location. Urban schools generally have better access to healthcare services compared to rural ones. A teacher from the Khomas region remarked that: *"In our school, we are fortunate enough to have regular health visits, but I know schools in rural areas are not as lucky. Some of my colleagues say they haven't seen a nurse in months"*. Another nurse commented that: *"The distances between schools, especially in rural areas, are too great for us to cover adequately with the few nurses we have. It's impossible to reach everyone"*.

***Low awareness of the NSHP***

The interviews revealed that many stakeholders, especially teachers, were not fully aware of the policy or its provisions. There appeared to be a communication gap between policymakers and

implementers at the school level. A teacher from the Oshana region stated that: *"I didn't even know there was a formal school health policy until this interview. We have some health initiatives here, but they seem more like random visits than a structured programme"*.

***Need for better coordination and training***

Many stakeholders emphasized the need for improved coordination between the Ministry of Health and Social Services, school administrations, and district health officers. There was also a call for better training of school staff to handle minor health issues without health personnel. A school principal from Khomas region remarked that: *"We need more collaboration between the schools and the health department. Right now, it feels like everyone is working in isolation, and we are left to fend for ourselves when health issues arise"*. A health officer added that: *"Teachers should receive basic first aid training. In many cases, they are the first point of contact for learners' health issues, and they need to be better equipped to handle them"*.

***Barriers to effective policy implementation***

The interviews identified several barriers to the effective implementation of the NSHP, including limited government support, geographic challenges, and financial constraints. These barriers often prevented the programme from reaching its full potential. One school principal in the Kavango region noted that: *"The biggest problem we face is the lack of transport. Even when we refer learners to health centres, getting them it is almost impossible due to long distances and no available transportation"*. Table 1 presents participants' responses with regard to the resource factors that influencing NSHP implementation.

**Table 1: Resource factors influencing NSHP implementation**

| Resource Factor | Agree (%) | Mean Score | Standard Deviation |
|---|---|---|---|
| Ablution facilities | 63.7% | 4.67 | 0.88 |
| Water availability | 50% | 4.82 | 0.70 |
| Garbage disposal system | 50% | Not specified | Not specified |
| Recreation facilities | 67% | 4.57 | 0.72 |
| Fire extinguishers | 33.3% | 4.17 | 0.80 |
| Clinical facilities (first aid services) | 67% | 4.82 | 0.00 |
| Staff accommodation | 83% | 4.57 | 0.005 |

***Ablution facilities***

The 63.7% of respondents agreed that ablution facilities were a crucial factor influencing the implementation of the NSHP, with a mean score of 4.67. However, the standard deviation of 0.88 shows some variability in the availability and quality of these facilities across regions. Schools in the urban Khomas region generally had better sanitation infrastructure compared to rural schools in Oshana and Kavango regions, where the lack of proper ablution facilities posed a significant challenge.

***Availability of water***

Water availability was identified as one of the most significant factors affecting the NSHP's success, with 85% of respondents from all three regions agreeing on its critical importance. The mean score of 4.82 and a low standard deviation of 0.70 indicate that stakeholders across regions unanimously emphasised the need for consistent access to clean water. Schools in urban areas like Khomas region had relatively better access to water, while those in rural areas of Oshana and Kavango regions struggled with intermittent water supplies, affecting hygiene practices.

***Garbage disposal system***

In the context of factors influencing the effective implementation of the NSHP, a survey conducted among 300 participants revealed that half of them, or precisely 150(50%) respondents, acknowledged proper garbage disposal systems as a significant determinant. The calculated mean and standard deviation values were indicative of an overall agreement towards this assertion amongst the majority of participants. Upon investigation, it was found that most schools had adopted appropriate waste management practices; however, in certain instances, improvised approaches to handling waste materials were noted.

***Recreation facilities***

Although 67% of respondents acknowledged

the importance of recreational facilities, they had the least impact on the overall implementation of the NSHP, with a mean score of 4.57. The standard deviation of 0.72 suggests that while physical activity is recognized as beneficial, it was not seen as a priority compared to more immediate health needs, such as water and sanitation. Schools in Khomas region had more established recreational facilities, while those in rural regions like Oshana and Kavango regions often lacked proper sports grounds and equipment.

***Fire extinguishers***

From the findings presented in Table 1, fire safety in schools was seen as a lesser priority, with 33.3% of respondents agreeing that fire extinguishers are necessary for the safe implementation of the NSHP. The mean score for this factor was 4.17, but with a higher standard deviation of 0.80, indicating more variability in how participants perceived the significance of fire extinguishers about school health.

***Clinical facilities***

The presence of clinical facilities, especially first aid services, was deemed essential by 67% of respondents, with a high mean score of 4.82 and no variation in responses (standard deviation of 0.00). This unanimity highlights the critical role that first aid facilities play in supporting the NSHP's objectives, particularly in dealing with emergencies and ensuring that learners receive immediate care when needed.

***Staff accommodation***

Staff accommodation was seen as a crucial factor by 83% of respondents, with a mean score of 4.57 and a very low standard deviation of 0.005, indicating strong agreement. Adequate staff housing, especially in rural areas, was linked to better staff retention and availability, which directly impacts the quality of health services and programme implementation.

**Discussions**

The finding of this study is that there was a lack of ablution facilities, fire extinguishers, not enough recreation facilities, and no access to clean drinking water. The study participants expressed their satisfaction with the ablution facilities available in schools, attesting to their effectiveness in maintaining hygienic conditions.

***Ablution facilities***

The finding that 63.7% of respondents agree with the quality of ablution facilities, combined with a mean score of 4.67, suggests that these facilities are generally considered satisfactory. The variability in responses (standard deviation of 0.88) implies that while the majority are pleased, there may be specific issues affecting some users. Barrett et al. (2019) in their study discussed how the quality of sanitation facilities in schools can impact student health and attendance, especially for female students. This variability highlights the need for targeted improvements, perhaps in specific locations or features, to address the concerns of those who are less satisfied.

***Water availability***

Water availability, with a 50% agreement rate and a high mean score of 4.82, shows that half of the respondents find the water provision excellent. The lower standard deviation (0.70) among satisfied respondents indicates that their positive perception is consistent. According to World Health Organization (2021), the availability and accessibility of drinking water, sanitation, and hygiene in schools is crucial as it positively contribute to the individuals' healthy in schools worldwide. However, Odiyo et al. (2020) suggests that the other half of respondents might face challenges with water availability. According to Makoelle (2019) understanding the reasons behind this divide is crucial for implementing solutions that ensure equitable access to water for all users. These findings highlighted the need for targeted interventions aimed at improving the availability and quality of clean drinking water across all school settings, particularly those situated within resource-constrained environments where such basic amenities are not readily accessible (Thirathon et al., 2022).

***Garbage disposal system***

The absence of specific mean and standard deviation data for the garbage disposal system complicates the analysis, but the 50% agreement rate indicates a divided opinion. This mixed feedback suggests that the garbage disposal system may not be meeting the needs of all users equally (World Health Organization, 2021). There may be areas where the system is functioning well and others where it is lacking. Detailed investigation into specific issues and user experiences could help in improving the system to achieve higher overall satisfaction.

***Recreation facilities***

With 67% agreement and a mean score of 4.57, recreation facilities are viewed positively by a majority. The standard deviation of 0.72 indicates some variation in opinions, suggesting that while the facilities are generally well-regarded, there may be specific aspects or locations that could benefit from enhancement. Thirathon et al. (2022) suggested that to optimize the use and satisfaction with these facilities, it would be beneficial to gather more detailed feedback on specific areas for improvement.

***Fire extinguishers***

The low agreement rate of 33.3% and a mean score of 4.17 point to significant concerns regarding fire extinguishers. The high standard deviation (0.80) reflects considerable variability in user perceptions, indicating that some may find the current provision of fire extinguishers inadequate. UNESCO (2021) report suggests an urgent need for review and possible upgrades to fire safety measures, ensuring that they meet safety standards and are accessible to all users.

***Clinical facilities (first aid services)***

Clinical facilities, with a high mean score of 4.82 and 67% agreement, are perceived very positively. The zero standard deviation suggests that there is a uniform high level of satisfaction among those who agree. UNESCO (2021) study highlighted the consistent positive feedback highlights the effectiveness of the clinical services provided. Maintaining and possibly expanding these services could help in sustaining this high level of satisfaction and addressing any emerging needs.

***Staff accommodation***

Staff accommodation shows the highest level of satisfaction with an 83% agreement rate and a mean score of 4.57. The extremely low standard deviation (0.005) indicates that virtually all respondents who provided positive feedback share a uniform view of the accommodation's quality. Barrett et al. (2019) reflect the impact of school infrastructure on the school health programme delivery and how the management of staff accommodation is handled to ensure it does not interfere with school health service delivery. To maintain this high satisfaction, ongoing evaluation and addressing any minor issues promptly will be essential.

**Recommendations**

Based on the findings from the study and discussions, the study makes the following recommendations. The Ministry of Education, Arts and Culture should:

- Conduct a detailed assessment to identify healthcare needs and resource gaps in schools to develop targeted improvement strategies.
- Upgrade and improve healthcare facilities and services in schools, particularly in underserved and remote areas, to ensure equitable access.
- Implement mobile health units and telemedicine services, and partner with local health facilities to expand healthcare access for learners.
- Develop and enforce guidelines for healthcare services and conduct regular quality audits to maintain high standards of care.
- Offer comprehensive training for school health staff, teachers, and administrators to enhance their skills in healthcare provision and first aid.
- Educate learners and parents about health topics and available services to encourage active participation in health promotion activities.
- Establish a data collection system to track healthcare access, utilization, and satisfaction for informed decision-making and improvements.
- Work with policymakers to develop and fund policies that enhance healthcare services and support for school health programmes.
- Allocate resources based on identified needs, focusing on areas with significant gaps to ensure effective and equitable distribution.
- Collaborate with local healthcare providers and community organizations to support and enhance healthcare service delivery in schools.
- Develop a framework with performance indicators and regular evaluations to monitor and adjust the healthcare programme based on feedback.

**Conclusion**

The findings from this study highlight significant disparities in healthcare accessibility and quality for learners under the NSHP in Namibia. While some schools, particularly in urban areas, have access to essential healthcare services and resources, rural schools face critical challenges, including limited

infrastructure and inadequate resource allocation. Addressing these issues requires targeted interventions, such as improving healthcare infrastructure, increasing access to services, and ensuring equitable distribution of resources. By implementing strategic recommendations and fostering collaboration with key stakeholders, the NSHP can enhance healthcare outcomes for all learners, ensuring that their health needs are met regardless of geographic location. This will not only improve student well-being but also contribute to better educational outcomes across the country.

**References**


Aguboshim, F. C. (2021). Adequacy of sample size in a qualitative case study and the dilemma of data saturation: A narrative review. *World Journal of Advanced Research and Reviews, 10*(3), 180-187.

Ames, H., Glenton, C., & Lewin, S. (2019). Purposive sampling in a qualitative evidence synthesis: A worked example from a synthesis on parental perceptions of vaccination communication. *BMC Medical Research Methodology, 19*(1), 1-9.

Ashipala, D. O., & Shapopi, M. (2022). Factors affecting the provision of health service delivery in schools in Engela district, Ohangwena region, Namibia. *Health SA Gesondheid (Online), 27*, 1-7.

Barrett, P., Treves, A., Shmis, T., & Ambasz, D. (2019). *The impact of school infrastructure on learning: A synthesis of the evidence*.

Brannen, J. (2017). Combining qualitative and quantitative approaches: An overview. *Mixing methods: Qualitative and quantitative research*, 3-37.

Creswell, J. W., & Clark, V. L. P. (2017). *Designing and conducting mixed methods research*. Sage publications.

Darling-Hammond, L., Flook, L., Cook-Harvey, C., Barron, B., & Osher, D. (2020). Implications for educational practice of the science of learning and development. *Applied Developmental Science, 24*(2), 97-140.

Fleming, J. (2018). Recognizing and resolving the challenges of being an insider researcher in work-integrated learning. *International Journal of Work-Integrated Learning, 19*(3), 311-320.

Habermas, J. (1987). *The theory of communicative action rationality 2. Life world and system: Critique of functionalist reason*. Beacon Press.

Makoelle, T. M. (2019). *Action research in South African education: A critical praxis*. African Sun Media.

Mitchell, T. R. (1979). Organizational behaviour. *Annual Review of Psychology, 30*, 243-281.

Ministry of Health Social Services. (2008). *National Policy for School Health*. Ministry of Health Social Services.

National Planning Commission. (2013). *Namibia's 4th National Development Plan (NDP4): 2012/13 - 2016/17*. National Planning Commission.

Odiyo, J. O., Mathoni, M. M., & Makungo, R. (2020). Health risks and potential sources of contamination of groundwater used by public schools in Vhuronga 1, Limpopo Province, South Africa. *International Journal of Environmental Research and Public Health, 17*(6912), 1-15.

Parson, T. (2009) *After Parsons: A theory of social action for the twenty-first century*. Russell Sage Foundation.

Phiri, C. (2017). The social act of exchange in power relations: The study of the phenomenon of Nichekeleko at the Weighbridges in Zambia. *African Sociological Review/Revue Africaine de Sociologie, 21*(2), 100-114.

Phiri, C. (2021). Internal strategies and mechanisms for combating corruption during the COVID-19 pandemic in Zambia: A linguistic turn. *Journal of Anti-Corruption Law, 5(*1). 23-40.

Phiri, C. (2022). Internal strategies and mechanisms of combating corruption: The Nolle Prosequi phenomenon in Zambia. *International Journal of Advanced Multidisciplinary Research and Studies, 2*(4), 188-193.

Phiri, C., Musi, M., Munkoyo, D., Kalimaposo, K., Kaiko, M., & Lawrence, I. M. (2023). Corruption-violence against women in Zambia and Lesotho correctional facilities of abettors and heroines. *International Journal of Research and Innovations in Applied Social Sciences IJRIARS, 8*(6), 70-6.

Rossouw, M. E., Cotton, M. F., Esser, M. M., & Cornell, M. (2016). Feeding practices and nutritional status of HIV-exposed and HIV-unexposed infants in the Western Cape. *Southern African journal of HIV medicine, 17*(1), 1-9.

Schultz, L., & Ruel-Bergeron, J. (2021). Considerations for monitoring school

health and nutrition programs. *Frontiers in Public Health*, 9, 645711.

Shung-King, M., Orgill, M., & Slemming, W. (2013). School health in South Africa: Reflections on the past and prospects for the future. *South African health review*, *2013*(1), 59-71.

Thirathon, U., Wieder, B., & Ossimitz, M. (2022). Determinants of analytics-based managerial decision making. *International Journal of Information Systems and Project Management*, *6*(1), 27-40.

UNESCO. (2021). *Making investments in early childhood development in Namibia: It is time to act*.

World Health Organization. (2021). *Making every school a health-promoting school: implementation guidance*. World Health Organization.