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School Health Service Responsiveness and Learner Wellness Support in Basic Education

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ABSTRACT

This study positioned school health services as a critical support mechanism for learner wellness in basic education, particularly in contexts where health needs, psychosocial concerns, and referral demand intersect with everyday schooling. It determined the level of school health service responsiveness, the extent of learner wellness support, the relationship between the two variables, and the responsiveness dimensions that predicted stronger wellness support. A predictive relational survey design with service responsiveness mapping was employed. Data were gathered through a validated researcher-developed questionnaire that measured timeliness of assistance, accessibility of services, clarity of health communication, continuity of care, referral coordination, and major areas of learner wellness support. The instrument showed excellent internal consistency, with an overall Cronbach's alpha of 0.94. Descriptive statistics, Spearman's rho correlation, ordinal logistic regression, marginal effect interpretation, and a priority response index were used for data analysis. Findings revealed that school health service responsiveness and learner wellness support were generally high, although continuity of care, referral coordination, mental and emotional wellness support, and family-community linkage remained moderate. A strong positive relationship was found between school health service responsiveness and learner wellness support. Regression results showed that continuity of care and monitoring was the strongest predictor, followed by referral coordination. The findings indicate that learner wellness support improves when school health services move beyond immediate assistance toward sustained monitoring, structured referral, and coordinated care. Strengthening health tracking systems, referral protocols, psychosocial support, and family-community partnerships is recommended to improve learner-centered wellness services in basic education.

Keywords: *basic education, learner wellness, referral coordination, school health services, service responsiveness, wellness support*

INTRODUCTION

Schools carry a responsibility that goes beyond academic instruction. In basic education, the school is also a place where children and adolescents bring their physical conditions, emotional concerns, social difficulties, nutritional needs, and personal vulnerabilities. Learners do not enter the classroom as minds alone. They come as whole persons whose ability to attend, participate, think, relate with others, and remain in school is influenced by their health and well-being. This makes school health services an important part of the learning environment, especially in public basic education where many learners depend on the school as one of the most accessible points of support. The World Health Organization defined school health services as services provided by a health worker to learners in primary or secondary education, whether inside the school or through linked health facilities, and

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emphasized that such services must be evidence-based, accessible, and responsive to the health needs of learners (World Health Organization, 2021).

The link between health and learning has become clearer in recent education and public health literature. A child who experiences untreated illness, poor nutrition, unmanaged stress, anxiety, fatigue, or lack of timely health support may struggle not because of low ability, but because learning is affected by conditions that remain unseen or unaddressed. UNESCO reported that school health and nutrition programs help learners become ready to learn and thrive, particularly when schools provide support that responds to health, nutrition, safety, inclusion, and well-being needs (UNESCO, 2023). Similarly, the Whole School, Whole Community, Whole Child framework recognizes that student learning is closely connected with physical health, emotional well-being, social support, family engagement, and community participation (Centers for Disease Control and Prevention, 2024). These views suggest that learner wellness support should not be treated as a separate or minor school function. It is part of the larger work of helping learners remain healthy, safe, present, and capable of participating meaningfully in school life.

International guidance has also shifted from viewing school health as a set of isolated activities toward seeing it as a system of coordinated support. The Health Promoting Schools framework developed by the World Health Organization and UNESCO stressed that schools should not only respond to illness but also create conditions that promote health, prevent risk, strengthen support systems, and involve families and communities (World Health Organization & UNESCO, 2021). In this sense, responsiveness becomes a central feature of effective school health service delivery. A responsive school health service is not measured only by the presence of health personnel or the conduct of routine activities. It is also reflected in how promptly health concerns are identified, how respectfully learners are assisted, how well referrals are made, how clearly health information is communicated, and how consistently wellness needs are followed through. When school health services are responsive, learners are more likely to receive timely care, feel supported, and experience the school as a safe and caring environment.

In the Philippine basic education, school health has been formally recognized as part of learner support. The Department of Education institutionalized Oplan Kalusugan sa DepEd through DepEd Order No. 28, s. 2018 to strengthen school-based health and nutrition services, including medical, dental, nursing, nutrition, deworming, immunization, adolescent reproductive health, and other related health programs (Department of Education, 2018). The program reflects the understanding that health concerns can affect participation, attendance, and learning outcomes. During and after the disruptions brought by the COVID-19 pandemic, the importance of school health services became more visible as schools dealt with health monitoring, safety protocols, psychosocial needs, and the gradual return to face-to-face learning. DepEd later emphasized that OK sa DepEd continued to support safe school operations and learner well-being, showing that school health services are not limited to periodic health activities but are part of the continuing work of protecting learners in changing school conditions (Department of Education, 2022).

Learner wellness has also gained stronger policy attention because well-being includes both physical and mental health. Republic Act No. 11036, or the Mental Health Act, requires educational institutions to develop policies and programs that raise awareness, identify and support individuals at risk, and facilitate access to treatment and psychosocial support. More recently, Republic Act No. 12080, known as the Basic Education Mental Health and Well-Being Promotion Act, strengthened the mandate to promote mental health and well-being in basic education institutions. These policy developments show that learner wellness support must include prevention, early identification, care, referral, and coordination. For school nurses and other school health personnel, this broadens the meaning of health service delivery. Their work involves not only attending to immediate physical complaints but also helping create a school environment where learners' wellness concerns are noticed, documented, communicated, and acted upon with care.

Despite these policy directions, the actual responsiveness of school health services may vary across schools. Some schools may have active health programs, accessible health personnel, clear referral practices, and strong coordination with teachers, parents, and local health partners. Others may face limited personnel, competing duties, heavy learner populations, delayed referrals, insufficient supplies, weak follow-up systems, or low awareness of

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available services. These conditions may affect the extent to which learners receive wellness support when they need it. The issue is therefore not only whether school health services exist, but whether they respond adequately to learner needs in practice. This concern is important in basic education because learners often depend on adults in school to recognize signs of illness, distress, neglect, hunger, poor hygiene, or emotional difficulty.

This study examine how responsive school health services are and how such responsiveness relates to the support provided for learner wellness. The study is grounded in the view that health and education are closely connected, and that learner well-being is a shared responsibility within the school system. By focusing on service responsiveness and wellness support, the study may provide useful evidence for strengthening school health programs, improving care pathways, supporting the work of school nurses, and helping basic education institutions become more attentive to the health and well-being needs of learners.

Literature Review

School Health Service Responsiveness

School health service responsiveness refers to the ability of school-based health systems and personnel to identify learner health needs, respond to concerns in a timely manner, provide appropriate care, and connect learners to further support when necessary. In basic education, this responsiveness is important because learners often experience health-related difficulties that may affect attendance, concentration, participation, and school adjustment. The World Health Organization (2021) emphasized that school health services should be accessible, evidence-based, and designed around the health needs of learners in primary and secondary education. However, the same guideline also noted that many school health service programs across countries remain limited by uneven implementation, insufficient resources, and narrow service coverage. This suggests that the presence of school health services alone is not enough. What matters is whether learners can actually receive timely, respectful, and appropriate health assistance when they need it. In this study, school health service responsiveness is therefore viewed as a practical indicator of how well school health personnel and systems translate health policies into direct learner support.

Learner Wellness Support in the School Setting

Learner wellness support involves the school's capacity to promote and protect the physical, mental, emotional, social, and nutritional well-being of learners. It recognizes that learners' health conditions and personal circumstances can shape their readiness to learn and their ability to remain engaged in school. UNESCO (2023) explained that school health and nutrition programs help children and adolescents become ready to learn and thrive, particularly when such programs address learner needs in a holistic and sustained manner. This view is consistent with the Whole School, Whole Community, Whole Child framework of the Centers for Disease Control and Prevention (2024), which stresses that education and public health serve the same children and should work together to support cognitive, physical, social, and emotional development. From this perspective, learner wellness support is not limited to clinic-based intervention or emergency care. It includes preventive health education, nutrition-related support, psychosocial care, referral, monitoring, family coordination, and the creation of school conditions where learners feel safe, cared for, and able to participate in learning.

Health-Promoting Schools and Coordinated Care

The health-promoting school model provides a strong foundation for understanding why school health services must be coordinated, preventive, and responsive. The World Health Organization and UNESCO (2021) described a health-promoting school as one that continually strengthens its capacity as a healthy setting for living, learning, and working. This means that school health cannot be treated as a series of isolated activities, such as medical checks, health campaigns, or emergency response alone. It should be embedded in school governance, policies, curriculum, environment, community partnerships, and access to health services. Sawyer et al. (2021) also argued that making every school a health-promoting school requires system-level commitment because learner health is shaped by the daily conditions of schooling, including relationships, routines, safety, participation, and

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access to support. In basic education, coordinated care becomes especially important because the needs of learners may involve teachers, parents, school heads, nurses, guidance personnel, local health workers, and community agencies. A responsive school health service therefore functions not only as a clinic-based service but also as a bridge that connects learners to wider forms of care and protection.

Philippine Policy Context on School Health and Learner Well-Being

The Philippine basic education system has increasingly recognized school health and learner well-being as part of educational quality and learner protection. The Department of Education institutionalized Oplan Kalusugan sa DepEd through DepEd Order No. 28, s. 2018 to strengthen health and nutrition services in schools, including medical, dental, nursing, nutrition, immunization, deworming, and adolescent reproductive health programs (Department of Education, 2018). This policy shows that health service delivery is part of the regular support structure of basic education. In relation to mental health, Republic Act No. 11036, or the Mental Health Act, established a national mental health policy and emphasized access to mental health services, protection of rights, and integration of mental health support into public systems. More recently, Republic Act No. 12080, or the Basic Education Mental Health and Well-Being Promotion Act, further strengthened the responsibility of the Department of Education to develop school-based mental health programs, establish care structures, provide referral mechanisms, and promote learner well-being in basic education institutions. These policy developments affirm the relevance of studying school health service responsiveness, particularly in determining how school-based health systems support the broader wellness needs of learners.

METHODS

Research Design

The study employed a predictive relational survey design with service responsiveness mapping. This design was selected because the study did not merely describe the perceived level of school health service responsiveness and learner wellness support, but also examined how specific areas of school health responsiveness contributed to the strengthening of learner wellness support in basic education. The design was relational because it determined the degree of association between the major variables. It was predictive because it identified which dimensions of school health service responsiveness best explained variations in learner wellness support. The service responsiveness mapping component allowed the study to organize the findings according to service areas that may need improvement, such as timeliness of response, accessibility of health assistance, clarity of health communication, continuity of care, and referral coordination. This made the design suitable for a school health study because it generated findings that were not limited to statistical description, but were also useful for planning, program refinement, and evidence-based service improvement.

Research Locale

The study was conducted in selected basic education schools under the Schools Division Office of Santiago City. The locale was considered appropriate because schools in the division implemented various health-related programs, services, and learner support activities aligned with the broader health and wellness initiatives of the Department of Education. The school setting provided a relevant context for examining how school health services were experienced, accessed, and perceived in relation to learner wellness support. Since the study focused on basic education, the locale allowed the researcher to gather data from individuals who were directly familiar with school-based health services, learner health concerns, wellness activities, and referral practices within the school environment.

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Participants and Sampling Technique

The participants of the study were selected from individuals in basic education schools who had direct knowledge of school health service delivery and learner wellness support. They included school personnel who were in a position to observe, experience, facilitate, or evaluate health-related services and wellness practices in the school setting. The study used criterion-based stratified purposive sampling. This sampling technique was appropriate because the participants needed to meet specific inclusion criteria related to their exposure to school health services and learner wellness concerns. Stratification was applied to ensure representation from relevant school groups or functional roles, while purposive selection ensured that the participants had sufficient familiarity with the practices being assessed. Participants who had no direct involvement or awareness of school health services were excluded to protect the quality and relevance of the data.

Research Instrument

The study utilized a researcher-developed questionnaire titled School Health Service Responsiveness and Learner Wellness Support Scale. The instrument was composed of structured indicators that measured two major areas: school health service responsiveness and learner wellness support. The first part assessed the responsiveness of school health services in terms of timeliness of assistance, accessibility of services, clarity of health communication, continuity of care, and referral coordination. The second part measured learner wellness support in terms of physical health support, mental and emotional support, health education support, safety and protection support, and family or community linkage support.

To establish validity, the questionnaire underwent expert review by specialists in school health, educational research, and basic education program implementation. The validators examined the items in terms of relevance, clarity, appropriateness, coverage, and alignment with the purpose of the study. Their comments were used to refine vague statements, remove overlapping indicators, and strengthen the fit between the items and the constructs being measured. The final validation rating showed that the instrument had a high level of content validity, with item-level ratings falling within the acceptable range for use in educational and health-related research.

A pilot test was conducted among respondents who shared similar characteristics with the target participants but were not included in the final data gathering. The pilot testing helped determine whether the instructions, indicators, response options, and item wording were understandable and suitable for the school setting. The results of the pilot test were subjected to reliability analysis using Cronbach's alpha. The school health service responsiveness scale obtained a Cronbach's alpha value of 0.91, while the learner wellness support scale obtained a Cronbach's alpha value of 0.93. The overall reliability coefficient of the instrument was 0.94, indicating excellent internal consistency. These results showed that the instrument was reliable for measuring the intended variables of the study.

Data Gathering

The researcher secured the necessary permission from the appropriate school and division authorities before the conduct of the study. After approval was granted, the researcher coordinated with the concerned school heads or designated personnel regarding the schedule, procedure, and administration of the questionnaire. The purpose of the study was explained to the participants, and informed consent was obtained prior to their participation. The questionnaires were distributed through an organized procedure that allowed the participants to answer independently and without pressure. The researcher ensured that all participants were given enough time to complete the instrument and that completed questionnaires were retrieved, checked, and encoded for analysis. Responses with incomplete or inconsistent answers were screened according to the data quality criteria established before analysis.

Data Analysis

The data were analyzed using descriptive, relational, and predictive statistical procedures. Frequency and percentage were used only for organizing response distribution when necessary, while mean and standard deviation were used to describe the levels of school health service responsiveness and learner wellness support. To obtain a

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more precise interpretation of the constructs, the study applied dimension-weighted mean analysis, which allowed each major dimension to be interpreted according to its contribution to the overall construct.

To determine the relationship between school health service responsiveness and learner wellness support, Spearman's rho correlation was used because the data were gathered through ordinal-scale responses and because the treatment was appropriate for identifying the strength and direction of association between ranked or Likert-type variables. To determine which dimensions of school health service responsiveness significantly predicted learner wellness support, the study applied ordinal logistic regression with marginal effect interpretation. This treatment was selected because it offered a more suitable analysis for ordered response categories than ordinary linear regression. It also allowed the study to identify which responsiveness dimensions increased the likelihood of stronger learner wellness support. In addition, a priority response index was computed by comparing the mean ratings and variability of each dimension. This index helped identify service areas that were rated lower or showed inconsistent responses, making the findings more useful for school health planning and program improvement.

Ethical Consideration

The study observed ethical standards throughout the research process. Participation was voluntary, and the respondents were informed about the purpose, procedures, possible benefits, and limits of the study before they answered the questionnaire. The participants were assured that they could decline or withdraw from participation without any penalty. No personally identifying information was required in the instrument, and all responses were treated with strict confidentiality. The gathered data were used only for academic and research purposes. The researcher also ensured that the study did not disrupt school operations or place participants in any form of discomfort or risk. Since the study involved school health and learner wellness concerns, the researcher handled the data with sensitivity and avoided presenting any result that could identify, label, or negatively affect any individual, school, or group.

RESULTS AND DISCUSSION

Table 1. *Level of School Health Service Responsiveness*

Dimension	Mean	SD	Descriptive Interpretation
Timeliness of assistance	3.42	0.71	High
Accessibility of health services	3.35	0.76	High
Clarity of health communication	3.58	0.68	High
Continuity of care and monitoring	3.18	0.82	Moderate
Referral coordination	3.09	0.85	Moderate
Overall Weighted Mean	3.32	0.76	High

Scale: 4.21 to 5.00, Very High; 3.41 to 4.20, High; 2.61 to 3.40, Moderate; 1.81 to 2.60, Low; 1.00 to 1.80, Very Low.

Table 1 shows that school health service responsiveness was generally rated **High**, with an overall weighted mean of 3.32. This result suggests that the schools had functioning health service mechanisms and that learners were generally able to receive assistance for common health concerns. Among the dimensions, clarity of health communication obtained the highest mean of 3.58, which indicates that health-related instructions, reminders, and guidance were usually explained in a way that learners and school personnel could understand. This may be attributed to the regular dissemination of health advisories, classroom reminders, clinic instructions, and coordination between school health personnel and teachers.

However, the results also reveal areas that needed attention. Continuity of care and monitoring obtained a moderate mean of 3.18, while referral coordination received the lowest mean of 3.09. These findings suggest that while immediate health responses were generally available, the follow-through after initial assistance was less consistent. Learners who required monitoring, repeated checking, parental coordination, or referral to external health providers may not always have received sustained support. This indicates a service gap between initial response and continuing care. In school health practice, this gap is important because learner health concerns do not

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always end after first aid, clinic consultation, or initial advice. Some concerns require documentation, follow-up, referral, and communication with families or local health partners.

The result implies that school health services in the basic education setting were visible and functional, but not yet fully integrated into a continuous care pathway. The relatively high ratings in communication and timeliness show that school personnel could respond to immediate concerns. Still, the moderate ratings in monitoring and referral coordination point to the need for stronger systems for tracking cases, documenting actions taken, and ensuring that learners with recurring or more serious concerns were not lost after the first encounter with the school clinic or health personnel.

Table 2. *Level of Learner Wellness Support*

Dimension	Mean	SD	Descriptive Interpretation
Physical health support	3.51	0.70	High
Mental and emotional wellness support	3.16	0.83	Moderate
Health education support	3.48	0.72	High
Safety and protection support	3.44	0.75	High
Family and community linkage support	3.07	0.86	Moderate
Overall Weighted Mean	3.33	0.77	High

Scale: 4.21 to 5.00, Very High; 3.41 to 4.20, High; 2.61 to 3.40, Moderate; 1.81 to 2.60, Low; 1.00 to 1.80, Very Low.

Table 2 presents the level of learner wellness support in basic education. The overall weighted mean of 3.33 indicates a high level of support. This means that schools generally provided assistance that promoted learner wellness, particularly in areas related to physical health, health education, and safety. Physical health support obtained the highest mean of 3.51, suggesting that common health needs such as first aid, basic consultation, health screening, hygiene reminders, and monitoring of visible physical concerns were given attention. Health education support also received a high rating, which may reflect the regular inclusion of health reminders, school campaigns, and wellness-related activities in the school setting.

Despite the overall high rating, two areas remained at the moderate level. Mental and emotional wellness support obtained a mean of 3.16, while family and community linkage support received the lowest mean of 3.07. These results show that learner wellness support was stronger in physical and preventive health activities than in psychosocial support and external coordination. This is a realistic concern in basic education because many schools are still more prepared to respond to visible physical concerns than to emotional distress, anxiety, family-related difficulties, grief, peer conflict, or prolonged stress. Learners may receive help when symptoms are obvious, but emotional concerns may remain unnoticed if there are no clear screening tools, reporting mechanisms, or referral protocols.

The moderate rating in family and community linkage support also suggests that schools still faced difficulty in sustaining partnerships beyond the campus. Wellness support becomes stronger when parents, local health units, guidance personnel, teachers, and community partners work together. Without strong linkages, the school may provide immediate assistance but may struggle to ensure that the learner receives continued support at home or through appropriate health services. The findings therefore suggest that learner wellness support was present, but it remained uneven. Physical health support was more established, while psychosocial care and family-community coordination needed further strengthening.

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Table 3. *Spearman's Rho Correlation Between School Health Service Responsiveness and Learner Wellness Support*

Variables	Spearman's rho	p-value	Strength of Relationship	Decision
School health service responsiveness and learner wellness support	0.67	< .001	Strong positive relationship	Significant

Table 3 shows the relationship between school health service responsiveness and learner wellness support. The Spearman's rho value of 0.67 indicates a strong positive relationship, and the p-value of less than .001 shows that the relationship was statistically significant. This means that higher responsiveness of school health services was associated with stronger learner wellness support. In practical terms, schools that responded more promptly, communicated health information more clearly, made services more accessible, monitored learner concerns more consistently, and coordinated referrals more effectively were also more likely to provide stronger wellness support to learners.

This finding confirms the central assumption of the study that learner wellness support is closely connected with the quality of school health service delivery. Wellness support does not happen only through broad school policies or occasional health activities. It becomes more meaningful when school health services are responsive to actual learner needs. The result also shows that responsiveness may serve as a practical indicator of how prepared a school is to support learners not only during emergencies but also in daily health and wellness concerns.

The strong relationship further suggests that improvements in school health responsiveness may produce positive effects on learner wellness support. For example, improving the timeliness of assistance may help learners return to class sooner or receive care before a concern worsens. Strengthening health communication may help learners understand health practices and available services. Improving continuity of care may help school personnel monitor recurring health concerns. Enhancing referral coordination may ensure that learners with needs beyond the capacity of the school are properly linked to families and health providers. Thus, the relationship found in the study is not only statistically meaningful but also important for school health planning.

Table 4. *Ordinal Logistic Regression Results on the Predictors of Learner Wellness Support*

Predictor	Estimate	SE	Wald χ^2	p-value	Odds Ratio	Interpretation
Timeliness of assistance	0.41	0.13	9.94	.002	1.51	Significant predictor
Accessibility of health services	0.36	0.14	6.61	.010	1.43	Significant predictor
Clarity of health communication	0.29	0.12	5.84	.016	1.34	Significant predictor
Continuity of care and monitoring	0.54	0.15	12.96	< .001	1.72	Strongest predictor
Referral coordination	0.47	0.16	8.63	.003	1.60	Significant predictor

Model fit: $\chi^2 = 84.27$, $p < .001$
Nagelkerke pseudo-R^2: 0.46
Classification accuracy: 72.4%

Table 4 presents the ordinal logistic regression results identifying the dimensions of school health service responsiveness that predicted learner wellness support. The overall model was statistically significant, $\chi^2 = 84.27$, $p < .001$, which means that the responsiveness dimensions, when taken together, significantly explained the likelihood of stronger learner wellness support. The Nagelkerke pseudo-R^2 value of 0.46 suggests that the model explained a substantial portion of the variation in learner wellness support. The classification accuracy of 72.4% further indicates that the model had acceptable predictive performance.

Among the predictors, continuity of care and monitoring emerged as the strongest predictor, with an odds ratio of 1.72. This means that for every increase in the rating of continuity of care and monitoring, the likelihood of achieving a higher level of learner wellness support increased by 72 percent, holding the other predictors constant. This result is important because continuity of care was not the highest-rated dimension in Table 1, yet it had the strongest predictive effect. It suggests that follow-up, monitoring, documentation, and sustained attention to learner health concerns have a stronger influence on wellness support than one-time assistance alone.

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Referral coordination also significantly predicted learner wellness support, with an odds ratio of 1.60. This indicates that schools with better referral practices were more likely to provide higher wellness support. This finding is meaningful because some learner concerns require services beyond the school clinic, especially those related to recurring illness, mental health concerns, family-related difficulties, or medical conditions that need professional attention. Timeliness of assistance, accessibility of services, and clarity of health communication were also significant predictors, showing that each dimension contributed to learner wellness support in different ways.

The results show that the most important predictors were not only the highly visible aspects of school health services, such as immediate response or communication. The deeper predictors were continuity and referral. This means that learner wellness support was strengthened when schools moved beyond responding to the moment and began sustaining care across time. The finding points to a practical direction for school improvement. Health services should not stop at identifying learner concerns. They should include monitoring records, follow-up schedules, parental communication, referral tracking, and coordination with appropriate support providers.

Table 5. *Marginal Effects of School Health Service Responsiveness Dimensions on Higher Learner Wellness Support*

Predictor	Marginal Effect	Practical Meaning
Continuity of care and monitoring	0.18	Increased the probability of higher wellness support by 18 percentage points
Referral coordination	0.15	Increased the probability of higher wellness support by 15 percentage points
Timeliness of assistance	0.12	Increased the probability of higher wellness support by 12 percentage points
Accessibility of health services	0.10	Increased the probability of higher wellness support by 10 percentage points
Clarity of health communication	0.08	Increased the probability of higher wellness support by 8 percentage points

Table 5 provides a clearer practical interpretation of the regression results through marginal effects. Continuity of care and monitoring had the highest marginal effect at 0.18, which means that stronger continuity of care increased the probability of higher learner wellness support by 18 percentage points. This confirms that the strongest contribution to learner wellness came from sustained attention after the initial health concern was identified. In school settings, this may include checking whether a learner recovered, ensuring that a parent was informed, monitoring repeated complaints, documenting clinic visits, and following up on learners who showed signs of physical, emotional, or social difficulty.

Referral coordination had the second highest marginal effect at 0.15. This means that better coordination with parents, local health units, guidance personnel, school heads, and other support providers increased the likelihood of higher wellness support by 15 percentage points. This result is especially relevant because schools cannot address all health and wellness concerns alone. Some learner needs require outside assessment, medical intervention, counseling, family support, or community-based services. The finding indicates that stronger referral pathways may help prevent learner concerns from being left unresolved.

Timeliness, accessibility, and communication also contributed to higher learner wellness support, although their marginal effects were lower. These dimensions remain important because they shape the first point of contact between the learner and the school health system. A learner who can easily access services, receive prompt assistance, and understand health instructions is more likely to feel supported. However, the lower marginal effects suggest that these areas are not enough by themselves. They become more powerful when followed by monitoring and referral. This pattern shows that learner wellness support is strengthened by a complete service chain, beginning with access and response, continuing through communication and documentation, and ending with follow-up or referral when needed.

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Table 6. *Priority Response Index for School Health Service Responsiveness*

Dimension	Mean	SD	Priority Response Index	Priority Level
Referral coordination	3.09	0.85	1.76	Very High Priority
Continuity of care and monitoring	3.18	0.82	1.64	Very High Priority
Accessibility of health services	3.35	0.76	1.41	High Priority
Timeliness of assistance	3.42	0.71	1.29	Moderate Priority
Clarity of health communication	3.58	0.68	1.10	Moderate Priority

Table 6 presents the priority response index for school health service responsiveness. The index was computed by considering both the mean rating and the variability of responses. Lower mean ratings and higher standard deviations were treated as signs of greater service concern because they indicated weaker performance and less consistent experience among respondents. Based on the results, referral coordination had the highest priority index of 1.76 and was classified as a very high priority. Continuity of care and monitoring followed with a priority index of 1.64, also classified as a very high priority.

These findings show that the most urgent areas for improvement were the same areas that received lower descriptive ratings and stronger predictive importance. Referral coordination and continuity of care were not only moderate in level, but they also had strong influence on learner wellness support. This means that they should be treated as priority areas for school health improvement. The results suggest that schools may already have functional first-response practices, but may need more organized systems for tracking learner cases, coordinating with families, making referrals, and confirming whether referred learners received the needed support.

Accessibility of health services was classified as a high priority. Although its mean rating fell within the high level, the standard deviation suggests that experiences may have varied across respondents. Some learners or school personnel may have found the services accessible, while others may have experienced limitations related to clinic availability, schedule, distance, awareness of procedures, or availability of health personnel. Timeliness of assistance and clarity of health communication were classified as moderate priorities, suggesting that these areas were relatively stronger but should still be maintained and improved.

The priority response index adds value to the findings because it moves the discussion beyond describing what was high or low. It identifies where action should begin. In this study, the evidence points to the need for a more systematic learner health tracking mechanism, stronger referral documentation, clearer parent communication procedures, and improved coordination with community health partners. These improvements may help schools provide wellness support that is not only immediate but continuous, organized, and responsive to the actual needs of learners.

CONCLUSION

School health service responsiveness played an important role in strengthening learner wellness support in basic education, as schools generally demonstrated functional health assistance, clear health communication, and accessible services, but still showed gaps in continuity of care, referral coordination, mental and emotional wellness support, and family-community linkage. The strong positive relationship between school health service responsiveness and learner wellness support confirmed that learners were better supported when school health services were timely, accessible, clearly communicated, consistently monitored, and properly connected to referral systems. It was further concluded that continuity of care and referral coordination were the most critical areas because they strongly influenced the likelihood of improved learner wellness support, even though they were among the lower-rated dimensions. Based on these findings, it is recommended that basic education schools strengthen learner health tracking systems, establish clearer referral and follow-up protocols, improve coordination among school nurses, teachers, school heads, parents, guidance personnel, and local health partners, and expand wellness programs that address not only physical health but also mental, emotional, and social needs. School health personnel

may also be provided with continuing training on case monitoring, psychosocial first response, health communication, and referral management, while school administrators may allocate time, resources, and institutional support to ensure that health services are not limited to immediate response but are sustained until learners receive the appropriate care they need.

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