A CRITICAL STUDY OF THE INTEGRATED SCHOOL HEALTH POLICY AND SOCIAL DETERMINANTS OF HEALTH

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Abstract

The Social Determinants of Health constitute a foundational concept in population health, playing a crucial role in achieving overall public health and addressing health inequalities. Moreover, the phenomenon of the Social Determinants of Health is essential for the development and management of policies.

This study aims to conduct a qualitative retrospective policy analysis of the South African Integrated School Health Policy to assess whether the policy contents and imperatives align with the Social Determinants of Health. Furthermore, the study aims to explore the role of academics in shaping the Integrated School Health Policy, specifically focusing on their understanding of the Social Determinants of Health and the associated structural factors that underpin compromised health in school-going children. The data for this study was gathered through semi-structured interviews conducted with academics, who have direct experience in the policy process of school health policies.

The secondary method of data collection included document analyses. Central to the findings is the realisation that the policy process of the Integrated School Health Policy encompassed the amalgamation of policy decisions and agenda-setting. It is a complex process which makes the identifying of decision-making protocols challenging and emphasises the impact of stakeholders' perspectives.

The data presented advances the notion that the change in political norms and political will emerge as the critical drivers for the policy challenges associated with the Integrated School Health Policy. Notably, there was a lack of a systematic approach to addressing the Social Determinants of Health and providing comprehensive school health services.

The study’s findings provide a basis for promoting evidence-based policies concerning school health services and examining ways to establish a health-ecosystem within an educational system. This approach not only benefits school-going children and individuals within the educational system, but also holds potential benefits for individuals residing in the communities located within the educational system.

Declaration

I declare that this report is my own, unaided work. It is submitted in partial fulfilment of the requirements of the degree of Master of Management at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other university.

Neo Thabisile Mofokeng

Dedication

I dedicate this to my dearly departed father, Mpu Daniel Mofokeng, I had hoped you would be around to witness me finalising this work; unfortunately, fate had other plans. Your encouragement, love and support will not be forgotten. I miss you more than words can say. To my beloved mother, Nomasonto Geraldine Mofokeng, I would not be where I am today if it were not for you. Thank you for your teachings, your love and mostly importantly, instilling a love for education in me. I am, because of your prayers. Finally, to my dearest son, Mohau Mofokeng, I can only hope that this inspires you to reach your goals in future; I love you.

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Contents

List of abbreviations

Care and Support of Teaching and Learning	CSTL
Council Health Management Team	CHMT
Health Promoting Schools	HPS
Intervention Generated Inequalities	IGI
Millennium Development Goals	MDGs
National Health Insurance	NHI
National Rural Health Mission	NRHM
National School Health Policy	NSHP
Out-of-School-Children	OOSC
Primary Health Care	PHC
Quality Learning and Teaching Campaign	QLTC
Recommended Daily Allowance	RDA
School Health Programme	SHP
Sustainable Development Goals	SDGs
United Kingdom	UK
United Nations	UN

United Nations International Children's Emergency Fund	UNICEF
Universal Health Coverage	UHC
Ward-Based Outreach Teams	WBOTs
World Health Organization	WHO

CHAPTER 1: FOREGROUNDING THE SOCIAL DETERMINANTS OF HEALTH

1.1.INTRODUCTION

The current study will conduct a qualitative retrospective policy analysis of the Integrated School Health Policy to ascertain whether the policy contents and imperatives align with the Social Determinants of Health. Additionally, the study explores the role of academics in the development of the Integrated School Health Policy, focusing specifically on their understanding of the Social Determinants of Health and the related structural factors influencing compromised health in school-going children. Within the context of the policy process, Muluk and Winoto (2018) position the Government as policy practitioners and underscore that the Government, in its capacity as policy practitioners, necessitates expertise from professionals in the field to aid in the formulation of policies that are tailored to specific needs and are evidence-based. Consequently, the inclusion of academics in the policy process, becomes an indispensable mechanism for the development of applicable evidence-based policies.

Furthermore, Muluk and Winoto (2018) assert the perspective that policy practitioners should leverage the dual role of academics, involving both the generation and debunking of social phenomena, as well as rely on their expertise. In this regard, academics assume three (3) primary roles within the policy process, encompassing research and the development of policies, along with the provision of education and training in the realm of policy formulation.

A study conducted by Lane et al., (2020) on strengthening health policy development and management systems in low- and middle-income countries: South Africa's approach; asserts that within such countries, the management and development of health policies are disintegrated for various reasons. Primary to these, is the protracted policy process, attributable to flawed and faulty processes, inadvertently resulting in poor health policy management practices that unnecessarily prolong policy development and adoption processes.

Moreover, Lane et al., (2020) contend that the pitfalls can aid in the slow adoption and expansion of programmatic best practices associated with health policies. Following a situational analysis of South Africa’s health policy practices and processes, Lane et al. (2020) affirm that the existing policies of the National Department of Health differ in terms of the

approach to policy content and policy processes. The National Department of Health relatedly, is also observed to lack a comprehensive database of its existing health policies, along with exhibiting inconsistent policy development and management practices. Ultimately, these inconsistencies may result in policy uncertainty and unintended consequences, particularly at the level of implementation. Relatedly, the Social Determinants of Health, as a phenomenon, is essential for policy development and policy management practices. The agenda of The Social Determinants of Health gained prominence in 2005 when the World Health Organisation's (WHO) established the Commission on the Social Determinants of Health. The organisation's primary mandate was to produce evidence and pathways to promote equity in healthcare globally, as exemplified in the "Closing the gap in a generation" Commission on Social Determinants of Health report (2008). Subsequently, the Rio Political Declaration on the Social Determinants of Health, followed the Commission's report. Member States declared their commitment to upholding social equity through substantive actions linked to the Social Determinants of Health, being executed through an intersectoral approach.

Consequently, the phenomenon of the Social Determinants of Health is not a novel discourse. Rather, it prompts enquiries into the extent of effective ratification and harmonisation of healthcare policies and how intersectoral public policies advance the Social Determinants of Health, while addressing health inequalities. The predominant definitional approach used to conceptualise health equity, asserts its nature as the absence of systematic disparities in health among diverse social strata. Literature by Embrett and Randall (2014) underscores the linkages between systematic disparities and the social conditions that place specific social strata at a disadvantage, thereby giving rise to health inequalities. The discerned health inequalities are ascribed to the social, political, and economic settings in which individuals are socialised and are collectively titled the Social Determinants of Health.

Embrett and Randall (2014) state further that the identified social, political, and economic settings emanate from distributive public policies that allocate financial and human resources at local, national, regional, and global levels. It is by virtue of these conditions, that the Social Determinants of Health perpetuate health inequalities, thereby reciprocally affecting differential health statuses across various social strata. Relatedly, the authors contend that public policies ought to be formulated to reduce the identified health disparities across social strata by way of securing social, economic, and political conditions for the benefit of all social groups.

The Social Determinants of Health are recognised as a foundational concept in the field of population health, contributing significantly to the attainment of overall public health. According to the World Health Organisation (WHO), the Social Determinants of Health are defined as the material conditions within which individuals exist. These conditions are influenced by political, economic, and social considerations. The composition of the Social Determinants of Health is both informed and shaped by public policies, despite health not being the primary focus of the socio-politico-economic policies. This underscores the idea of health being integral to all policies, which is premised on the understanding that policies across various sectors impact health through the pathways expressed within the Social Determinants of Health. Therefore, when governments adopt a health-for-all policy approach, it is possible to identify structural determinants of health effectively and simultaneously work towards health equity in a systematic manner through public policy (Shankardass et al., 2018). This notion is further demonstrated in Geoffrey Rose's "causes of the causes" concept, where the Social Determinants of Health are situated within the midstream. Public policy is positioned in the upstream, and the social resources in the midstream, are influenced by public policies located in the upstream (Ataguba et al., 2015; Islam, 2019).

In a responsive state, the socio-politico-economic conditions in each society should guarantee its citizens a set of appropriate economic and social resources, which are equally distributed, such as access to education, nutrition, a healthy living environment, and employment. These resources in quality, quantity, and distribution cumulatively result in citizens' health and wellbeing.

An analysis of the literature from Embrett and Randall (2014), highlights that within public policy, interventions to ameliorate the existence of the Social Determinants of Health have not been fully incorporated into the public policy agenda. It is imperative to analyse a society's wider political milieu, using a policy analysis lens to have a more informed understanding of why the Social Determinants of Health have not been fully incorporated into the public policy agenda. A policy analysis is therefore critical, as it aids in appreciating both the outcomes of past policies retrospectively and the adoption of future policies prospectively. It also provides a framework for outlining the structural features that contribute to policy adoption (Embrett & Randall, 2014).

What is more, the existing literature from Ataguba et al., (2015), Embrett and Randall (2014) and Zere and McIntyre (2003), strengthens the argument that policymakers increasingly appreciate the Social Determinants of Health. However, there is an ineffective uptake in the policy process, despite the Social Determinants of Health being substantiated as having a disproportionate impact on the status of public health among different racial, gender and socio-economic groups. This can be attributed, as posited by Embrett and Randall (2014), to policy implementation often being seen as the penultimate stage of the policy process. Many factors contribute to how a problem is defined, whether a policy issue ever makes it to the Government policy agenda, and whether acceptable policy options are ever formulated, long before policy adoption and implementation become possibilities. Although often oversimplified, the policy process is a concept that can be pragmatically viewed as sequential phases that begin with an issue being defined as a problem that then gets placed on the policy agenda for potential Government action.

An illustrative example of the Social Determinants of Health can be found in food security. Kheswa et al., (2021) and Madiba et al., (2019) define food security as a state in which individuals have both physical and economic access to nutritious food to meet their dietary requirements. At the household level, food security constitutes accessibility to food, the financial means and access to food; sufficient food consumption for managing the body's use of nutrients; and the quality of food consumed, as well as a reliable supply of food. An absence of any of these elements can drive food insecurity. Research from Chakona and Shackleton (2018), highlights that at the household level, access to food is positively correlated with stunting. The research emphasises that children from households belonging to lower income quintile groups with limited access to food, have a higher probability of experiencing malnutrition, which manifests itself as stunting.

Wang and Fawzi (2020), as well as Kristjansson et al., (2016), describe school-feeding programmes as interventions, delivering nutritious food to school-going children, with the primary objective of reducing child hunger and food insecurity; diminishing micronutrient deficiency and anaemia; averting overweight and obesity, while simultaneously improving low school attendance and cognitive performance.

Contrary to the dominant literature on school-feeding programmes and the added benefits of addressing malnutrition on cognitive development and learning ability, Kristjansson et al., (2007) argue that school-feeding programmes have a limited impact on children's health

outcomes. This is because nutritional deficiencies occur in the first thousand days of life, leaving a few options to address the impairments caused by early childhood developmental nutritional deficiency, experienced by school-going children. Furthermore, school-feeding programmes only temporarily alleviate hunger for poor school-going children and do not successfully affect their socio-economic conditions, as expressed by Marmot (2005).

Traditionally, the Social Determinants of Health and health equity have not received much policy attention. Embrett and Randall (2014), emphasise five (5) primary reasons for this: firstly, there are multiple connections between social conditions and health. Secondly, there is a lack of technical feasibility of policy solutions, and thirdly, the life-course perspective of policies may not have an immediate impact. Fourthly, there is a dominance of other policies, such as biomedical solutions and lastly, there is difficulty obtaining data that relate social conditions to health outcomes. Consequently, the barriers have resulted in limitations for a policy problem to be successfully framed in the context of the Social Determinants of Health and health equity and subsequently to develop responsive public policies.

Therefore, given the existing evidence on the relationship between the Social Determinants of Health, nutritional support and educational development, the present study will focus on a retrospective policy analysis of the Integrated School Health Policy. It aims to address whether there is a consideration of the Social Determinants of Health in the policy-conceptualisation by policy-making interest groups. Simultaneously, it will evaluate if the Social Determinants of Health are adequately represented in the policy framework and subsequent policy programmes.

1.2.BACKGROUND

Shung-King et al. (2014) reveals that school health services in South Africa can be traced as far back as the 1920s, operating within the margins of school feeding programmes. Besides the primary focus on school feeding programmes, these services also provided inoculations, eye and hearing tests for school-going children. It is essential to note that these school health services were exclusively designed for non-black school-going children.

Centralised within the National Department of Health, these services were operationalised as vertical school-based outreach programmes, delivered by nurses specifically assigned for school health services. Post-apartheid school health services were introduced in South Africa

to address the barriers to education for school-going children and mitigate the structural inequalities created by the apartheid state. This policy shift was critical for ensuring that children gain access to education at the recommended age and remain in school until their high school completion, since non-attendance of school, due to health issues, is the primary observable barrier to education (Lenkokile et al., 2019).

Shuro and Waggie (2021) highlight that historical discrimination under apartheid required the post-apartheid government to enact the National School Health Policy (NSHP) and related implementation guidelines in 2003, aiming to redress the inequalities in school health services created by the apartheid state. Despite the implementation of the National School Health Policy (NSHP), there was no significant improvement in school health outcomes. Shung-King (2013) identifies three (3) observable deficiencies of the National School Health Policy (NSHP), namely: the inadequate deployment of nurses to schools; poor referral services for children; and a lack of efficient and effective health service delivery at sub-district level. This inefficiency primarily stems from the centralised operationalisation and decision-making of the National School Health Policy (NSHP). In 2012, the South African Government introduced the Integrated School Health Policy, imperative to address the health and educational performance of school-going children. The primary objective of the Integrated School Health Policy was to establish relevant parameters for the delivery of school health services (Rasesemola et al., (2019).

In a case study titled "Building support and policy change for integrated school health," D'Ambruoso et al., (2019) indicate that, in his 2010 State of the Nation Address, former President Jacob Zuma articulated his support for school health programmes. The presidential support gave credence to the Care and Support of Teaching and Learning (CSTL), Primary Health Care (PHC), and Health Promoting Schools (HPS). This, in turn, led to the collaboration between the National Department of Health and the Department of Basic Education in developing the Integrated School Health Policy. This initiative took advantage of the favourable window of opportunity aligned with international evidence and initiatives.

The new Integrated School Health Policy encompasses a comprehensive healthcare package for all school-going children in Grades R to 12. This package includes health assessments, screening, the promotion of health and education, on-site services, and referrals. This package marks a significant departure from the 2003 strategy, which mainly concentrated on visual and

hearing impairment screening for Grade R and Grade 1 in school-going children (D'Ambruoso et al., (2019). Additionally, the Integrated School Health Policy, specifically emphasises equity and adopts a constitutive, phased implementation strategy. Initially, the focus was on younger school-going children and schools in the most disadvantaged communities - drawing lessons from the National School Health Policy (NSHP) of 2003, before eventually expanding to encompass all school-going children.

The authors further elaborate that the Millennium Development Goals (MDGs), the Education for All initiative, and other international research were influential in the development of the Integrated School Health Policy (ISHP). The South African Government is observed to have utilised the Integrated School Health Policy (ISHP) as a critical mechanism towards achieving family wellbeing. D'Ambruoso et al. (2019) underscore that the policy change from the National School Health Policy (NSHP) of 2003 to the Integrated School Health Policy (ISHP) did not occur in isolation; instead, it was reinforced by several complementary laws, programmes, and initiatives aimed at promoting the health and well-being of school-going children. An example of such an initiative is the National School Nutrition Programme (NSNP).

The Department of Basic Education expanded its primary mandate in 2009 to include supporting learners in all facets of their lives outside the classroom. The extended mandate was expressed in the Care and Support of Teaching and Learning (CSTL) proposal. Teacher unions also reiterated their commitment to the Quality Learning and Teaching Campaign (QLTC) to eliminate obstacles limiting children's potential. The Quality Learning and Teaching Campaign (QLTC), a comprehensive initiative, supported by the United Nations International Children's Emergency Fund (UNICEF), aimed to forge alliances with all stakeholders, particularly with the Department of Basic Education and teacher unions (D'Ambruoso et al., (2019).
Secondly, and more significantly, the new Minister of Health, Dr. Aaron Motsoaledi, prioritised school health. He was a staunch advocate of Universal Health Coverage (UHC) and the proposed National Health Insurance (NHI). This initiative was spearheaded by a substantial Primary Health Care (PHC) revival, reinforcing district health services.

Subsequently, the Primary Health Care Re-Engineering Strategy was introduced and sanctioned by the National Health Council. This occurred after Minister Aaron Motsoaledi and provincial members of the Executive Council visited Brazil in 2010 to study the Family Health

Strategy. The Primary Health Care Re-Engineering Strategy was divided into three streams: maternity and child health district, clinical specialist teams, ward-based outreach teams (WBOTs), and school health. Schools were identified as an ideal site to fulfil the mandate of the Primary Health Care Re-Engineering Strategy, because the approach aimed to bring services closer to the people (D'Ambruoso et al., (2019).

The case study from D'Ambruoso et al., (2019) reveals that the creation of the Integrated School Health Policy was facilitated by leveraging the favourable political and policy environment at the time. Committed ministers in the National Department of Health and the Department of Basic Education established crucial high-level inter-sectoral connections. They codified commitments to health promoting schools, and created reform agendas that were mutually compatible, demonstrating political will from the South African Government. Evidently, the setting of the policy agenda drew on prior knowledge, regional expertise, and integration as a powerful strategy for policy adoption. The ministerial mandate and administrative support allowed the Integrated School Health Policy to be developed in the National Department of Health and the Department of Basic Education, with a lesser extent of involvement from the National Department of Social Services, addressing a variety of socio-economic barriers to teaching and learning.

Therefore, the Integrated School Health Policy should be understood as an adjusted policy imperative informed by global frameworks on education and health. Primarily, it addresses both the health difficulties of school-going children and responds to education barriers, such as household-level food insecurity. Moreover, the health services under the Integrated School Health Policy are designed to address the Social Determinants of Health by making provision for food insecurity and malnutrition and to address the consequences of stunting and obesity. The primary recipients of the Integrated School Health Policy are grade R to Grade 12 school-going children, with the National Department of Health and the Department of Basic Education serving as the custodians of the policy. Simultaneously, the Department of Social Development is described as a joint partner, addressing the social determinants connected to school health services. However, given the differential operationalisation, governance framework, and implementation, Shuro and Waggie (2021), show that the Integrated School Health Policy exacerbates existing structural inequalities, such as those related to access to services.

When contextualising the critical role of academics in adopting a policy agenda, regularised to the Social Determinants of Health, due consideration should be given to the best practices in the agenda-setting stage for policy development and management processes in South Africa. According to Lane et al., (2020), some of the best practices to consider, include conducting a situational analysis. The authors contend that a situational analysis supports a nuanced understanding of the contextual factors that contribute to specific public health issues. The objective behind a situational analysis, is to advance a common understanding of contextual factors resulting in the identified public health issue, with these factors linked to gender political, economic, and social determinants. Furthermore, a situational analysis, according to Lane et al., (2020), should enable the incorporation of recommendations and inputs from key stakeholders to Government policy practitioners. Facilitating Government policy practitioners' access to evidence, has also been noted as important by Lane et al., (2020). The authors add that it aids in the formulation of evidence-based policy formulation and agenda-setting.

1.3.PROBLEM STATEMENT

Health-promoting schools have been cited as integral components of the South African Government's efforts to re-engineer the Primary Health Care (PHC) system and have established an equitable, integrated health system. Before the adoption of the Integrated School Health Policy, there were earlier attempts to promote school health systems through the National School Health Policy (NSHP) of 2003. Relatedly, school health policies and services are vital because they strategically prevent and address the disease burden, while improving health and education outcomes for school-going children. Despite various policy responses in school health services to address national health inequalities, particularly concerning child malnutrition and improving child health outcomes, significant levels of malnutrition persist in children. Malnutrition predominantly manifests itself as stunting and has a detrimental impact on the cognitive development of a child.

The literature associated with the Integrated School Health Policy, primarily focuses on the policy context and content. However, there is limited literature addressing a retrospective analysis of the Integrated School Health Policy within the context of the policy process and critical elements of the Social Determinants of Health, as well as the related structural factors that underpin the reproduction of compromised health in school-going children. Therefore, the present study aims to address this identified gap.

1.4.RESEARCH QUESTIONS

1.4.1. Primary research question

What was the role of academics in the policy development process that resulted in the Integrated School Health Policy (ISHP) and the extent to which the Integrated School Health Policy (ISHP) engaged concerns of the social determinants of health?

1.4.2. Secondary research questions

What are the academics' understanding of the Social Determinants of Health linked to the Integrated School Health Policy process?

What was the critical role of academics in ensuring policy decisions are based on understanding the Social Determinants of Health and the related structural factors that underpin the reproduction of compromised health in school-going children?

1.5.RESEARCH OBJECTIVES

- Detail how health policies at the school level are underpinned by recognising the Social Determinants of Health and their relationship to understanding compromised health in school-going children.
- To retrospectively analyse the Integrated School Health Policy framework and guidelines concerning the Social Determinants of Health and health inequalities.
- To illustrate how academic research on the Social Determinants of Health can be used as a basis for policy formulation and agenda setting.

CHAPTER 2: LITERATURE REVIEW

2.1.INTRODUCTION

A literature review serves to analyse, examine and synthesise the existing body of knowledge on a particular social discourse under investigation. This process allows a researcher to debunk the discourse under investigation critically, while developing a specific line of argument (Bryman, 2012). In line with the introductory chapter, a large volume of biomedical literature exists on the causes of ill health and educational performance in school-going children. The dominant literature's approach is reductionist and places little attention on the implications of the Social Determinants of Health in the context of the health policy process. The National School Nutrition Programme is cited as an intervention under the Revised Integrated School Health Policy that creates an enabling environment for access to education for school-going children, while simultaneously contributing to the health of school-going children. Moreover, limited literature addresses a retrospective analysis of the Integrated School Health Policy in the context of the policy process and critical elements of the Social Determinants of Health as the underlying causes of health and health inequalities in school-going children.

As a result, the current chapter aims to illustrate the linkages between the Social Determinants of Health and social policy, primarily health policy. Secondly, the chapter aims to contextualise the conceptual framing of health-promoting schools to pinpoint a locality for the argument for school health services. This chapter will also review conceptions of the policy process, linked to the Social Determinants of Health and how this conception allows for the progression of the Social Determinants of Health into a policy agenda.

2.2.THE SOCIAL DETERMINANTS OF HEALTH AND SOCIAL POLICY

Titmuss (1974) asserts that the policy concept should be understood in terms of rules and regulations that provide a directive for a particular course of action driven by the Government or any organisation. The policy also denotes an intended or executed course of action, resulting in the desired direction of change in systems, practices, societal behaviour, and situations (Titmuss (1974), Lasswell (1971). Cited in Torgerson (1985), policy is defined as being primarily concerned with knowledge of the decision process. He views policymakers as being involved with having the prerequisite skillset – the practice of problem-solving in the public

interest, to inform decision-making in a public setting and the civic order. It is, therefore, reasonable to interpret the policy as being action-orientated through regulation, management, and the implementation of solutions to identified problems.

The concept of social policy has, over the years, encompassed various definitions that are both limited and comprehensive. What is available through characterisation, is broad. Despite the varying definitions, it is worth remarking that a social policy can be categorised into three main definitional domains. Firstly, social policy is seen as a set of applied policies within the context of public administration and its institutional arrangements. Secondly, social policy is also considered an interdisciplinary field of study (Alcock et al., 2008); and thirdly, social policy is an intended or executed course of action geared towards societal change.

Social policy, as a set of applied policies within the context of public administration and its institutional arrangements, refers to how governments systematise the provision of welfare services through institutional mechanisms to achieve developmental objectives articulated by the Government. According to Peters (2015), a substantial amount of policy work is completed through civic bureaucratic structures and is conceived as the formal, legal implementers of policies made elsewhere.

South Africa's healthcare system, for example. follows a pyramidal structure, with three concurrent health systems at the national level. The National Department of Health is responsible for overall national policy development and coordination. At the provincial level, the provincial Government is the leading provider of public healthcare services through hospitals and primary care clinics. Lastly, local Government is responsible for environmental health services and other non-facility-based primary healthcare services (Ataguba & McIntyre, 2018; Katuu, 2018).

Secondly, social policy, as an interdisciplinary field of study, is defined as the actions comprised of understanding the factors that influence a particular course of action related to a social policy and understanding the impact of such policies on an individual's livelihood (Alcock et al., 2008). This definition emphasises the need for evidence-based policy formulation and societal transformation through the collective well-being of citizens.

Titmuss (1974), whose theorisation of social policy has contributed significantly to both the theory and practice of social policy, defines it as a process involving moral and political value. This is premised on the observation that political propaganda commonly pretexts itself under

social policy descriptions. Titmuss's definition heavily focuses on the role of Government and legislation, underscoring that social policy emanates from decision-making processes influenced or informed by political interest groups in society with political power.

Subsequently, social policy investigates the intersectionality of social welfare and its relationship to politics and society. Through an analysis of this relationship, Titmuss cautions against applying altruism to social policy, primarily because what is deemed welfare for certain societal groups, may result in the ill-fare of other groups (Titmuss, 1974). The conception above, refers to the underlying inequalities of class, gender and race that exist within modern industrial capitalist societies. By accepting the existence of these inequalities at the philosophical level, Titmuss indicates the need to analyse the relationship between redistribution and social citizenship critically.

Relatedly, global debates on the Social Determinants of Health, have simultaneously focused on the socio-political and economic factors of health and health inequalities. The prevailing literature and data on the Social Determinants of Health, indicate a rise in health inequalities, with only a few countries leveraging the available evidence to reform healthcare policies and introduce responses that target the Social Determinants of Health, aiming to mitigate these health inequalities.

Health inequalities vary, and the definitional approach carries implications for policy processes and interventions geared towards addressing inequalities. According to Whitehead (1992), health inequalities are preventable differences in health, and their existence is deemed socially unjust. Furthermore, Whitehead (1992) posits that health equity should result in affording all individuals the same prospects to achieve full health, with no avoidable barriers to attaining it. Whitehead (1992) argues persuasively that equity in the healthcare system should present itself as equal access to care, utilisation, and quality of care. This perspective gains significance with the introduction of the Social Determinants of Health in the healthcare system policy discourse which introduces uncertainty around existing policy responses. This uncertainty arises due to empirical evidence from epidemiologists and social scientists, underscoring that a considerable amount of illness can be attributed to inequality in the context of income distribution – a Social Determinant of Health.

According to Low et al., (2005), the dominant principle underlining the conceptualisation of the Social Determinants of Health, is the differential distribution of health, resulting in a health gradient informed by socio-economic vantage points. The observed health gradient is less steep in countries with lower levels of social stratification, such as Sweden, where disparities are relatively minor in relation to income distribution, while normative social and economic policies endorse social integration.

This perspective is supported by scholars like Sir Michael Marmot, who argued that individuals' socio-economic conditions impact their health throughout life (Marmot, 2004). Marmot further asserts that health policies must be fit for purpose by positively affecting an individual's socio-economic conditions. This is premised on the belief that effective strategies to enhance population health, reducing health inequalities, not only rely on improving access to healthcare, but also on implementing structural changes and increasing security in individuals' socio-economic conditions and overall well-being. Introducing the Social Determinants of Health in healthcare policies, has created uncertainty about the effectiveness of current bio-medical approaches. Empirical evidence from epidemiologists and social scientists, underscores that a considerable amount of illness can be attributed to income distribution inequalities, prompting a need for an increased emphasis on health policy analysis. Furthermore, research on the Social Determinants of Health is essential, as it postulates policy opportunities and identifies additional areas for consideration. This holds particular significance for countries like South Africa, grappling with issues of social stratification, demographic changes, and globalisation.

The pervasive nature of health inequalities in South Africa is most apparent in child health outcomes. Despite increased Government-spending on social welfare, post-1994, research by Nkonki et al., (2011), reveals that inequalities for infants and children under five (5) have persisted. An examination of the socio-economic position of individuals and child health outcomes, indicates a significant reduction in infant mortality with an improved socio-economic standing. Nkonki et al., (2011), argue that infant mortality is higher in lower-income quintile groups. The disaggregated data shows disparities between rural and urban townships within geographical settings, contributing significantly to the variations in child health outcomes.

Given the complexities of the Social Determinants of Health, the concept of health equity points towards an existing injustice in current distributive systems. Health equity carries ethical implications and normative connotations, emphasising the need for a thorough health policy analysis. Achieving improved population health and reduced health inequalities, requires multiple policy approaches. Social policies related to school health services, play a crucial role, as schools serve as excellent research domains to make population health and development projections. Moreover, evidence highlights that improved health results in better education outcomes, as poor health inhibits favourable educational outcomes. Lynch (2020) substantiates that social policies can effectively and efficiently improve population health and reduce health inequalities associated with the Social Determinants of Health. However, Martins (2021), articulates the challenge of the insufficient understanding and integration of the Social Determinants of Health into policy, and that it impacts effective policy formulation by policymakers to street-level bureaucrats.

The Lancet Public Health (2020) emphasises the critical role of schools, not only in providing education but also in promoting children's health and welfare. Therefore, school health services should be integrated across education departments and agencies, recognising the profound influence of education on health outcomes. Implementing health policies, as outlined by Gilson et al., (2017), entails a decision-making process and the efforts of operational implementers to translate policy intentions into practice. It is important to recognise the political nature of the process, as these decisions impact the nexus between street-level bureaucrats and citizens' access to resources and social benefits.

Research on the implementation of intersectoral nutrition policies from Reeve et al. (2021) proposes that effective nutrition policy implementation requires significant political will and interest, influencing the allocation of resources and institutional structures for long-term gains. Additionally, the study emphasises the necessity of intersectoral-ministerial overseeing of regulations, to ensure accountability concerning nutritional and educational performance in school-going children.

The countries examined in Reeve et al.'s (2021) study, reveal that oversight governance mechanisms designed for intersectoral nutrition policies, struggle to prioritise nutrition due to low political will and interest along with inadequate financial and human capital resources. Moreover, there are gaps in the existing literature regarding the governance relationship between government departments and agencies concerning the Social Determinants of Health

and how these are operationalised in the policy frameworks, guiding school-going children's nutritional support programmes.

2.3.HEALTH PROMOTING SCHOOLS

In determining if the Integrated School Health Policy aligns with the Social Determinants of Health, it is imperative to consider the Social Determinants of Health within the social contexts of individuals. In this study, the exploration of individuals' social contexts, will be guided by the conceptualisation of Health Promoting Schools (HPS).

According to Macnab et al., (2014), the World Health Organization (WHO) theorised Health Promoting Schools (HPS) as social settings that consistently enhance their capacity as healthy environments for living, learning, and working. Additionally, the Health Promoting Schools, as social settings, extend the delivery of health services within the schooling context in a bid to engage the entire school ecosystem effectively, encompassing parents, school governing bodies, the broader community and caregivers. The World Health Organization has cited this approach to be beneficial in addressing health equity, theoretically ensuring that no-one is left behind.

Consequently, Newman et al., (2015) bring to the fore that the Social Determinants of Health can be effectively addressed within the Health Promoting School (HPS) settings. This is premised on the notion that education plays a crucial role in health as it provides literacy, numeracy and analytical skills, enhancing employability and the ability to cope with a various issue, including health. At the core of this argument is the idea that entrenching health promotion into the school curriculum, is a practical mechanism for reaching all school-going children. It also recognises that all aspects of the life of a school community are potentially important in promoting health, particularly in Health Promoting Schools.

Successful interventions of Health Promoting Schools (HPS) and school health services, addressing health equity, can be illustrated through the provision of school feeding programmes. Research evidence from Kristjansson et al., (2016), validates that school feeding programme interventions are most favourable and likely to reduce malnutrition during the early childhood development phase, thereby maximising educational potential and achievement. Furthermore, school feeding programmes contribute to the attainment of the United Nations

(UN) Sustainable Development Goals (SDGs), particularly those related to ending hunger and achieving food security, promoting inclusive and quality education, and enhancing the overall wellbeing for all. The National School Nutrition Programme has reached 20 000 schools that fall under quintiles 1, 2 and 3; and it aims to strengthen school-going children's ability to learn by delivering nutritious school meals, promoting increased energy levels, and bettering micronutrient consumption.

According to Hassanally et al., (2020), the National School Nutrition Programme provides only 18% of the recommended dietary allowance of micronutrients for children, signalling a need for improved micronutrient consumption. A micronutrient deficiency may lead to learning disabilities or severe diseases in children. Despite the National School Nutrition Programme only delivering 18% of the recommended daily allowance (RDA) of micronutrients for school-going children, Prentice et al., (2013) record a potential for the National School Nutrition Programme to improve child health performance, particularly in reducing child stunting. Mostert (2021) argues that this research area is limited in South Africa, lacking quantified impact studies. The collective efforts to address current nutrition issues, lack a satisfactory focus on generating school health-centric services. Governance also lacks synchronisation across policy areas, and there is insufficient technical support for the Integrated School Health Policy's content from the national to the district level. Consequently, gaps in alignment and coordination concerning school health services, become apparent.

Moreover, it is equally important to note that, particularly when addressing health equity, social contexts, such as Health Promoting Schools (HPS) may overlook out-of-school children (OOSC), leaving them vulnerable as they are not reached through programmes like the National School Nutrition Programme. Relatedly, children residing in disadvantaged communities but attending schools in affluent neighbourhoods, are also overlooked, leading to intervention-generated inequalities (IGI): Newman et al., (2015).

Global South perspectives on the implementation of health promoting schools: Brazil and India.

School health programmes were introduced in India in 1950, shortly after the establishment of the Expert Committee on School Health Services by the World Health Organization (WHO). According to Hlongwane and Lenkokile (2021), following the introduction of school health

programmes in 1950 by the Indian Government in 2005, the Government introduced the National Rural Health Mission (NRHM) as a mechanism to address the needs of school-going children. Furthermore, the cornerstone of the National Rural Health Mission (NRHM) was based on a bottom-up approach to planning and funding, centred around community needs. By way of this, the National Rural Health Mission (NRHM) has been described by Hlongwane and Lenkokile (2021) as being instrumental in creating pathways for the collaboration between the education and health sectors in India, simultaneously expanding the footprint of school health programmes.

Notwithstanding the collaborative nature of the coordination between the education and health sectors in India, the Indian Government also undertook a decentralised approach for the implementation of the school health programme. This approach enables public officials to develop implementation frameworks tailored to the specific needs of their locality. In India, each state is responsible for implementing its own school health programme, with the Government determining the national policy and providing guidelines used by the states for planning and implementation.

Hlongwane and Lenkokile (2021) record that the Indian model for integrated school health differs from the South African approach. The South African integrated school health model utilises a centralised framework for policy implementation, with each of the nine provinces aligning implementation alongside national policy objectives and guidelines. This is in contrast with the Indian decentralised model, which responds to community-specific needs. In South Africa, provincial coordinators are mandated by the National Department of Health to implement policy. As a result, the authors recommend that the South African Government ought to explore a decentralised model, allowing provincial departments of education to have more discretionary powers in planning and delivering school health services tailored to the specific needs of each community.

In the case of Brazil, the Government introduced its first school feeding programme in 1930 as a response to hunger and poverty-related diseases at the time. Subsequently, to ensure sustainability of the feeding scheme. The Brazilian Government legislated and enacted Law No. 11.947/2009, which stipulated that a minimum of 30% of the funds, which are received from the Brazilian Education and Development Fund, should be apportioned to the purchasing of agricultural products from subsistence farms. Subsequently, the Brazilian School Nutrition

Programme has been described as the most comprehensive school feeding programme with an estimated budget of 3.3 billion USD in 2012 that fed 45 million learners globally (Hlongwane and Lenkokile, 2021). In addition to the Brazilian School Nutrition Programme, the Brazilian Government established the School Health Programme (SHP) in agreement with the Presidential Decree No. 6286 of 5 December 2007, concentrating primarily on three focal areas, namely: "clinical and psychological evaluation; promotion and prevention of health; and training of managers, health and education professionals, and young people." (Hlongwane and Lenkokile, 2021).

The literature from Hlongwane and Lenkokile (2021) supports the viewpoint that the Brazilian model emphasises the integration of a school feeding programme into the healthcare system to circumvent malnutrition in school-going children. Consequently, the authors suggest that the South African Government should maintain and support the existing school feeding programmes as a preventative measure against malnutrition in school-going children from disadvantaged communities. This is crucial, as malnutrition tends to be prevalent among school-going children from socio-economically disadvantaged backgrounds (Hlongwane & Lenkokile, 2021).

The Brazilian case highlights the importance of active collaboration across the different levels of Government at the local level and that successful implementation of the school health programme requires the technical support of various stakeholders. According to Hlongwane and Lenkokile (2021), establishing strong relationships with key stakeholders, such as community members, educators, and healthcare professionals, is vital for garnering support for school health interventions. The Brazilian experience underscores the significance of considering stakeholder suggestions and obtaining their consent, enhancing participant trust while fostering better working relationships. The inclusion of community members and families in school health programmes, can improve comprehension and application, allowing students to share newly acquired health information. The aforementioned, aligns with the assertion of Brynard (2005) that the exclusion of key role players during the policy planning phase, negatively impacts implementation outcomes.

Regional perspectives on the implementation of health promoting schools: Tanzania.

In 1967, the independent Tanzanian Government ushered in its primary healthcare strategy, anchored on the World Health Organization's (WHO) classification of health for school-going children. Consequently, the Tanzanian Government - like the Indian Government - took on a decentralised approach to the promotion of school-based health, which is informed by the design of the National School Health Programme, including an institutional framework at the village/district level (Hlongwane & Lenkokile, 2021).

Given the decentralised nature of Tanzanian's healthcare system, the district Council Health Management Team (CHMT) is tasked with the mandate of safeguarding the provision of healthcare services at the district level. However, according to Hlongwane and Lenkokile (2021), there is a polaritandy in the decentralised approach to healthcare provision for school-based interventions. This disparity arises from the current practices in school health provision at the street-level bureaucrat echelons and the school health guidelines provided by the Tanzanian Government. Moreover, the impact of poverty creates impediments to the standard of school healthcare services.

In the case of Tanzania, healthcare providers and street-level bureaucrats, as highlighted by Hlongwane and Lenkokile (2021), encounter hurdles in the implementation and inference of policy guidelines linked to the school health programme. Additionally, despite the requirements for Council Health Management Team (CHMT) representatives to visit healthcare facilities, these visits occur sporadically due to a lack of political will and willingness to accelerate healthcare provision for school-going children. The existing situation underscores the need for enhanced political willingness and support to make school health services more effective and efficient.

As mentioned earlier, the Tanzanian Government's approach to school-based health promotion is comparable to India's. However, Hlongwane and Lenkokile (2021) highlight that the decentralised model has not been as successful in Tanzania as in India. The authors attribute this to the misalignment between current practices in school health provision at the street-level, bureaucrat level and the school health guidelines provided by the Tanzanian Government. They further argue that, based on the Tanzanian experience, the South African Government should aim to avoid disparities between implementation at the street-level bureaucrat level and the

national policy guidelines set at the national policy level. This precaution is vital to prevent negative, unintended consequences of policy implementation.

Furthermore, implementation in Tanzania has been significantly hampered by the substantial pre-conditions of poverty and unemployment. Consequently, levels of poverty should be considered thoroughly in the policy design process. This further solidifies the conceptualisation and application of the Social Determinants of Health in the context of school healthcare services and policy. Interestingly, Hlongwane and Lenkokile (2021) indicate that in Tanzania, a large proportion of school-going children come from low-income households. Therefore, any school-based healthcare intervention should earmark children from low-income households as the primary recipients of school-based healthcare services and school nutrition programmes.

National perspectives on the implementation of health promoting schools: South Africa.

Shuro and Waggie (2021) contend that the Integrated School Health Policy, implemented in South African schooling, is designed to address the Social Determinants of Health for school-going children. This policy incorporates health reforms, encompassing comprehensive Primary Healthcare (PHC) and the Care and Support for Teaching and Learning (CTSL) framework. The Integrated School Health Policy is also driven by an intersectoral approach for policy implementation to achieve improved health and educational performance.

Research findings from Shuro and Waggie (2021) align with the argument made by Reeve et al., (2021) regarding oversight governance mechanisms. According to Reeve et al., (2021), intersectoral nutrition policy has struggled to prioritise nutrition adequately due to low political will, limited interest, and insufficient financial and human resources. In the context of the Integrated School Health Policy, obstacles in the policy process arise from poor collaboration among the National Department of Health, Department of Basic Education, and Department of Social Development. The absence of consultation with school and Primary Healthcare (PHC) facility managers, further exacerbates the situation, leading to divergent policy priorities and hindering the effective operationalisation of the Integrated School Health Policy within the framework of the Social Determinants of Health.

Reeve et al., (2021) suggest that intersectoral policies for addressing nutrition should work across all the policy implementation dimensions to ease all these barriers, by way of structuring

collective action on nutrition across different sectors, like the National Department of Health, the Department of Basic Education, and the Department of Social Development. The overall effect can be supported through intersectoral-ministerial support, advocacy, and evidence-based policy research. In essence, policies addressing nutrition, should be action-orientated through regulation, management, and the implementation of solutions to health inequalities experienced by school-going children. This will depend on the governance relationships across the various Government departments in that governance focuses on the policymaking process, and the resulting implementation of policy and dovetails on the impact of health through the pathways expressed within the Social Determinants of Health. Conversely, Embrett and Randall (2014) suggest that policymakers frequently suffer from poor dissemination and ineffective issue framing, that could include the lack of a causal link, which exists between problem and solution, public awareness, political legacies, and political will, all of which suggest that policymakers are aware of Social Determinants of Health problems but prefer to avoid investigating the complex policies needed to address them.

2.4.THE POLICY PROCESS AND THE SOCIAL DETERMINANTS OF HEALTH

In the context of this study, the policy process, as articulated by Weible et al., (2012), refers to the examination of the evolution and development of public policy, along with the subsequent interactions among policy actors. Public policy encompasses diverse schools of thought around the policy process, with the prevailing perspective being the heuristic approach, which views the policy process as a series of stages linked to agenda setting, formulation, implementation, and evaluation (Lasswell, 1956). Walt et al., (2008) highlight alternative policy processes that delve into on the individual stages of the heuristic approach. An example of this is illustrated through John Kingdon's multiple-streams theory, which focuses on agenda-setting and contends that the public policy process is arbitrary. The latter presentations posit the policy process as a linear progression from formulation to implementation and ultimately, evaluation. However, Exworthy (2008), expresses that the policy process ought to be understood as a disjointed progression.

In examining the health policy process, Exworthy (2008) posits that a combination of policy decisions and agenda-setting is a protracted process making it challenging to pinpoint the mechanisms behind decision-making. Furthermore, decision-making is influenced by the need

to ameliorate stakeholders' perspectives and introducing power dynamics into the process. Secondly, the policy-making process lacks transparency, as emphasised by Ingram et al., (2007), who underscore the uneven distribution of power in policy design. This manifests as the three (3) faces of power: the first face involves observable interplays between divergence and influence; the second face is unobservable and pertains to the ability to resist particular policy agendas. The third face of power is closely related to Marx's concept of false consciousness, addressing the rationalisation of adopting particular policy agendas (Ingram et al., 2007). Finally, Exworthy (2008) indicates that the policy process may lead to indecision, a consequence of the second face of power, hindering the effective uptake and validation of policy agendas. Within the South African context, the policy process is characterised by the collaborative relationship between Government and non-state actors. Gumede (2008) notes that the South African policy process incorporates arrangements for public participation in a bid to achieve equity and justice. However, it remains unclear how power disparities within the South African policy process are addressed, and the role of the Social Determinants of Health in informing policy development, is not evident.

Considering these conditions, Exworthy (2008) identifies eight (8) challenges associated with addressing the Social Determinants of Health within public policy. Firstly, given the complexity the Social Determinants of Health, policymakers face difficulties in defining their key features, potentially leading to negative implications for the policy process. Policymakers, may therefore, view complex problems as barriers to simplified policy solutions, resulting in non-decisions regarding the Social Determinants of Health.

Secondly, the life course approach that informs the Social Determinants of Health, poses a challenge for the policy process, which typically relies on policy cycles and organisational reporting cycles not measured over the life course. Thirdly, the integrated nature of addressing Social Determinants of Health across various sectors and Government departments, faces obstacles. However, research has also shown that differing organisational accountabilities and priorities hinder effective partnerships for the uptake of the Social Determinants of Health. At the Government level, the vertical structure of Government departments acts as a barrier to effective partnership and coordination, resulting in a siloed approach to the Social Determinants of Health (Exworthy, 2008).

The fourth obstacle entails that the Social Determinants of Health can be overshadowed by the need for Government departments to deliver healthcare. Financing and service delivery become the primary focus within the policy process in such instances. The fifth challenge arises in the fact that there are limitations in the level of understanding the causal pathways related to the Social Determinants of Health, which create barriers, impeding the development of policies that are well-suited for their intended purposes.

The sixth challenge focuses on the importance of linking epidemiological developments over time to inform the policy process. However, empirical evidence suggests that there is limited data available for analysing these developments effectively. The seventh obstacle pertains to the Government's ability to construct the Social Determinants of Health for improved public health. Globalisation constrains this capacity because it is one of the key factors influencing the Social Determinants of Health and is not limited to a specific geographical location within a state.

Lastly, Exworthy (2008) observes a limited understanding among policymakers regarding the policy process and the interplay between the policy process and the Social Determinants of Health. Embrett and Randall (2014) advocate for the use of a conceptual model in addressing these challenges. This model should contextualise the policy issue, specifically the Social Determinants of Health and health equity. Moreover, it should concentrate on discerning the nuanced aspects of power, politics, and practice. This approach helps elucidate both the similarities and differences in policy patterns among different initiatives.

2.5.PROGRESSION OF THE SOCIAL DETERMINANTS OF HEALTH INTO THE PUBLIC POLICY AGENDA

Baker et al., (2018) convincingly share that within the framework of interest group mobilisation in the policy process; civil society mobilisation has played a critical role in prioritising the Social Determinants of Health through empirical research findings. This assertion is supported by observational research findings, where advocacy emerges as a pivotal tool defined as "the use of tools and activities that can draw attention to an issue, gain support for it, build consensus about it, and provide arguments that will sway decision-makers and public opinion to back it.". Despite this significance, Baker et al., (2018) highlight concerns related to civil society advocacy, which may lead to varied interests and institutions, which can consequently lead to

disintegrated advocacy efforts and diluted policy influence. Accordingly, it is imperative for any social justice advocacy, linked to policy influence, to be built on consensus, with all concerned persons or parties of interest. This includes but is not limited to the public; academics; civil society and thought leaders.

In the Australian context, interest group mobilisation related to the Social Determinants of Health, can be illustrated through the former Australian health minister acknowledging the influential role of healthcare providers and professionals in shaping the Government's stance on the health agenda. This in turn, resulted in the marginalisation of the proponents of the Social Determinants of Health in the political stream (Baker et al., 2018). Similarly, in the United Kingdom (UK), medical professionals dominate and shape the health policy sphere.

Other mechanisms for advancing the Social Determinants of Health into the public policy agenda, include leadership. Baker et al., (2018), emphasise the critical role of leadership in promoting the Social Determinants of Health agenda in public policy. This can be achieved, as seen in South Africa, through the appointment and election of civil society leaders into positions of power and influence within Government. This facilitates the inclusion of social justice and human rights issues in the policy agenda. Furthermore, it is evidenced that the inclusion of health equity advocates within Government, aids in the promotion of a perspective centred around health reforms and health equity (Baker et al., 2018).

It is equally important to highlight that certain Government institutions serve as structural barriers for the progression of the Social Determinants of Health into the public policy agenda. This is premised on the understanding that the siloed nature of government results in disjointed efforts regarding the Social Determinants of Health and a misalignment in policy approaches when contextualising the Social Determinants of Health. According to Baker et al., (2018), adopting a "health in all policies" approach is a legitimate mechanism for influencing the inclusion of the Social Determinants of Health into the policy process. This approach involves simultaneously contextualising and appreciating the agendas of various sectors.

Finally, according to Baker et al., (2018), institutional norms are identified as a key barrier for the progression of the Social Determinants of Health into public policy. Governments are still considered the primary custodians of policymaking, and historical approaches that have placed focus on hospitals and acute healthcare services, are structurally hostile to a more all-

encompassing Social Determinants of Health approach. This leads to path dependency and this phenomenon is directly associated with the “lifestyle drift” hypothesis, suggesting that the initial commitment to address the "upstream" material-structural determinants of health in the problematisation and agenda-setting phases of the policy process, is later redirected towards a "downstream" approach, focusing on clinical services and the provision of primary healthcare.

2.6.THEORETICAL FRAMEWORK

The omission of the Social Determinants of Health from public policies, may stem from poorly defined issues that fail to make it onto the policy agenda, rendering the construction of policy options impossible. Consequently, the application of theories addressing the fundamental mechanics of the policy process, becomes essential to explain why a policy issue has either progressed or not for inclusion in the policy agenda. The initiation of the problem description phase occurs when a problem is defined in a manner that establishes it as a public issue, addressable by policy. However, given the frequent existence of multiple competing definitions for a given issue, framing the problem in a clear and theoretically anchored manner, proves exceedingly challenging. Some analysts consider achieving this effectively as a significant political accomplishment.

A problem can be effectively framed by using language and symbols that highlight the advantages and/or disadvantages of a policy choice or the effects of current policy in a causal way. The strategic use of language plays a pivotal role in this process.

The likelihood of a policy problem advancing into the policy agenda, is significantly enhanced. Moreover, how a policy problem is framed, has the potential to promote certain policy solutions while disfavouring others, (Embrett & Randall, 2014). Therefore, adopting a theoretical pluralism perspective, the theoretical framework employed in the current study, is rooted in the social construction framework positioned by Ingram et al., (2007), and Shiffman and Smith’s (2007) framework for generating political priority for global health initiatives.

Ingram et al., (2007) define social construction as the way real life is shaped and informed. Social construction argues that all knowledge systems are social and not predetermined by the world; therefore, social constructionism is contrary to determinism (Allen, 2017). The roots of the theory of social constructivism can be traced back to Berger and Luckmann (1966), who conceptualised the sociology of knowledge. Here, reality is defined as a by-product of social

construction processes influenced by political, social, economic, and historical contexts. Berger and Luckmann (1966) theorised the process by which perceptions and beliefs about population groups become institutionalised and forming social constructions and creating a system for categorising reality. Moreover, Berger and Luckmann (1966) broaden the perspective that social construction is organised through externalisation, objectification, and internalisation in society.

Ingram et al., (2007) utilise the social construction criterion in the context of public policy, by way of illustrating how social construction and the process of categorising populations influence the shaping and targeting of specific public policies. Lim and Tinivata (2022) elaborate on this process, explaining that policymakers categorise target populations either through positive constructions, deeming them as deserving or negative constructions, labelling them as undeserving of public policies. Additionally, the social construction of target populations, representing groups affected by policy, results in these depictions becoming normative and evaluative. By way of this, the modelling of target populations aids in explaining why public policy may fail in its official goals and objectives and subsequently perpetuate social injustice and unequal citizenship. This aspect is particularly crucial in policy analysis, as social constructions aid in the appreciation of policy change.

Lim and Tinivata (2022) add that the social construction of target populations illustrates how policymakers may formulate decisions influenced by their own preconceived notions as well as moral understandings prior to intellectualising a societal problem that aligns with the devised interventions. Consequently, employing the social construction framework in the context of modelling target populations, highlights the subjective evaluations that policymakers communicate when explaining a policy agenda and/or design.

In the context of public policy, the primary thesis of the social construction framework posits that the policy agenda and design are determined by social constructions of modelled target populations. The framework from Ingram et al., (2007) illustrates that the policy process entails the modelling of target populations, constructing representations of the target population that give grounds for the allocation of benefits or burdens to the target population. Consequently, the policy agenda and design are differentially created and influenced by the social construction of the target population. In-addition, Ingram et al., (2007) indicate that policy design predetermines the ensuing opportunities of participation, administration of resources as well as

the emerging levels of participation from the target populations. Ingram et al., (2007) add that the process of socially constructing policy determines institutional knowledge systems by way of governing the implementation and the administration of information and resources.

Ingram et al., (2007) articulate a social construction framework that delineates six (6) primary propositions. The initial proposition posits that policy designs, by way of modelling target populations, convey distinct messages to different target populations regarding their perception and treatment by the Government through public policy. As a result, these conveyed messages, and the ensuing opportunities for participation, shape political orientation of the target populations.

The second proposition asserts that the administration and allocation of resources for target populations concerning public policy, are dependent on both the political power and the social construction of the target population. The third proposition elucidates that policy design components vary, based on the target populations' political power and social construction.

Fourthly, policymakers reproduce social constructions of target populations in pursuit of public endorsement. The fifth proposition contends that the social construction of target populations can be altered through public policy design components, as evidenced by the unintended consequences of the preceding public policy designs. Lastly, Ingram et al., (2007) postulate that degenerative policymaking contexts result in differential models of policy change and can affect future social constructions of target populations.

2.7.SYNOPTIC CONCLUSION

The present chapter argued that introducing the Social Determinants of Health in the healthcare system policy discourse, initiated uncertainty around the existing bio-medically influenced policy responses, particularly when contextualising school health services.

CHAPTER 3: RESEARCH METHODOLOGY AND DATA COLLECTION

3.1.INTRODUCTION

The literature associated with the Integrated School Health Policy focuses on the policy context and content. However, limited literature that undertakes a retrospective analysis of the Integrated School Health Policy in the context of the policy process and critical elements of the Social Determinants of Health, serve as the underlying causes of the reproduction of compromised health in school-going children.

Therefore, this study aims to clarify how health policies at the school level are underpinned, by recognising the Social Determinants of Health and their relationship to understanding compromised health in school-going children. Secondly, the study aims to conduct a retrospective analysis of the Integrated School Health Policy framework and guidelines concerning the Social Determinants of Health and health inequalities. Lastly it aims to demonstrate how academic research on the Social Determinants of Health, can be used as a foundation for policy formulation and agenda setting.

To extrapolate the aforementioned, the study employed a qualitative research methodology to achieve its research objectives. By extension, the following chapter will delineate the research, including the research methodology, paradigm, method, and design. This chapter will detail how the research problem was approached, investigated, which research tools were employed as well as depicting the process of analysis that was used.

3.2.RESEARCH APPROACH

Research methodology is understood as the process in which a researcher intends to conduct a chosen study. Daniel et al., (2018) articulate that research methodology explains the subsequent research paradigm and the research method to be employed. The primary purpose of research methodology is to provide a systematised process of collecting and interpreting data to reach specific findings for a chosen study. Furthermore, the research methodology comprises qualitative, quantitative, and mixed methods.

The quantitative research methodology is primarily focused on the collection of numerical data and places emphasis on quantification to describe a phenomenon, while determining if there exists a causal relationship between the identified variables that are under investigation. Determining a causal relationship, involves hypothesising the relationship between theory and research and testing the existing theory around a phenomenon. Bryman (2012) points out that qualitative research methodology primarily focuses on collecting descriptive data and takes on an inductive process to the relationship between theory and research, while generating new theories.

Therefore, qualitative research methodologies take on an interpretivist approach to research. Wagner (2013) adds that qualitative research places an importance on the processes and social settings that inform specific social behaviours, which in turn allows the means through which research can judge the effectiveness of a particular intervention, project, or innovation. Although qualitative research methodologies have been critiqued as being less valid and reliable compared to quantitative research methodologies, qualitative research methodologies offer context-driven detail about social phenomena. Qualitative research results, therefore, can be utilised as a baseline for concepts and variables that can be employed in quantitative research (Gray, 2018). A mixed-method methodology involves the process of combining both quantitative and qualitative research methodologies.

Consequently, the study used a qualitative research methodology to investigate, collect, and analyse data relevant to the research questions, namely:

- What was the role of academics in the policy development process that resulted in the Integrated School Health Policy (ISHP) and the extent to which the ISHP engaged concerns of the social determinants of health?
- What are the academics' understanding of the Social Determinants of Health linked to the Integrated School Health Policy process?
- What was the critical role of academics in ensuring policy decisions are based on understanding the Social Determinants of Health and the related structural factors that underpin the reproduction of compromised health in school-going children?

A qualitative research methodology offered context-driven detail about the phenomenon of the Social Determinants of Health and the policy process.

The ontological assumptions of the present study were informed by a relativist ontology, which considers the subjective interpretations of the lived experiences of research subjects as a baseline for inductively constructing a theory. The basis of inquiry was located within the constructivist philosophical paradigm. According to Wagner (2013), constructivists seek to understand and describe specific phenomena from the experiences of the individuals facing the phenomenon.

The philosophical underpinnings of constructivism are informed by hermeneutics and phenomenology. Concerning the present study, a constructivist paradigm aided the researcher in analysing how school health policies are underpinned or not by recognising the Social Determinants of Health. Constructivism allowed the researcher to examine the policy process critically in terms of agenda-setting and implementation with a primary focus on delivering the associated benefits and liabilities of public policy.

Moreover, the research questions informed the constructivist paradigm as they are constructive and the primary objective of the present study, namely, to detail how health policies at the school level are underpinned, by recognising the Social Determinants of Health and how they influence child health and education performance.

3.3.RESEARCH DESIGN

The research design was used primarily to plan how the research problem would be approached and investigated. It also detailed the techniques employed for sampling, data collection and analysis to address the research problem under investigation effectively. Policy decisions often have their roots in longer-term processes, and the choice of timeframes for research is an essential factor. Temporal issues also affect research design; addressing these was an important aspect of the research design.

The present study adopted a case study research design to establish the role of academics in developing the Integrated School Health Policy. This investigation specifically referenced the understanding of the Social Determinants of Health and the related structural factors that underpin the reproduction of compromised health in school-going children. The study aimed to explore how this appreciation informs the policy process, particularly on agenda-setting and

defining the problem of the Social Determinants of Health within the Government policy agenda.

From the work of Rashid et al., (2019), a case study is understood as a comprehensive investigation of a phenomenon, aided by empirical evidence collected for the analysis of the relevant context and process. The authors further elaborate that the primary objective of a case study, is to conduct an in-depth analysis of a particular case, such as institutions, individuals, groups, or communities, to ascertain specific processes and relationships related to a phenomenon.

The research questions associated with the qualitative case study, employed a "how do?" feature, allowing the researcher to describe the phenomenon of the Social Determinants of Health and its integration into school health policies constructively, rather than formulating normative statements of the phenomenon. Guided by Rashid et al., (2019), the qualitative case study protocol included semi-structured interview questions, a research methodology, consent from research participants, ethical considerations, an analysis process, and criteria for assessment.

In framing the qualitative case study, it became apparent that examining the progression of the Social Determinants of Health into the public policy agenda, incorporating academics, serves as a practical illustration of the effectiveness or deficiency in the South African policy process. This process provides critical insights into how health policies at the school-level are either supported or not, by acknowledging the Social Determinants of Health.

3.4.RESEARCH TOOLS

According to Rashid et al., (2019), the qualitative case study method can employ an array of empirical materials for data collection. The study used secondary and primary data to answer the primary and secondary research questions. For the present study, the primary data collection tool used, was semi-structured interviews of at least 45 – 60 minutes with academics who have direct experience with the policy process of the Integrated School Health Policy and school health policies.

An interview schedule was compiled before the interviews took place. Secondly, an interview guide detailed the semi-structured interview questionnaire to equip the researcher with the relevant tools to guide the interview and predetermine the sequencing of the questionnaire. The semi-structured interview approach allowed the researcher to further probe research subjects and expand on their responses. Probing also allowed for the exploring of additional themes and content that may have previously been overlooked within the initial conceptualisation of the interview guide and qualitative case study protocol. Through semi-structured interviews, the researcher enquired on health policy at the school-level and the extent to which it is underpinned by the recognition of the Social Determinants of Health and how they influence child health policy interventions.

The secondary method of data collection included document analysis. Wagner (2013) explains that documents act as repositories of evidence, and their use in the social sciences primarily focuses on the contents rather than the utility of the document. Secondly, the researcher focused on the significance of the documents collected and the context in which they occurred, considering the consequences of the interface between the importance and the setting in which the documents originated. Document analysis was deemed essential as it provides a frame for exploring themes and data that may not have been articulated within the semi-structured interviews. Consequently, the researcher collected open-published documents in the form of the Integrated School Health Policy presentation to Parliament's health portfolio committee (2013), the management4health GmbH Integrated School Health Policy report (2021), and an online newspaper analysis of the Integrated School Health Policy.

3.5.SAMPLING

Purposive sampling, as a non-probability sampling method, was chosen for its ability to address both primary and secondary research questions, while exploring the investigated phenomenon. In this approach, participants are selected based on their capacity to answer research questions and contribute to the exploration of the phenomenon under study.

The study conducted semi-structured interviews with academics closely engaged in school health policies and school health. Given the specialised nature of the field, the study relied on referrals to identify relevant academics for interviews, employing snowball-sampling. The

initial academic interviews yielded recommendations for other academics directly involved in school health and the Integrated School Health Policy process. The entire research population, consisting of academics, was subjected to the same interview questions to ensure consistency.

Appreciating the technological advancements, all interviews were conducted online, using Microsoft Teams, and the interviews were recorded with the consent of all academics involved in the interview process.

3.6.SAMPLING CRITERION

The primary and secondary research questions played a fundamental role in shaping the essential criteria for selecting research participants. Additionally, the pool of participants was determined by the necessity to interview academics with direct experience in the policy process of the Integrated School Health Policy and school health policies.

It is imperative to note is that, given the specialised nature of the field in question, the study reached out to twenty (20) academics. Out of those contacted, thirteen (13) declined participation, resulting in a limited number of seven (7). Despite this limitation, the semi-structured interviews produced in-depth, comprehensive, and insightful data for analysis. Congruently, the research participants could be described as follows:

Research Participant 1

Research Participant One, currently an independent public health consultant, previously worked in the Mpumalanga Department of Health, having had direct involvement in the Integrated School Health Policy process. Furthermore, Research Participant One has conducted a case study as part of a research project, examining the impact of policies on maternal, child and family health in South Africa.

Research Participant 2

Research Participant Two is a lecturer who teaches Master of Public Health and Masters in Maternal and Child Health, as well as Child Age policies, with a particular interest in child age policies and programmes. When the Integrated School Health Policy was developed, Research Participant Two was part of the policy team on behalf of a Multilateral Organisation.

Research Participant 3

Research Participant Three has received formal training in nutrition and has worked as a consultant for the last twenty (20) years. Their involvement in the school health system, has been shaped by a long-standing interest in school nutrition education. Research Participant Three engaged in a project for the Kwa-Zulu Natal Department of Basic Education, assisting in the development of materials for schools in Kwa-Zulu Natal as part of the National Nutrition School Education programme.

Research Participant 4

Research Participant Four is a Professor in Health Policy and Systems and has conducted extensive research on the school health policy, utilising it as a case study to delve into child health policy and its approach equity or inequity. As a key member of the policy task team for the NSHP of 2003, they played a pivotal role in facilitating engagement with stakeholders nationwide concerning the School Health Policy of 2003 and the considerations stakeholders had regarding the provision of school health within the vertical services framework.

Furthermore, Research Participant Four has actively contributed to the development of national guidelines, outlining the implementation of the Integrated School Health Policy. Subsequently, the Western Cape Department of Health sought their expertise to work on formulating the implementation guidelines specific to the Western Cape.

Research Participant 5

Research Participant Five specialises in researching health issues and determinants among primary and high school children. Their involvement in school health services is focused on assessing various aspects of obesity in children, malnutrition, and physical activity.

Research Participant 6

Research Participant Six has worked as a researcher and academic in the field of maternal and child health. In addition, Research Participant Six, alongside Research Participant Four, has been part of the Technical Working Group that developed the National guidelines on how the Integrated School Health Policy could be implemented.

Research Participant 7

Research Participant Seven currently works as a senior researcher and is embarking on a research project titled: Assessment of Integrated School Health Policy of Programmes in KwaZulu-Natal.

3.7.PROCESS OF ANALYSIS

Theme generation was critical for the process of analysis. Consequently, a systematic interpretation process was utilised through pilot transcriptions and audio recordings of interviews. During the fieldwork, transcriptions were conducted regularly and securely. The transcriptions allowed the researcher to modify the semi-structured interview questions for subsequent interviews. The transcripts and interviews were then analysed using Thematic Analysis, a process in which the data is organised and coded to induce emerging themes.

The pilot phase of the fieldwork intended to interview Government policy practitioners and academics; however, there were limitations with Government policy practitioners' willingness to participate in the interview process, despite the researcher's approvals from the respective Government departments. For the pilot phase of the fieldwork, the researcher only secured an interview with the National Department of Basic Education, facing significant resistance concerning accessing the National Department of Health and the Department of Social Development.

A thematic analysis of the semi-structured interviews allowed the researcher to understand the subtexts and meaning of the interviews. The process of delineating the subtexts and meaning of the interviews, was fundamentally informed by the research questions and research aims. Of particular importance was the fact that thematic analysis allowed the researcher to coherently interpret subjective data to assess if the policy contents. Policy imperatives are harmonised with the Social Determinants of Health. The role of academics in developing the Integrated School Health Policy with specific reference to understanding the Social Determinants of Health and the related structural factors that underpin the reproduction of compromised health in school-going children is imperative. Therefore, a thematic analysis is presented as a feasible approach.

The semi-structured interviews were analysed using Tesch's eight-step analysis method (Creswell, 2014). Tesch's eight-step method of analysis includes the following phases:

Phase 1: The researcher will read all the collected data to get a sense check and understand the data.
Phase 2: The researcher will begin by selecting one of the research participant's transcribed interviews and debunk its meanings and the emerging themes.
Phase 3: The researcher will follow the same process in phase two for all the other participants' interviews and create a list of the emerging themes. Related themes will be clustered, and a list of the emerging themes will be made and disaggregated according to the level of relevance.
Phase 4: The researcher will apply the themes or topics to the data. The themes or topics will be abbreviated as codes, written next to the appropriate segments of the transcripts. The researcher will try this preliminary organising scheme to see whether new categories and codes emerge.
Phase 5: The relationship between the emerging themes will be determined and categorised.
Phase 6: Codes are created.
Phase 7: A preliminary analysis of the codes will be performed.
Phase 8: The researcher will recode existing material if necessary (Creswell, 2014).

3.8.VALIDITY AND RELIABILITY

Creswell (2014) points out that qualitative research methodologies are rarely concerned with accurate quantification of research measurements. Instead, they concentrate on credibility and trustworthiness as opposed to reliability and validity. Qualitative validity pertains to a researcher's capability to ascertain the accuracy of the research findings, while qualitative reliability involves maintaining consistency and generalisability in the researcher's approach.
Relatedly, Rashid et al., (2019) points out that reliability and generalisability are essential for assessing a research study. However, they highlight that reliability and generalisability align with a positivist approach to case studies. Subsequently, this alignment does not permit generalisation because qualitative case studies aim to interpret specific social phenomena and each interpretation is inherently unique. Critical for qualitative case studies, is assessing the congruency between reality and the research findings. This congruency can be enhanced through credibility, dependability, transferability, and conformability in the interpretation of qualitative empirical material.

3.9.TRUSTWORTHINESS AND CREDIBILITY

Credibility and trustworthiness were established through rigorous methods of synthesis and triangulation. These approaches enabled the researcher to detail and provide credible evidence regarding the critical role of academics in the adoption of a policy agenda regularised to the Social Determinants of Health. Additionally, it shed light on academics' understanding of the Social Determinants of Health, and how this understanding influences the policy process, particularly in terms of agenda-setting and defining the issue of Social Determinants of Health within the Government policy agenda.

Trustworthiness was ascertained through the accurate representation of the actual experiences of research participants. Credibility, which is connected to the trustworthiness of the research findings, is established when research participants recognise that the reported research findings accurately reflect their own experiences (Creswell, 2014). Credibility involved the researcher ensuring that all research participants use the same interview guide with identical interview questions.

3.10. POSITIONALITY

The persistence of poverty and the widening inequality gap in South Africa indicate that the social policies that have been employed in the post-apartheid era have not been sufficiently redistributive. This issue is compounded by policy uncertainty and a lack of comprehension regarding the nexus between governance and social policy on the part of non-state actors. In valuing social justice, academia should serve as a conduit to challenging the structural inequalities within South Africa, advocating for responsive policies to protect the most vulnerable members of our society. This research is seen as an opportunity to contribute towards the current social policy landscape, particularly on the cusp of South Africa, attempting to institutionalise National Health Insurance (NHI) under the umbrella of Universal Health Coverage (UHC).

3.11. ETHICS

Ethical considerations are central to social research, mainly when the research involves human participants. These considerations establish guidelines for conducting social research ethically.

Given that this study involved human participation in primary data collection, the researcher prioritised the rights of participants, specifically ensuring their anonymisation and safeguarding confidentiality.

The following measures were followed: communicating the study objectives to research participants, obtaining written permission to proceed with the study, and seeking ethical clearance from the University of the Witwatersrand Ethics Committee. In addition, the researcher prioritised the protection of research participants from harm, maintaining privacy and confidentiality by treating sensitive information about participants with utmost confidence.

3.12. SYNOPTIC CONCLUSION

This chapter commenced by foregrounding the research problem and objectives. Following that, it delineated the research approach by way of articulating the research methodology, the research paradigm, the research method employed, the research design and tools employed for investigating the research problem and addressing the primary and secondary research questions. A qualitative research method was argued for conducting a critical examination of the policy process regarding agenda-setting and implementation with a primary focus on delivering the associated benefits and liabilities of public policy. The subsequent chapter will employ the qualitative research methodology to present and discuss the research data.

CHAPTER 4: PRESENTATION AND DISCUSSION OF RESEARCH DATA

4.1.INTRODUCTION

The present chapter aims to present, analyse, and discuss the data gathered from the selected semi-structured interviews. Seven (7) research participants contributed to the data, as detailed in the preceding chapter.

In alignment with a retrospective analysis of the Integrated School Health Policy within the context of the policy process and critical elements of the Social Determinants of Health, the selection of research participants was crucial, considering their expertise and involvement in school health policymaking. Moreover, given the specialised nature of the field, the pool of academics interviewed, was limited to 7. Despite the limitation, the semi-structured interviews produced in-depth, valuable data for analysis.

Conducting a thematic analysis of the semi-structured interviews, allowed the researcher to understand the subtexts and meaning of the interviews, aligning them with the research questions and aims. The overall objective of this study was to examine the role of academics in shaping the Integrated School Health Policy critically, with specific reference to understanding the Social Determinants of Health and the related structural factors that underpin the reproduction of compromised health in school-going children. This examination focused on how academics, through their expertise and engagement, have contributed to informing the policy process. Consequently, the study used a qualitative research methodology to investigate, collect, and analyse data relevant to the research questions, namely:

- What was the role of academics in the policy development process that resulted in the Integrated School Health Policy (ISHP) and the extent to which the ISHP engaged concerns of the social determinants of health?
- What are the academics' understanding of the Social Determinants of Health linked to the Integrated School Health Policy process?
- What was the critical role of academics in ensuring policy decisions are based on understanding the Social Determinants of Health and the related structural factors that underpin the reproduction of compromised health in school-going children?

A qualitative research methodology offered context-driven detail about the phenomenon of the Social Determinants of Health and the policy process. It emphasised the importance of the analysis and contributions to the literature on the Social Determinants of Health, highlighting how academics contribute an evidence-based approach to the policy process; and address the skills gap in the field of school health policymaking.

The chapter will begin by detailing the method of analysis and describing the research participants. It will then discuss the themes identified and conclude with a summary of the conclusions.

4.2.PROCESS OF ANALYSIS

Theme generation was critical for the process of analysis. Consequently, a systematic interpretation process was utilised through pilot transcriptions and audio recordings of interviews. During the fieldwork, transcriptions were conducted regularly and securely, by way of safeguarding research participants' privacy and protecting their confidentiality. Regular transcription allowed the researcher to modify the semi-structured questions for subsequent interviews.

The transcripts and interviews underwent a thematic analysis, a process in which the data is organised and coded to induce emerging themes. This method allowed the researcher to discern the fundamental meaning behind the emerging themes. Additionally, the primary and secondary research questions and objectives informed the thematic analysis approach. Based on the former, the thematic analysis proved beneficial for examining subjective qualitative data, particularly when looking into the question, "What was the critical role of academics in the policy process of the Integrated School Health Policy?"

The semi-structured interviews were analysed, using Tesch's eight-step analysis method detailed in Creswell (2014). Tesch's eight-step method of analysis includes the following phases:

Phase 1: The researcher read all the collected data beforehand to get a sense check and understand the data.

Phase 2: The researcher initiated the analysis by selecting one of the transcribed interviews from a research participant, deciphering its meanings and the emerging themes.

Phase 3: The researcher followed the same process in phase two for all the other research participants' interviews and created a list of the emerging themes. Related themes were clustered, and a list of the emerging themes were made and disaggregated according to the level of relevance.
Phase 4: The researcher applied the themes or topics to the data. The themes or topics were abbreviated as codes, written next to the appropriate segments of the transcripts. The researcher tried a preliminary organising scheme to ascertain whether new categories and codes emerged.
Phase 5: The relationship between the emerging themes was determined and categorised. Phase 6: Codes were created.
Phase 7: A preliminary analysis of the codes was performed.
Phase 8: The researcher recoded existing material when necessary (Creswell,
2014).

4.3.DESCRIPTION OF RESEARCH PARTICIPANTS

The description of the research participants serves to outline the research participants' level of expertise, engagement, and proximity to the Integrated School Health Policy, simultaneously drawing attention to how research participants responded to the semi-structured interview questions.

Research Participant 1

Research Participant One, functioning as an independent public health consultant, previously served in the Mpumalanga Department of Health, directly engaging in the Integrated School Health Policy process. More recently, as part of a research project, Research Participant One conducted a comprehensive case study focusing on the of policies on maternal, child and family health in South Africa. The overall case study delved into the realm of policy and its implications for family health. Within this study, Research Participant One specifically scrutinised the developmental process of the Integrated School Health Policy, exploring its journey to approval. Additionally, Research Participant One has supervised a Master student, tasked with examining the knowledge of teachers and principals regarding the nutrition component of the Integrated School Health Policy.

By way of employing coding methods, Research Participant One addressed three significant sub-themes under the theme: Integrated School Health Policy Process during the interview

process. Primarily, Research Participant One consistently referenced the sub-theme of problem identification and recognition throughout the interview. The aforementioned sub-theme surfaced when Research Participant One was queried about the factors influencing the elevation of the Integrated School Health Policy to a national policy priority. In response, Research Participant One expressed that the Integrated School Health Policy became a national policy priority due to the political climate during the presidency of President Jacob Zuma. More pertinently, Research Participant One expressed that the Integrated School Health Policy became a national policy priority due to the role of researchers from the Children's Institute at the University of Cape Town, "the researchers, from the side-line led and pulled the process to get the policy consulted and ultimately approved."

Research Participant One also referenced the policy process in the context of the critical role of the Integrated School Health Policy Process, by indicating the benefits and pitfalls of academics being involved in formulating government policy. Research Participant One added that the strengths of having academics engaged in the policy process, are observable in their knowledge and capacity. This included access to national, regional, and global information, evidence and other research studies. Academics also could engage in targeted research if needed. Additionally, they are perceived as having a degree of neutrality when compared to the potential for bias within the Government context.

Research Participant One provided an illustrative example by sharing the experiences of the Children's Institute at the University of Cape Town. "I can use an example of the Children's Institute; while they relate to the University of Cape Town; they are primarily an organisation fighting for children's rights. So, it's not a group of researchers in a university, but it was an institute targeting children's rights. So, that brings again a more neutral base." The aforementioned is important, as it raises questions around the level of engagement that academics have in relation to the first phase of the agenda-setting of a policy process.

A third central sub-theme underscored by Research Participant One, was the implementation of the Integrated School Health Policy. When asked about the adequacy of addressing the objectives of the Integrated School Health Policy, Research Participant One indicated that the policy document specifies the objectives of the Integrated School Health Policy. However, there are limitations in the rollout of the objectives stated in the policy.

While the policy is defined as being integrated across the Department of Basic Education, the Department of Social Development, and the National Department of Health, it remains a National Department of Health Policy. This positioning means it falls under the overarching ultimate Key Performance Area (KPA) of the National Department of Health. The resulting challenge is that school health, a crucial component of Primary Health Care (PHC) re-engineering, demands the provision of comprehensive school health services, leading to the redirection of under-resourced school health nurses from their primary roles and to be pulled out of service, "for example, from a clinic, you are allocated to do school health, and then you are needed at the clinic again".

When COVID-19 emerged, the same school health nurses were recalled from the schools. Therefore, it seems that resources have not been allocated adequately – pertaining to both human as well as others, for example, transportation and equipment for the implementation of this policy." The challenges faced in delivering comprehensive school healthcare services, point to Maphumulo et al. (2019), asserting that health system inefficiencies in South Africa stem from poor leadership and governance, a lack of institutional capacity; corruption, financial mismanagement, and a lack of adequate public participation.

Insights from Research Participant One highlight the importance of governance and health system performance, as expressed by Fryatt et al., (2017). Governance is important for improving health system performance, especially for countries shifting towards achieving universal health coverage. It is therefore plausible to conclude that the provision of comprehensive school health services is reliant on governance for achieving efficient and effective healthcare planning, regulating the school healthcare system, and ensuring equitable delivery of school healthcare services.

Research Participant 2

When asked if the objectives of the Integrated School Health Policy are being sufficiently addressed, Research Participant Two highlighted that the objectives of the Integrated School Health Policy have not been addressed because the available Child Health indicators have not changed positively. Based on the analysis and research from Research Participant Two, Child Health indicators show that South Africa is still grappling with teenage pregnancies in schools, as well as adolescent obesity being on the rise, which contribute to non-communicable diseases (NCDs). "The Integrated School Health Policy is not delivering because, one, the indicators

are not improving. Secondly, the resources are constrained, and part of the resources is to have a well-trained, capacitated workforce. When the Government started with the Primary Health Care (PHC) re-engineering strategy, they had the school health programme, but it was shared among various primary healthcare initiatives. So, the primary healthcare nurses who were still in the clinics had to go to schools and deliver programmes, which meant clinics then lost their nurses." Pointedly, Research Participant Two's assessment of the implementation of the objectives of the Integrated School Health Policy, speaks to the underfunding of public healthcare, having adverse effects, particularly on the quality and availability of healthcare services, which disproportionately affect the already socio-economic vulnerable populus.

Associated with the conceptions of equal access to healthcare services, and how the Integrated School Health Policy addresses equity for school-going children, Research Participant Two was in two minds. Given South Africa's history of inequality, Research Participant Two noted the Government's continuous awareness of inequity and the need for equity-building initiatives. However, concerns were raised regarding the potential emergence of intervention-generated inequalities when a homogeneous approach is employed. For example, Research Participant Two noted that, "The Eastern Cape needs a lot more support than the Western Cape. The school health policy, I think doesn't address inequity very overtly. But again, we work with these notions in the back of our heads and that we must do more for the rural communities; we have to do more for vulnerable communities. But I don't think the resources are being discharged that way, even with staffing." The mentioned observations imply that the South African Government is presently grappling with unintended consequences related to the Integrated School Health Policy. More importantly, it illustrates the significance of involving academics in the policy process to establish an evidence base that is purposeful and responds effectively to intervention-generated inequalities.

Research Participant 3

Research Participant Three has formal training in nutrition and has worked as a consultant for the last twenty (20) years. Their involvement in the school health system stems from a sustained interest in school nutrition education. Research Participant Three has been actively involved in a project for the Kwa-Zulu Natal Department of Basic Education, contributing to the development of educational materials for schools in Kwa-Zulu Natal as part of the National Nutrition School Education programme.

Research Participant Three has also been seconded to the Valley Trust and attended a World Health Organisation International Conference on Health Promotion with the Valley Trust and served as one of ten experts on a World Health Organisation working group. This group was dedicated to developing guideline materials for school health education, with a specific focus on school nutrition education.

In addition to contributing to the theme generation of Integrated School Health Policy Process, Research Participant Three consistently demonstrated an understanding of the Social Determinants of Health by way of coding, which contributed to the theme of academics' understanding of the Social Determinants of Health and their connection to the Integrated School Health Policy.

The analysis shared by Research Participant Three highlighted the connection between the Social Determinants of Health relates to the social factors that exert the most influence on an individual's health or family situation. For instance, the level of education attained by an individual's parents plays a crucial role, as well-educated parents are more likely to possess sound health knowledge if they have had an opportunity to be well-educated or have a sound education. Research Participant Three continued to emphasise that, "People with a higher socio-economic status are more likely to have better health because they have access to nutritious foods, when compared to people with a lower socio-economic status."

Moreover, Research Participant Three highlighted that individuals in lower socio-economic settings are less likely to having easy access to health-promoting or health-saving interventions, such as vaccinations. This is mainly because individuals in lower socio-economic setting often have to rely on an overburdened public primary healthcare system. This, in the opinion of Research Participant Three, is "because the conditions in which your health is delivered or the environment which your healthcare is delivered, are not conducive to wanting to go there."

The aforementioned align with the research by Abera Abaerei et al., (2017), which investigated the frequency of public healthcare utilisation. The study revealed that 75 per cent of the research respondents relying on public healthcare in Gauteng, cited a lack of facilities near their homes as a barrier to public healthcare utilisation. Additionally, the quality of healthcare services provided, was a deterrent for utilising public facilities.

Research Participant 4

Research Participant Four, a professor specialising in health policy and systems, has conducted extensive research on the school health policy, specifically focusing on child health policy and its implications for equity or inequity. Research Participant Four worked for the University of Cape Town's Children Institute, where she actively engaged in the process of agenda-setting. This involvement included convening and facilitating engagements with stakeholders across South Africa, particularly addressing the School Health Policy of 2003. The aim was to examine how stakeholders envisioned the delivery of school health services within the framework of vertical services and to bring these perspectives to the attention of policymakers.

The outcomes of the agenda-setting process under the National School Health Policy of 2003, resulted in the identification of the need for developing a clear National School Health Policy. This policy aimed to provide more systematic and standardised guidance for school health services across the country. Research Participant Four also noted that following the agenda-setting process, there was a considerable gap of at least four years before the initiation of the National School Health Policy process at national level.

Once the National School Health Policy process commenced at the national level, Research Participant Four was invited to be part of the policy task team for the National School Health Policy. In this capacity, National Government sought Research Participant Four's assistance in drafting the policy.

Additionally, Research Participant Four played a pivotal role in developing the National guidelines on how the Integrated School Health Policy could be implemented. Subsequently, the Western Cape Department of Health requested Research Participant Four to work on developing the Integrated School Health Policy implementation guidelines for the Western Cape.

Research Participant Four emphasised the theme of the Integrated School Health Policy Process, particularly highlighting the sub-theme of problem identification and recognition. According to this participant, the transition from the 2003 National School Health Policy to the Integrated School Health Policy, was influenced by the overarching policy of the National Health Insurance and the aim to enhance certain aspects at a district level that could strengthen Primary Health Care.

According to Research Participant Four, “There were four to five key areas that were put on the table as interventions that could take the strengthening of Primary Health Care forward to prepare public sector services more for the implementation of a new system, now called the National Health Insurance system, which can be interpreted as a vehicle towards Universal Health Care and not universal Health Care in its totality.”

Research Participant Four continued to highlight that the envisioned transition from the 2003 National School Health Policy to the Integrated School Health Policy aimed to attract more doctors to operate at the Primary Health Care level and incorporate school health services.

Research Participant Four cites that the Minister of Health, Dr Aaron Motsoaledi was passionate about school health services, “Dr Aaron Motsoaledi was the Minister of Education prior to becoming the Minister of Health; I thought maybe he had witnessed in education what contribution health could make to children's ability to learn and progress optimally in the education system. But it could also be that he appreciated children being healthy for their own sake and not just as a vehicle towards improving education. So, it was a passionate Minister of Health that really pushed the school health agenda quite strongly and had managed to do what was not done in the first school health policy development of 2003, and that is to forge an integral link with basic education.”

The abovementioned is significant, illustrating political will in the context of the Integrated School Health Policy process, more importantly, it speaks to Shiffman and Smith’s (2007) generation of political priority for the global health initiatives framework, which emphasises that policymakers can make decisions based on their own pre-conceived notions and moral understandings prior to intellectualising a societal problem that is consistent to the devised interventions.

Interestingly, Research Participant Four indicated that for the Integrated School Health Policy Process, problem identification and problem recognition had a parallel agenda, which was, owed to the introduction of the Human papillomavirus vaccine (HPV) and additional factors that had to do with promoting the Human papillomavirus vaccine (HPV) for school-going children. The only way that this vaccine could be rolled out in schools, was through a school health service that focused on school-going children.

Research Participant 5

Research Participant Five focuses predominantly on researching health concerns of primary and high school children, specifically addressing health issues and determinants. Their involvement in school health services, is centred on evaluating aspects related to obesity, malnutrition, and physical activity in children.

Research Participant Five also played a role in drafting the National Strategy for the Prevention and Control of Obesity in South Africa (2015-2020) and contributed to the development of the new National Obesity Strategy (2022-2027), In these efforts, Research Participant Five's primary focus was on health issues related to children and their nutritional dietary practices, and issues concerning access to clean water for children.

Research Participant Five actively engages in educating communities about the value of physical activity, the importance of maintaining a healthy weight, and the benefits of participating in physical activities to manage and prevent non-communicable diseases (NCDs) in children.

A key sub-theme that emerged from the research interview with Research Participant Five was the critical role of academics in the Integrated School Health Policy Process. Research Participant Five was of the view that academics must be at the forefront of influencing policy direction. This viewpoint was informed by the premise that academics are there to educate, conduct research and engage with the community. Moreover, academics were described by Research Participant Five as being involved in research to understand the theoretical background of societal issues and to make a valuable contribution towards available solutions.

Ultimately, academics play a crucial role in providing an evidence base. The insights shared by Research Participant Five hold significance as they address the importance of academics in shaping the policy process. Cairney and Oliver (2020) highlight that the inclusion of academics in policymaking, is valuable as they offer evidence-based perspectives that can inform policy decisions. In a time where public trust in politicians is often limited, the availability of objective and unbiased data becomes crucial.

Secondly, evidence-based information holds decision-makers accountable because when academics participate in the policy process, they can refute presumptions, offer counterarguments, and guarantee that decisions are supported by facts. Lastly, by bridging the knowledge-gap between research and policy, academics ensure that sound reasoning underpins decision-making. Their participation improves societal outcomes and reinforces governance.

Research Participant 6

Research Participant Six, with two decades of experience as a researcher and academic in the maternal and child-health field, has worked in diverse South African settings. Her primary academic focus encompasses child health, early childhood development (ECD), and child disability research. Research Participant Six also serves on various technical and advisory groups linked to child health, early childhood development (ECD), and child disability.

In addition, Research Participant Six has been part of the Technical Working Group that developed the National guidelines on how the Integrated School Health Policy could be implemented alongside Research Participant Four.

In addition, Research Participant Six made valuable contributions to the thematic area of the Integrated School Policy Process. They shared an insightful analysis of academics' understanding of the Social Determinants of Health and the Integrated School Health Policy. Research Participant Six asserted that the Social Determinants of Health exist at different levels - on the one end of the spectrum, they manifest at the structural level, encompassing factors like the policy environment.

This appreciation of the policy environment points to Geoffrey Rose's "causes of the causes" concept, where the Social Determinants of Health exist within the midstream, while public policy exists in the upstream and the social resources in the midstream, are caused by public policies located in the upstream (Ataguba et al., 2015; Islam, 2019).

Research Participant Six continued to share an illustrative example of the Social Determinants of Health within the school context by sharing, "If we say that basic services such as water, sanitation, and hygiene are not available within school environments, that is a huge problem linked to the Social Determinants of Health."

Research Participant 7

Research Participant Seven currently works as a senior researcher and is embarking on a research project titled: Assessment of Integrated School Health Policy of Programmes in KZN.

Research Participant Seven discussed the interaction between Government policy practitioners and academics in the policy development process of the Integrated School Health Policy. They expressed the view that the Government formulated the Integrated School Health Policy with minimum consultation. This perspective is based on the observation that, despite the enactment of the Integrated School Health Policy in 2012, there are still inconsistencies related to its implementation.

To highlight the implementation challenges further, Research Participant Seven indicated that "As we know the Integrated School Health Policy, is a collaboration between three departments, which is the Department of Health, Department of Education and Department of Social Development. But, as it stands, it seems as if the implementation of the Integrated School Health Policy is the sole responsibility of the Department of Health. However, the Department of Education plays a big role in the implementation of the Integrated School Health Policy because services are being brought into schools. Some officials across the three departments still do not understand how the collaboration should work. And in some instances, there is the Department of Social Development. But they usually refer to it as a dead partner."

The perceptions expressed above by Research Participant Seven bring to the fore matters related to health governance, primarily because The Department of Health, the Department of Basic Education, and the Department of Social Development are three important stakeholders that must work closely together on the Integrated School Health Policy.

Furthermore, the educational ecosystem including teachers, school governing bodies, learner organisations, and teacher unions, must support the delivery of comprehensive school health services. In the context of the view shared by Research Participant Seven, governance should be understood as a hybrid concept that involves the interaction, decision-making process, the dynamics of the policy-making process, and institutional arrangements. These aspects are therefore, informed by different actors and networks, depending on the policy area and political regime. Importantly, as evidenced by Fryatt et al. (2017) governance plays a crucial role in improving health systems, especially for countries progressing towards Universal Health Coverage.

4.4.THEMES

4.4.1. Integrated School Health Policy Process

The predominant theme addressed by research participants, pertained to the Integrated School Health Policy Process. In the preceding chapters of the research report's literature review, reference was made to how the policy process ought to be understood. In the main, the policy process should be understood as the analysis of change and development of public policy and the subsequent interactions among policy actors.

Moreover, the data acquired, supports the position that the Integrated School Health Policy process was the amalgamation of policy decisions and agenda-setting as a complex process which complicates identifying how decisions are concluded. Moreover, decision-making is influenced by a need to ameliorate the stance of stakeholders, which brings power-dynamics into play in the decision-making process.

The above observation could be evidenced by Research Participant Six, who emphasised that the development of the Integrated School Health Policy had limited consultation with civil society, particularly academia. Research Participant Six further expressed the importance of broader deliberations and representation in a policy process to incorporate diverse thinking and multiple perspectives.

Research Participant Six continued to express that, "For me, the minimal consultation with civil society highlights the deficiency in the way the Integrated School Health Policy was developed, because having civil society involvement later on, means that you almost have to try and fix things that could have been fixed from the beginning, or you've got to try and address issues or include issues that were never even considered at the beginning."

It is equally important to bring to the fore that some Government institutions serve as structural barriers to the integration of the Social Determinants of Health into the public policy agenda. This is premised on the understanding that the siloed nature of Government results in disjointed efforts and misalignment in policy approaches when contextualising the social determinants of health. Baker et al., (2018) further argue that adopting a "health-in-all policies" approach offers

a legitimate mechanism for influencing the inclusion of the Social Determinants of Health into the policy process. This involves simultaneously acknowledging and appreciating the agendas of other sectors.

Finally, Baker et al. (2018) describes institutional norms as a key barrier for the progression of the Social Determinants of Health into public policy. Governments, traditionally considered the primary custodians of policymaking, have historically prioritised hospitals and acute healthcare services. This structural inclination, therefore, poses challenges to adopting a more comprehensive Social Determinants of Health approach, resulting in path dependency.

Drawing on the historical institutionalist approach, school health services in South Africa have traditionally been centralised within the National Department of Health. These health services were implemented through vertical school-based outreach-programmes delivered by nurses. The current Integrated School Health Policy maintains this historical approach, as noted, and evidenced by Research Participant One. Despite being framed as integrated across the Department of Basic Education, the Department of Social Development, and the National Department of Health, the policy continues to be identified as a National Department of Health Policy. Consequently, it remains under the ultimate Key Performance Area (KPA) of the National Department of Health.

Moreover, the data reveals that the same deficiencies observed under the National School Health Policy (2003), persist within the Integrated School Health Policy. These deficiencies include the inadequate deployment of nurses to schools, poor referral services for school-going children, and an absence of effective and efficient health service delivery at the sub-district level. This situation is primarily attributed to the centralised operationalisation and decision-making structure of the Integrated School Health Policy.

The aforementioned occurrence is also directly linked to the “lifestyle drift” hypothesis. This hypothesis argues that the initial commitment to address the "upstream" material-structural determinants of health, observed during the problematisation and agenda-setting phases of the policy process, later undergoes a reconfiguration towards a "downstream" approach. This shift ultimately emphasises clinical services and the provision of primary healthcare.

The abovementioned supports the assertion that the policy-making process lacks transparency. This is consistent with prior studies conducted by Ingram et al., (2007), who highlight the unequal distribution of power in the policy design process. Three (3) faces of power are identified wherein the first face speaks to observable interplays between divergence and influence; the second face of power is unobservable and relates to an ability to suppress certain policy agendas, and the third face is closely associated with Marx's concept of false consciousness and refers to the rationalisation of adopting certain policy agendas (Ingram et al., 2007).

The data identified the observable interplays between divergence and influence, indicating an unequal distribution of power within the process of policy design. This was particularly evident in the research participants' view that, in the policy development process of the Integrated School Health Policy, there was little engagement with civil society, and the policy process was largely driven and managed within the South African Government.

Moreover, the second face of power, which is unobservable, and Government having the ability to hold off certain policy agendas, Research Participant Six contended that many academics have been involved in policy processes where time and intellectual resources are invested. According to Research Participant Six, "…intellectual, human time, financial opportunity, cost resources are invested into a process like that, whether it be about pro-policy development, program development reviews, etcetera. For Government only to find that the contributions and recommendations do not see the light of day, because it was never supported at a particular administrative or political level, and so that is the pitfall."

The application of Marx's concept of false consciousness became evident as research participants discussed the reasons behind specific decisions within the policy process. Research participants strongly emphasised the importance of Government clarifying what is being debated and discussed, as well as outlining the resulting policy options and trade-offs. However, within the South African context, and particularly in the case of the Integrated School Health Policy, clear communication, and transparency on decision-making within the policy process are seldom disclosed even though there is ongoing contestation throughout the process.

The phased approach was designed to address the educational and health needs of school-going children from quintile 1 and quintile 2 public schools; however, the data analysed, demonstrates

very little evidence indicating whether the South African Government progressed from quintile 1 and quintile 2 public schools. Moreover, not all school-going children are being reached through the Integrated School Health Policy implementation.

Under the conditions mentioned earlier, the Social Determinants of Health caused continued health inequalities in school-going children, reciprocally impacting a differential health status across South Africa. The Integrated School Health Policy should be designed to reduce the identified health disparities of school-going children by securing social and economic conditions for the benefit of all school-going children.

The abovementioned findings reveal that in addressing health equity, social contexts such as Health Promoting Schools, have neglected some children within the public school system, resulting in heightened vulnerabilities and the emergence of intervention-generated inequalities, as not all school-going children are being reached through the Integrated School Health Policy implementation.

4.4.2. Problem Identification and Problem Recognition

Policy problems are socially constructed in politics and in the policy process. Relatedly, the policy problem needs to be defined by someone, primarily because problem definition is not self-evident. Consequently, interest groups seeking to solve a particular problem, need to present a case for solving an identified problem by way of defining it and presenting possible pathways to a solution to Government policy makers.

A pivotal pathway to solving the presented problem, is through illustrating the causal relationship of specific phenomenon and using symbols. The aforementioned, is supported by the work of Embrett and Randall (2014) who highlight that the process of defining a policy problem is reliant on the use of language and symbols that bring attention to both the advantages and disadvantages of a particular policy choice, as well as the likelihood of a policy problem being progressed into the policy agenda. Additionally, the process of defining a policy problem presents the potential to advance specific policy solutions, while disfavouring others.

Equally noteworthy is the potential for solutions to yield unintended consequences. The point is evident in the intervention-generated inequalities resulting from the Integrated School Health

Policy. Research respondents, for example, observed that despite the extensive policy development of the Integrated School Health Policy, the initial intent of the South African Government was to implement it gradually in a phased approach.

The phased approach was designed to address the educational and health needs of school-going children from quintile 1 and quintile 2 public schools. However, the data analysed, demonstrates that there is very little evidence indicating if the South African Government progressed from quintile 1 and quintile 2 public schools. Research Participant Six says, “We got stuck and even if equity was trying to be addressed, it may have not ever been realised because of all the things that we were trying to address.”

Within the milieu of the Integrated School Health Policy, specific conditions preceded the policy problem for school-going children. These conditions presented themselves as the historical legacy of the apartheid state and school health services being exclusively designed for non-black school-going children. School health services were being operationalised as vertical school-based outreach programmes, delivered by nurses. Consequently, over time, the conditions referenced above became problems which required policy interventions. The data presented, advances the notion that the change in political norms and political will became the key drivers for the policy problem of the Integrated School Health Policy.

This is further evidenced by research participants responding to the factors influencing the elevation of Integrated School Health Policy to a national policy priority. The results from the semi-structured interviews, underline that in 2012, during President Jacob Zuma’s presidency, the President mandated a process for the school health services to address the barriers to education for school-going children and ameliorate the structural inequalities created by the apartheid state and as a result the Integrated School Health Policy was adopted.

It is important to note is that the Integrated School Health Policy gained priority status due to presidential endorsement. This assertion was further substantiated by a document analysis of a presentation given to the Health Portfolio Committee in Parliament on 21 August 2013.
Research Participant One expressed that, "Interestingly, it was during the presidency of President Zuma and his specific strategic goals actually created a good time. Now we often think negatively when we think about President Zuma's as President, but this is one part where the political climate was very conducive for this.”

Moreover, the decision-making process of the Integrated School Health Policy is understood as being political, involving a presidential mandate and political will from the then Minister of Health, Dr Aaron Motsoaledi, who drove the agenda for comprehensive school health services.

The aforementioned is evidenced by Research Participant Four expressing that, “It was a passionate Minister of Health that pushed the school health agenda quite strongly and had managed to do what was not done in the first school health policy development of 2003, and that is to forge a really integral link with basic education.”

The case study from D’Ambruoso et al. (2019) anchors the analysis shared by the Research participants, emphasising that the Integrated School Health Policy was created by utilising the favourable political and policy environment at the time. D’Ambruoso et al. (2019) further state that committed ministers in the National Department of Health and the Department of Basic Education advanced crucial high-level intersectoral connections, codified commitments to health-promoting schools and created reform agendas. As is evidenced by the Research Participants, the Integrated School Health Policy agenda setting drew on prior knowledge for policy adoption. Therefore, the Integrated School Health Policy should be understood as an adjusted policy imperative on education and health for school-going children.

During the Integrated School Health process, alternative viewpoints were expressed by research participants. Some noted that school health services were implemented throughout the country in diverse and non-standardised ways. Therefore, the Children’s Institute at the University of Cape Town was central in coordinating and convening key stakeholders to identify the need for developing a clear National School health policy to guide school health services in the country in a more systematic and standardised way.

Moreover, research respondents highlighted additional conditions that preceded the policy problem and resulted in the formulation of the Integrated School Health Policy. Chief among these conditions was the prevalence of sexual reproductive health concerns during the policy process. These concerns detailed a significant number of adolescent teenage pregnancies, widespread Human Immunodeficiency Virus (HIV) among adolescents, and an increasing prevalence of mental health disorders. Consequently, all of these conditions, came together at a nexus, which was the Integrated School Health Policy.

Research Participant Two expressed that, “I think something happened in the Department of Basic Education because, the Department wanted to deliver deworming medicines in schools, but it's not the mandate of the Department of Basic Education to deliver deworming medicines. At time the Department of Basic Education had bought albendazole tablets and had to deliver the tablets to school going children. At this point, the National Department of Health came on board, in terms of school health services, primarily because the National Department of Health viewed deworming as part of its mandate. Also, important to note is that the Department of Basic Education did not have the capacity to deliver deworming. They didn't also have the mandate to do that.”

The research interviews made it evident that there were multiple viewpoints on problem identification and problem recognition for the Integrated School Health Policy. Subsequently, the framing and identification of problems have consequences for a policy agenda regularised to the Social Determinants of Health.

The specific role of the academics in relation to problem identification and problem recognition, underscores a lack of transparency on the part of the South African Government. Research participants note that the process was not inclusive nor transparent, due to a lack of buy-in from other key Government Departments. The engagement and consultation levels, facilitated by the Children's Institute at the University of Cape Town, through research, were primarily confined to the National and Provincial Departments of Health, Education and Social Development.

The presentation made to the Health Portfolio Committee reiterates the point of view shared by research participants. The document specifically outlines that stakeholder consultations for the Integrated School Health Policy commenced with a joint meeting between the Minister of Health; Minister of Basic Education; Deputy Ministers; Director Generals; Deputy Director Generals and Government Officials on 10 September 2012.

The subsequent consultative process occurred on 03 October 2012, with School Governing Bodies; Unions and The South African Principals’ Association. The aforementioned was reiterated by Research Participant Two in mentioning that, “In the policy development process there was very little engagement with civil society. It was largely an internal Government

process managed by Government. But where the civil society engagement came in was through the launch of the Integrated School Health Policy."

Beyond the specific role of academics in relation to problem identification and recognition, the experiences of the research participants challenge the assertion of Gumede (2008), that the South African policy process adequately incorporates public participation in a bid to realise equity and justice. Thematic data analysis, on the contrary, reveals that within the Integrated School Health Policy process, policy actors struggle to account for the disparities in power distribution. Furthermore, it is not overtly evident how the Social Determinants of Health informed the process of problem identification and recognition.

In addition, the starting point for the problem identification and recognition, illustrates the challenges associated with addressing the Social Determinants of Health within public policy, as expressed by Exworthy (2008). In the main, it was apparent that the paucity of collaboration with academics, impacted negatively on defining key features of the Social Determinants of Health, inadvertently impacting the policy process.

Moreover, the Social Determinants of Health require an integrated approach across various sectors and Government departments. However, by virtue of the Integrated School Health Policy process being conducted and managed in-house by Government; it presented a space for the limited uptake of the Social Determinants of Health.

The aforementioned is illustrative of the vertical nature of governance within the South African Government. In the main, the vertical nature of governance refers to the hierarchical system of governance, which results in command and control where there is a central authority. The National Department of Health that informs the governance framework, ultimately shapes the level of engagement with various stakeholders and the outcomes in the sectors. From the interview analysis, it became evident that the hierarchical organisation encompassing different levels of authority arranged vertically, one above the other (vertical nature) of the South African Government, acted as a barrier to effective partnership and coordination, giving rise to a siloed approach to the Social Determinants of Health.

The analysis of the problem identification and recognition resonates with the case study by D'Ambruoso et al., (2019), who reveal that the Integrated School Health Policy was created by

utilising a favourable political and policy environment. Committed ministers in the National Department of Health and the Department of Basic Education advanced crucial high-level inter-sectoral connections, codified commitments to Health Promoting Schools, and created reform agendas that were compatible with one another, which illustrated political will from the South African Government.

Evidently, the setting of the policy agenda drew on prior knowledge, regional expertise, and integration as a powerful strategy for policy adoption. The ministerial mandate and administrative support allowed the Integrated School Health Policy to be developed in the National Department of Health and the Department of Basic Education, with a lesser extent of involvement from the National Department of Social Services, addressing a variety of socio-economic barriers to teaching and learning.

4.4.3. Critical Role of Academics in The Integrated School Health Policy Process

Under the preceding sub-theme, mention was made of the vertical nature of Government presenting itself as an impediment for effective partnership and coordination. Relatedly, when analysing the specific role of academics in terms of the problematisation of an issue and the policy process, it is possible to infer that there was a passive approach to engaging with academics. A key contention from Research Participant Two was that academia should serve as the think-tank and voice of reason. However, there is a growing trend of a passive approach to partnering with academia, which would eventually diminish the value of academia in the policy development process. Research Participant Two expressed that, “It is becoming more of a shrunk space to have meaningful engagements and dialogue with academia and that is something new,”

The former is noteworthy, principally because the inclusion of academics in the policy process serves as an indispensable mechanism for formulating evidence-based policies. Additionally, academia plays a crucial role in providing information on public policy to promote public interest.

In support of the above point of view, Research Participant Six emphasised the importance of including academics in the Integrated School Health Policy process in the context of the social determinants of health, by way of stating that, “Academics often are people who have thought

about societal issues more than many others. For academics, this is what we do, we conduct research. We read, we theorize, we examine. We debate. We often think about these things more intentionally than many other people."

Research Participant Two noted the necessity of involving academics in the policy process, highlighting that they contribute to the evidence-base. Academics are protected by their institutions to remain uninfluenced by political or economic agendas.

In sharing the analysis, Research Participant Two asserted that "Because some of the things we're doing now is not to solve the problems of now. It is supposed to prevent problems that we do not know yet. It should be future focused. And academics bring credibility. Academics also bring ethics, the moral compass because we can't depend on our political structures to do that."

While this may be the case, it is equally important to consider the ideological perspectives that academics bring into the policy process. Some academics may hold libertarian views, while other academics may approach public policy matters from the left with a social justice lens.
Ultimately, Government should leverage the role of academics in generating and critiquing social phenomena, as well as their expertise in the field.

Research Participant Six further states that, "I'm of the opinion that a policy processes or any big decision making at government level, that it needs civil society involvement and buy in. One way to do that is to involve academics as members of civil society. But it is not only academics, it could be many other key stakeholders who not only have interests but expertise in the area."
In the final analysis of the critical role of academics in the Integrated School Health Policy process, it was evident that there was limited scope in terms of academia's involvement.

4.4.4. The Implementation of The Integrated School Health Policy

Policy implementation is vital, serving as a key component within the broader policy process. This understanding is rooted in the idea that the policy process performs as a necessary condition for delivering services associated with a particular policy. By design, the Integrated School Health Policy is meant to address health inequalities for school-going children in

quintiles 1 and 2. However, the interview findings strongly highlight significant gaps that result in implementation failures.

Initially, the critical role of academics in the Integrated School Health Policy process was only apparent in the drafting of the implementation guidelines. Notably, academics were neither engaged nor consulted during the policy development stage. The South African Government, it seems, had not thoroughly conceptualised the approach for the implementation of the Integrated School Health Policy.
Therefore, a need arose for experts to develop policy implementation guidelines. Noteworthy, is that Professor Maylene Shung-King led a government-commissioned consultancy for an implementation planning process for the Integrated School Health Policy. In addition, Professor Maylene Shung-King convened a group of colleagues and individuals with expertise in this field to aid the Government in the implementation planning process.

Research Participant Six cites that, "It was a well thought through, well considered, well consulted document. We do not know how much of the information from the guidelines was taken onboard by the South African Government. It was never made publicly available."

The uncertainty from research participants on whether the implementation guidelines were utilised, suggests that the guidelines were not fully endorsed by the South African Government and there is no clarity on the engagement of the South African Government regarding the implementation guidelines.

It is imperative to question how the South African Government employed the policy implementation guidelines for the Integrated School Health Policy, as the efficacy of a policy is contingent on its implementation. What is more, the research participants were conscious that implementation is not the mandate of academics, ultimately the South African Government's approach to the Integrated School Health Policy model is a centralised framework of policy implementation, whereby the nine provinces align implementation to national policy objectives and guidelines.

The observed policy application gaps for the Integrated School Health Policy can be illustrated through the lens of health equity based on the conception that health equity can have important policy implications with practical consequences. The inquiry on health equity is critical,

considering that the Integrated School Health Policy specifically emphasised equity and was constitutive of a phased implementation strategy that initially prioritised younger school-going children and schools in the most disadvantaged communities, before eventually expanding to include all school-going children, drawing insights from the National School Health Policy of 2003.

Chief among the policy application gaps, is the question on inequality, as research participants conveyed that the Integrated School Health Policy does not address inequity very overtly.
"We work with these notions in the back of our heads that we must do more for the rural communities, we have to do more for vulnerable communities. But I do not think that the resources are being discharged in that way, even with staffing. If you look at a rural clinic where there are more challenges, there should be a lot more support because you are not going to get the same outcomes."

Literature by Ibewuike and Weeks (2014) suggests that governments regulate and enforce the operation of health services to improve health system performance through different financing mechanisms, such as budget-allocation, adoption of specific health standards and the regulation of pharmaceuticals to meet patients' service expectations. The enforcement of these and the entrustment of the resources, responsibilities and protection of the public, are controlled by various consultative and monitoring committees, from health system levels to hospital management and community engagement.

However, in the case of the Integrated School Health Policy, the service expectations of school-going children are not fully met due to some communities not being able to provide all the schools with the services of the Integrated School Health Policy, due to a lack of human resources. This is an issue related to the Department of Basic Education, the National Department of Health, and the Department of Social Development with a notable lack of actual integration across these three departments.

Research Participant Two stressed that, "The resources are not there, and part of the resources is to have a well-trained, capacitated workforce. So, when the Government started with the re-engineering of primary health care, they had something called the school health programme, but it was shared between primary health care. So, the primary healthcare nurses who were still

in the clinics had to go to schools and deliver a programme which meant clinics then lost nurses."

Historical legacies of the National School Health Policy (NSHP) of 2003 shared by Shung-King et al. (2014) are still observable within the Integrated School Health Policy, such as the defective deployment of nurses to schools; poor referral services for children; and a lack of efficient and effective health service delivery throughout the sub-district level. The centralised nature of operationalisation and decision-making also plays a role.

The research data illustrated that there are no specific resources allocated to the Integrated School Health Policy in schools, and programmes linked to the policy, are still running parallel within the Department of Basic Education, the National Department of Health, and the Department of Social Development. What is more, the document analysis substantiates the existence of the abovementioned challenges by way of highlighting that screening services of additional learners for the period 2013/14, required additional school health nurses, transport and equipment, and implementation in some provinces. The rollout in some districts remained weak due to insufficient numbers of school-health nurses.

The document analysis of a report conducted by management4health GmbH in 2021, additionally underscores the observed challenges and adds that The Integrated School Health Policy has not fully met its objectives due to screening targets not being met. Learner pregnancies and Human Immunodeficiency Virus (HIV) infections were on the rise as well as resource allocations being limited in the form of financial and human capital.

A lack of authoritative leadership linked to the policy implementation, also posed challenges. The 2021 report from management4health GmbH cites a lack of coordination between the Department of Basic Education, the National Department of Health, and the Department of Social Development. In the context of the Integrated School Health Policy, the National Department of Health dominates and provides and delivers school health services.

Central to the lack of integration and a siloed approach between the Department of Basic Education, the National Department of Health, and the Department of Social Development, is the question of health governance. The dominant literature on health governance underscores governance as a central component toward improving health system performance, particularly

for countries moving towards achieving Universal Health Coverage (UHC). Congruently, research participants communicated, that while South Africa needs Universal Health Coverage (UHC), it is far down the line and is essentially not part of school health, rather, school health is part of Primary Health Care Re-engineering.

Research Participant Seven believed that "As it stands, it seems as if this is the sole responsibility of the Department of Health, but the Department of Education also plays a big role in it because services are being brought into schools. Some still do not understand how the collaboration should work. In some instances, there is the Department of Social Development. But they usually refer to the Department of Social Development as a dead partner."

An additional policy application gap was identified in the involvement of street-level bureaucrats. There exists a lack of consultation with school managers, and Primary Health Care (PHC) facility managers. The cumulative impact of this is that both departments present different policy priorities related to school health services, which place limitations on the effective operationalisation of the Integrated School Health Policy in the context of the Social Determinants of Health. One of the research participants was of the opinion that it is complicated to forge and foster real, meaningful intersectoral collaborations, where all of the sectors would own their responsibility and exercise accountability towards a particular societal goal.

In the context of the Integrated School Health Policy, having optimal health for school-going children is crucial to fostering optimal engagement with the education system. The lack of seamless collaboration with Government departments, is attributed to the fact that every Government department has to account for their own mandate. They have their own budgets, and each department has its own siloed Auditor General (AG) reporting requirements.

Furthermore, the evidence suggests that due to the siloed nature of the respective Government departments engaged in the Integrated School Health Policy, policy overlaps exist within the Department of Basic Education; this is illustrative of a lack of earnest integration of school health services.

In conclusion, the document-analysis of the Integrated School Health Policy suggests that the implementation of the Integrated School Health Policy required intersectoral and

interdisciplinary action to realise the primary objectives of the policy. Secondly, the implementation of the Integrated School Health Policy was to be done, using a Primary Health Care (PHC) lens which is constitutive of curative, preventative, promotive and rehabilitative elements. It is understood that the combination of the four (4) elements, results in comprehensive school healthcare services that can address the Social Determinants of Health identified in school-going children. Moreover, the document-analysis emphasises the Department of Basic Education's Care and Support of Teaching and Learning (CSTL) framework as being central for the effective and efficient implementation of the Integrated School Health Policy.

4.4.5. The Monitoring and Evaluation of The Integrated School Health Policy

The policy document of the Integrated School Health Policy references that the joint National Integrated School Health task team is discharged with the responsibility to initiate monitoring and evaluation mechanisms for the Integrated School Health Policy. The policy document also adds that the process of monitoring and evaluation should be integrated into the district and provincial health information systems, and the education management information system.

However, the document analysis of the article published by Spotlight in 2013, underscores that the monitoring and evaluation plan, purportedly initiated by the joint National Integrated School Health task team, encompasses an assessment of the implementation of the Integrated School Health Policy.

The aforementioned presents hurdles, as it poses obstacles for identifying key indicators and outcomes, as well as assessing how the Integrated School Health Policy is being implemented in accordance with the Public Health Care (PHC) Re-engineering strategy.

The document analysis of the presentation to the Health Portfolio Committee in Parliament, circa 2013, underscores that key to the challenges associated with the Integrated School Health Policy, was that the reporting and collation of data was a predicament, and was subsequently addressed by way of incorporating school health indicators into the district health information system.

In the context of monitoring, which is dependent on assessing key indicators on a quarterly basis, the document analysis also indicates that, for the targets in the 2013/14 annual performance plan, the Integrated School Health Policy coverage of quintiles 1 and 2 schools in quarter 1 was 17,5% that is 2416 schools of 9666 schools were targeted for coverage. However, there is no publicly available report for the reporting year and subsequent years. The Social Determinants of Health, from an evaluation perspective, are informed by the life course approach, and this may present a challenge for the policy process insofar as the policy process leans on policy cycles and organisational reporting cycles that are not measured over the life course.

The abovementioned scenarios can be attributed to the capacity level within the Government departments, as expressed by the research participants. They pointed out that not processing certain elements of a policy through to the impact stage, and not incorporating monitoring and evaluation along the way, pose significant challenges for the South African Government.

According to Research Participant Three "You are more likely to get monitoring and evaluation capabilities from an academic, than you are from a person who is just a civil servant. Because, unless civil servants are told that they should work in a monitoring and evaluation manner, it is not commonly done in South Africa."

In addition, Shung-King et al. (2014) indicates that one of the key outcome metrics of school health services, is the degree to which referred school-going children receive the necessary interventions, but this information is currently unknown. Many of the expected results and outcomes of the Integrated School Health Policy can only be evaluated through recurring evaluations, due to the identified monitoring challenges.

4.4.6. Academics' Understanding of The Social Determinants of Health

In the literature review, primary barriers to the incorporation of the Social Determinants of Health into policy attention were discussed. The data analysis, however, revealed that the decision-making and agenda-setting process for the Integrated School Health Policy lacked transparency, making it challenging to discern the factors influencing decision-making.

Consequently, these barriers have impeded the successful framing of a policy within the context of the Social Determinants of Health and health equity, hindering the development of fit-for-purpose public policies. The aforementioned, raises questions about the understanding of Government policy practitioners regarding the Social Determinants of Health linked to the Integrated School Health Policy, and whether this understanding was regularised into the policy itself.

Despite a lack of transparency, the data analysed in the semi-structured interviews, revealed varying views on the regularisation of the Social Determinants of Health into the Integrated School Health Policy. On the one hand, research participants believed that the South African Government attempted to address or correct some of the impacts of the Social Determinants of Health by rendering services where they are most needed.

Research Participant Seven highlighted "I would say to a certain extent the government tried to address some of the Social Determinants of Health, but maybe not all of them." Simultaneously, Research Participant Four was of the same view in expressing that "I think the government has tried. Certainly, education as a Social Determinant of Health, is present."

Conversely, some research participants expressed the opinion that the Integrated School Health Policy involves nurses and teams frequently screening children but lacks a systematic approach to addressing the Social Determinants of Health and providing comprehensive school health services.

Relatedly, policy-application gaps were brought to the fore with research participants, underscoring that while the Integrated School Health Policy theoretically recognises the importance of the Social Determinants of Health, there has been a lack of meaningful engagement with other sectors to comprehend their impact on child health and the well-being of school-going children in practice.

Similarly, the Department of Labour was scrutinised regarding accountability for the economic well-being of the caregivers of school-going children, which has implications for child health and the overall well-being of school-going children.

Research Participant Four indicated that "There is very little that holds the Department of Trade and Industry accountable for allowing the advertising and the promotion of very unhealthy food to the school going age group. There are no clear ideas or plans or guidelines as to how you really going to hold the Department of Safety and Security accountable for school children not being safe when they go to school, when they are in school, when they return from school during holidays and so forth."

Consequently, determining how the Integrated School Health Policy practically engages with other sectors in the context of the Social Determinants of Health, collaboratively and meaningfully impacting the health of school-going children, is challenging. This suggests a limited understanding and incorporation of the Social Determinants of Health into policy by the South African Government, directly influencing both policy formulation from policymakers and implementation by street-level bureaucrats.

Given the differential operationalisation, governance framework, and implementation, Shuro and Waggie (2021) show that the Integrated School Health Policy exacerbates existing structural inequalities, such as those related to service accessibility. The challenges observed in addressing child health needs within schools, mirror what is happening in the broader socio-economic context of South Africa.

South Africa is a country that continues to grapple with the challenges associated with what is termed the triple challenge, that is, unemployment, poverty, and inequality. Therefore, the health-needs of school-going children mirror what is prevalent within their respective communities. Interlinked to this phenomenon, is the lack of technical feasibility of policy solutions with regard to the Social Determinants of Health. By the same token, the document analysis of an article published by Spotlight in 2013, reveals that the Integrated School Health Policy is heavily reliant on health education. The focus on health education in this regard, is viewed as a barrier to addressing the broader Social Determinants of Health.

From the perspective of the research participants, the point of departure in understanding the Social Determinants of Health, was expressed as an appreciation of the Social Determinants of Health being a critical starting point for moving towards the removal of inequities, not only addressing inequalities but mitigating inequities in society and service delivery.

An analysis of the Integrated School Health Policy document, reveals a lack of overt emphasis on addressing inequity, particularly considering that the allocation of resources and staffing associated with policy is not carried out in an equitable manner.

Moreover, by virtue of taking on a phased approach for the implementation of the Integrated School Health Policy, research participants observed that the South African Government claimed the approach was implemented to address the question of equity. However, research participants put forward that the approach is not indicative of equity – instead, it was based on prioritisation, which does not target equity issues. What is more, research participants asserted that the resource allocation has to address the magnitude of the problem, which was not conducted effectively by the Government.

Accordingly, Research Participant Six shared that "I do not know what equity we were trying to replace with the policy. For instance, children who were not in quintile 1 and 2, I'm not sure if they ever got any services at all. And so. I don't think it really dealt with equity in a way that it should have. It was maybe meaningful for all the things that transpired since policy adoption."

Additionally, research participants proposed that the Social Determinants of Health do not pertain to a singular element; instead, their composition is influenced shaped by public policies, structured elements, and individual choices. The structural elements of the Social Determinants of Health are connected to the concept of health in all policies. This is premised in the recognition that policies across various sectors have an impact on health through the pathways articulated within the Social Determinants of Health.

Therefore, when a government adopts a health-for-all policy approach, it is possible to identify the structural Determinants of Health effectively, simultaneously working towards health equity in a systematic manner through public policy (Shankardass et al., 2018). Research Participant Four remarked that, "For example, health is a Social Determinant of whether you are able to pursue your education in an optimal fashion if you are not healthy. It is not a unilateral relationship; it is a bilateral influence. An important issue for me is that health itself is also a Social Determinant for other sectors. Therefore, those are all the structural determinants that influence health."

Ultimately, the Social Determinants of Health are understood by academics as the full range of political, economic imperatives, as well as the various social determinants, such as education, housing, and social services. The structural determinants of health are therefore, all the facets that operate in society which impact the health of individuals in a society, determining whether they enjoy good and equitable health and have access to health care services. This aspect is also linked to ensuring that individuals actively and fairly participate in managing their own health, contributing to the shaping of healthcare services, addressing factors that may impede such participation.

At the intermediate level, illustrative examples of the Social Determinants of Health were highlighted. These examples indicated a growing trend where schools grant concessions to sell alcohol on their premises during social functions. Linkages were made with the Social Determinants of Health, suggesting that commercial influences are enabling the sale of unhealthy consumables on school premises. This practice opens the door for various other concerns emerging in the school environment.

At the individual level, research participants described the Social Determinants of Health as determining social norms and creating a particular frame of mind. An illustrative example was provided in the context of the COVID-19 vaccine drive, wherein some members of the South African population exhibited a general mistrust of the Government. This mistrust, coupled with conspiracy theories associated with the COVID-19 vaccine, led to a portion of society abstaining from receiving the regulated vaccine shots.

4.4.7. Academics' Appreciation of The Primary Objective of The Integrated School Health Policy

The research data aligns with previous academic case studies, underscoring that the Integrated School Health Policy was influenced by political mandates and the prevailing political climate. Work from D'Ambruoso et al. (2019) emphasises the contention that former President Jacob Zuma articulated his support for school health programmes. The presidential support gave credence to the CSTL, PHC, HPS and resulted in the National Department of Health, Department of Basic Education and Department of Social Development developing the Integrated School Health Policy.

The common thread for the three departments involved, is promoting the health and well-being of school-going children in South Africa and to improve the health outcomes of the country.

Primarily, research participants perceived the development of the Integrated School Health Policy as an aim to address school-going children's health and educational performance. Research participants further expressed that the Integrated School Health Policy was attempting to integrate the various programmatic interventions related to school-going children's health, simultaneously aligning it with the Primary Health Care re-engineering strategy.

The Primary Health Care Re-Engineering Strategy was introduced and sanctioned by the National Health Council after Minister Aaron Motsoaledi and provincial members of the Executive Council visited Brazil in 2010. Their aim was to learn more about the Family Health Strategy. The Primary Health Care Re-Engineering Strategy was divided into three streams: maternity and child health district clinical specialist teams, Ward-based Outreach Teams (WBOTs), and school health. Schools were identified as an ideal site to accomplish the mandate of the Primary Health Care Re-Engineering Strategy because this approach aimed to bring services closer to the people (D'Ambruoso et al.,2019).

Research participants shared the perspective that the South African Government aimed to establish health within the education system, an intricate health ecosystem within an educational environment. This initiative was seen not only being advantageous for school-going children, but also an opportunity to benefit the broader school communities.

The aforementioned analysis was made apparent by way of a research participant stating that, "It was really about building health within the educational ecosystem in a number of ways, the implementation process we were trying to get involved in trying to bring these different pieces together."

Simultaneously, the Integrated School Health Policy was viewed as an attempt of the South African Government to connect with other stakeholders to get their buy-in. While the National Department of Health, Department of Basic Education and Department of Social Development, were integral to the process, it was noted that other pertinent Government Departments were also included: the Department of Transport, Safety and Security, as well as National Treasury.

The consideration of community-based organisations and initiatives that do related work in the field of Health Promoting Schools, key to the objectives of the Integrated School Health Policy, was the establishment of a platform to unite all the stakeholders, ensuring a shared vision for the well-being of school-going children.

However, the subtheme concerning the implementation of the Integrated School Health Policy highlights that, due to the siloed nature of the respective Government departments, policy overlaps exist. As a result, the Integrated School Health Policy has not fully met its objectives. with screening targets remaining unresolved; with learner pregnancies and Human Immunodeficiency (HIV) infections being on the rise, as well as resource allocations in the form of financial and human capital not being sufficient. There is also a lack of authoritative leadership linked to policy implementation.

The document analysis further reiterated that the Integrated School Health Policy considered various Social Determinants of Health. These factors included but were not limited to poverty; household level food insecurity; nutrition and child-headed homes.

4.5.SYNOPTIC CONCLUSION

The data analysis revealed that the decisions and agenda-setting for the Integrated School Health Policy was not a transparent process, and the South African Government managed the policy development process internally. The Social Determinants of Health are understood by academics as the full range of political and economic imperatives, as well as the various social determinants, such as education, housing, and social services.

Based on the understanding of the Social Determinants of Health, linked to the Integrated School Health Policy process, it was evident from the data analysis that there were varying views on the incorporation of the Social Determinants of Health into the Integrated School Health Policy.

On the one hand, research participants were of the view that there was an attempt by the South African Government to address, or to correct some of the impact of the Social Determinants of Health, by rendering services where they were most needed.

Conversely, some academics contended that the Integrated School Health Policy includes initiatives where nurses and teams frequently screen children, lacking a systematic approach to addressing the Social Determinants of Health and Comprehensive School Health Services.

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

5.1.INTRODUCTION

The chapter will summarise the key findings from the presentation and discussion of the research data chapter, and the dominant limitations of the study. The limitations will be followed by identified opportunities for future studies and contributions to the field.

5.2.SUMMARY OF THE KEY FINDINGS

The objective of this was to perform a qualitative retrospective policy analysis of the Integrated School Health Policy, assessing the alignment of policy contents and imperatives with the Social Determinants of Health. Categorically, the study aimed to detail how health policies at the school level acknowledge, or fail to acknowledge the Social Determinants of Health, and how this aspect correlates with the perceptions of child health and educational performance.

Secondly, the study aimed to analyse the Integrated School Health Policy framework and guidelines retrospectively in relation to the Social Determinants of Health and health inequalities. Simultaneously, it aimed to illustrate how research results on the Social Determinants of Health can be used as a basis of policy formulation and agenda-setting. The study employed a qualitative research methodology to achieve the research aims - congruently, a case study research design was adopted with semi-structured interviews being conducted with seven (7) academics intimately involved in school health policies and the field of school health.

The contributions and insights shared by the academics were consequently systematically processed and interpreted, using a thematic analysis, a process in which the data is organised and coded to induce emerging themes. The emerging themes provided critical insights and agreed with previous work from Exworthy (2008), who underscores that within the ambient of health policy processes, a combination of policy decisions and agenda-setting is a protracted process, which makes it difficult to pinpoint how decisions are made.

Moreover, the emerging themes support Exworthy's (2008) eight (8) challenges associated with addressing the Social Determinants of Health within public policy. Primary to the eight (8) challenges for the study, was the question on the complex nature of the Social Determinants of Health and how this aspect creates difficulties for policymakers in defining the key features of the Social Determinants of Health.

Secondly, the Social Determinants of Health require an integrated approach across various sectors and Government departments, however, the study has shown that differing organisational accountabilities and priorities hinder effective partnerships for the integration of the Social Determinants of Health.

Thirdly, focusing on delivering healthcare by Government departments, can overshadow the consideration of the Social Determinants of Health and in such instances, financing and service delivery rather become the primary focus within the policy process.

Lastly, and more importantly, there is a limited understanding among policymakers of the policy process and the interplay between the policy process and the Social Determinants of Health.

In relation to the study, the emerging themes appeared to support the conception that the Integrated School Health Policy process was not a transparent process, making it difficult to pinpoint how decisions were made. The Integrated School Health Policy was observed to have nurses and teams frequently screening children, lacking a systematic approach to addressing the Social Determinants of Health. The heavy focus on service delivery, instead of following a more structured, systemised approach, was prevalent.

The study primarily sought to explore the academics' comprehension of the Social Determinants of Health in connection to the Integrated School Health Policy process. The thematic analysis underscored that the academics are well-positioned in their understanding of the Social Determinants of Health linked to the Integrated School Health Policy process. From the perspective of the academics, the Social Determinants of Health are understood as a full range of political and economic imperatives, the various social determinants, such as education, housing, and social services.

Furthermore, the academics disaggregate the Social Determinants of Health into structural intermediate and individual levels. The thematic analysis, examining the link between the Integrated School Health Policy, highlights diverse perspectives on the regularisation of the Social Determinants of Health into the Integrated School Health Policy.

Some research participants believe that Government aims to address the impact of Social Determinants of Health by providing necessary services. Conversely, other academics argue

that the Integrated School Health Policy involves screening practices without a systematic approach to the Social Determinants of Health and comprehensive school health services.

The study also explored the pivotal role of academics in the Integrated School Health Policy process. Notably, their influence was evident during the formulation of national implementation guidelines, rather than the initial policy development phase. The South African Government lacked a comprehensive conceptualisation for the national implementation of the Integrated School Health Policy. During the problem identification and agenda-setting stage, minimal collaboration occurred with academics, and the policy process was predominantly centralised, driven and managed by the South African Government.

Lastly, the study delved into the critical role of academics in the adoption of a policy agenda aligned with the Social Determinants of Health. Thematic analysis revealed distinct conditions within the Integrated School Health Policy framework, that set the stage for the policy problem concerning school-going children. These conditions were rooted in the historical legacy of Apartheid, with school health services historically tailored for non-black school-going children. Furthermore, the operationalisation of school health services relied on vertical, nurse-led outreach programmes.

Consequently, over time the conditions referenced above became problems which required policy interventions. The data presented, advances the notion that the change in political norms and political will became the key drivers for the policy problem of the Integrated School Health Policy.

5.3.LIMITATIONS

The case study approach has been unable to postulate generalisation; however, this can be addressed by incorporating respondent validation; theoretical sampling, explicitly defining the process of data collection methodology and the researcher's positionality (Crowe et al., 2011).

Secondly, the pilot phase of the fieldwork intended to interview both Government policy practitioners and academics, however, there were limitations with Government policy practitioners' willingness to participate in the interview process, despite approvals the researcher had obtained from the respective Government Departments. For the pilot phase of

the field work, the researcher only secured an interview with the National Department of Basic Education, facing significant resistance about accessing the National Department of Health and the Department of Social Development. Moreover, the field of school health policies is complex and specialised, and the pool of research participants was exceptionally limited. The aforementioned had, therefore, a bearing on the sample size for the study.

5.4.OPPORTUNITIES FOR FUTURE STUDIES

Future studies can examine the governance relationship between the two departments in an effort to comprehend the implications of collaboration between the National Department of Health and Department of Basic Education, hindered by divergent organisational accountabilities and priorities, impeding effective partnerships for integrating the Social Determinants of Health.

Given the expansive nature of the Integrated School Health Policy, it necessitates the establishment of a governance framework for school health services within the context of Health Promoting Schools (HPS).

The study results emphasised the challenges associated with forging and fostering real, meaningful intersectoral collaboration where each sector assumes responsibility and accountability towards a particular societal goal - in this case, promoting their optimal engagement with the education system.
Currently, there is a scarcity of prominent case studies in South Africa, demonstrating seamless collaboration across various sectors, where each sector understands their mandate, responsibilities and engages in integrated, cross-sectional approaches, rather than siloed practices.

5.5.CONTRIBUTIONS

The findings of the study (from a practical perspective) have created a basis for advocating for evidence-based policies in respect to school health services, examining how to build a health-ecosystem within an educational system that does not only have benefits for school-going children and the people within the educational system, but could also have potential benefits for individuals within the communities located within the educational system.

Moreover, the study has reiterated the importance of academic contributions in the policy process, particularly within the shrinking space and inertia of public policy. The study results supported the assertions of Muluk and Winoto (2018), that governments require experts in the field to help develop fit-for-purpose policies that are evidence-based; and that the inclusion of academics in the policy process, becomes an indispensable mechanism towards applicable evidence-based policies, as academics are better positioned to generate and debunk social phenomena as experts in their field.

The study (from a theoretical perspective) supported Exworthy's (2018) framing of the policy process being a disjointed progression and the challenges associated with addressing the Social Determinants of Health within the health policy process. This was evident in the policy process for the Integrated School Health Policy, rather heavily focusing on service delivery and having nurses and teams engaging in the ad-hock screening of children without following a well-designed structure. This clearly suggests the inefficient incorporation of the Social Determinants of Health into the Integrated School Health Policy. The vertical nature of Government departments, therefore, acts as a barrier to effective partnership and coordination, and results in a siloed approach to the Social Determinants of Health.
The study also aligns with the theoretical framework of the social construction framework proposed by Ingram et al., (2007). This framework suggests that the policy process entails the modelling of target populations, creating representations of them and providing a basis for administering benefits or burdens. Consequently, the policy agenda and design are differentially developed and informed by the social construction of the target population.

Lastly, from a research perspective, the study has effectively addressed the research problem and filled a knowledge gap. The existing on the Integrated School Health Policy, predominantly focuses on the policy context and content.

However, there is a scarcity of literature addressing a retrospective analysis of the Integrated School Health Policy in the context of the policy process and critical elements of the Social Determinants of Health. This includes their underlying role, affecting health and education in school-going children, particularly focusing on the academic community's role and the understanding of the Social Determinants of Health and their subsequent influence on policy.

Therefore, this study has made a valuable contribution to the existing body of literature, addressing a knowledge gap by showcasing the critical role academics play in adopting a policy agenda regularised to the Social Determinants of Health. It also delves into the academics' comprehension of the Social Determinants of Health, highlighting how this appreciation informs the policy process.

5.6.CONCLUSION

Given the importance of the Social Determinants of Health, this study aimed to conduct a qualitative retrospective policy analysis of the Integrated School Health Policy to determine if the policy contents and policy imperatives are harmonised to the Social Determinants of Health. The chapter concluded the study by way of underscoring the key findings of the study with respect to the research aims and questions.

The study also highlights the lack of transparency in the Integrated School Health Policy process, making it difficult to pinpoint how decision-making was reached. Moreover, the critical role of academics in the Integrated School Health Policy process was only apparent in the drafting of the national implementation guidelines, despite being well-positioned in their understanding of the Social Determinants of Health, in relation to the Integrated School Health Policy process.

Lastly, the contributions of the academics interviewed, highlighted their critical role in the adoption of a policy agenda regularised to the Social Determinants of Health. The chapter concluded with a review of overall limitations, from which future research recommendations could flow.

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7. ANNEXURES

7.1.Annexure 1

SEMI-STRUCTURED INTERVIEW GUIDE

INTRODUCTION

Good day, thank you for agreeing to participate in the research study. I am a post-graduate student at Wits School of Governance, and I am interested in studying the Integrated School Health Policy and how the policy addresses inequalities and the Social Determinants of Health in school-going children in the foundation phase. I'd like to highlight that participation in the interview process is completely voluntary and you have the right to withdraw from the interview process should you wish to do so.

The interview is scheduled to take an hour and may take longer, depending on how much information you would like to share. The interview session will be audio recorded for transcribing purposes; may I have permission to record this session? Both the transcripts and audio recordings will be made available to you upon your request. Please note that everything discussed during the interview session will be kept confidential.

Do you have any questions about what I have explained?

I will now be turning on the audio recorder and begin with the interview.

SEMI-STRUCTURED QUESTIONS
1. If I could begin by asking you to please indicate your current role and involvement in the school health system? **2.** Could you share your observations on what in your view influenced the Integrated School Health Policy becoming a national policy priority? **3.** What are your views on strengths and pitfalls of academics being involved in the process of formulating government policy?

4. From your experience, what was the relationship between Government policy practitioners and academia in the process of policy development?

- Was there sufficient consultation between Government policy practitioners and academics, in relation to the policy process for the Integrated School Health Policy?

5. I now wish to shift from the process of policy development to the substantive content of the policy. As an academic expert working in the field, could you please describe what in your views are about the objectives of the Integrated School Health Policy?

- How are these objectives being sufficiently addressed in your view?

6. What is your understanding of the Social Determinants of Health?

- From your understanding of the Social Determinants of Health, have they been sufficiently addressed and included into the Integrated School Health Policy?

7. In what ways did the Integrated School Health Policy process (policy attention) focus on equity for school-going children?

8. Prior to the adoption of the Integrated School Health Policy, was there a process conducted by academics to investigate and analyse school health policies in South Africa?

- In your view have the results from these investigations and analysis been incorporated into Integrated School Health Policy?

9. Do academics, in your view, play a role in determining the actual direction of policy?

7.2.Annexure 2

A Critical Study of The Integrated School Health Policy and Social Determinants of Health

Consent form to participate in research.

I ---------- voluntarily agree to participate in this research study.

- I understand that even if I agree to participate now, I can withdraw at any time or refuse to answer any question without any consequences of any kind.
- I have had the purpose and nature of the study explained to me and I have had the opportunity to ask questions about the study.
- I understand that my participation involves answering questions related to the Integrated School Health Policy.
- I understand that I will not benefit directly from participating in this research.
- I agree to my interview being recorded on the MS Teams platform.
- I understand that all information I provide for this study will be treated confidentially.
- I understand that in any report on the results of this research, my identity will remain anonymous. This will be done by changing my name and disguising any details of my interview which may reveal my identity or the identity of people I speak about.
- I understand that signed consent forms and original audio recordings will be retained in a secured space.
- I understand that a transcript of my interview in which all identifying information has been removed will be retained.

Contact details of researchers:

Neo Thabisile Mofokeng
1786317@students.wits.ac.za

Signature of research participant

Date:

I believe the participant is giving informed consent to participate in this study.
Signature of researcher

Date:

7.3.Annexure 3

WITS SCHOOL OF GOVERNANCE
UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Participant Information sheet

Study title: *A Critical Study of The Integrated School Health Policy and Social Determinants of Health*

Dear Potential Research Participant,

My name is Ms. Neo Thabisile Mofokeng. I'm a registered student at the Wits School of Governance - student number 1786317. I'm currently reading for my master's dissertation and my research topic is titled: The Social Determinants of Health: a South African Integrated School Health Policy Study.

As part of the requirements for my degree, I am required to submit a research report on the abovementioned research topic. My research is aimed at conducting a retrospective analysis of the Revised Integrated School Health Policy and determine whether consideration was placed on the Social Determinants of Health in the policy development process.

By way of this, I would like to request permission from you to participate in my research. In order to participate, you will be required to participate in a semi-structured one-on-one interview, that will take place via MS Teams, with the researcher. The duration of the interview will be an hour. The broad topic of the interview will be your experiences around the policy process of the Integrated School Health Policy.

The interview session will be recorded using the MS Teams platform. The audio recordings and transcriptions will be kept in password-protected files that only the researcher will have been able to access. The only other person besides the researcher who will have access to the transcriptions is my supervisor, Prof. Robert Van Niekerk – Professor: Wits School of Governance. Direct quotes may be used in the final report but will not be personally identifiable. All data will be kept for a period of two years (should publication of the results

occur) or six years (should no publication occur). After this time, all data will be destroyed or deleted.

All identifying information will be kept strictly confidential. In the final report (and any subsequent publications) your anonymity will be protected by using a pseudonym such as Participant A, B etc. Also, the identity of all extraneous persons mentioned by you will be kept anonymous through the use of pseudonyms.

Your participation in this research is completely voluntary and you are free to withdraw at any stage prior to submission/publication for any reason. You are also free to abstain from answering any question in the interview that makes you feel uncomfortable. There will be no reward or sanction as a result of participation in this research.

If you have any further questions, please contact me via email on 1786317@students.wits.ac.za or you can contact my supervisor Prof. Robert Van Niekerk on +27 (0) 117173583 or robert.vanniekerk@wits.ac.za

If you agree to participate in this research, please complete the consent form attached to this document.

If you have any questions during or afterwards about this research study, feel free to contact me or my supervisor on the details listed below. If you have any concerns or complaints about the ethical procedures of this research study, you are welcome to contact the University Human Research Ethics Committee (Non-Medical), telephone +27(0) 11 717 1408, email hrecnon-medical@wits.ac.za.

Yours sincerely,

Researcher:
Neo Mofokeng

+27 (0) 833624627

1786317@students.wits.ac.za

Supervisor:

Prof. Robert Van Niekerk

+27 (0) 117173583

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