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FACTORS IMPACTING NEGATIVELY ON THE IMPLEMENTATION OF THE INTEGRATED SCHOOL HEALTH POLICY IN GAUTENG

By

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A research report presented to the School of Public and Development management University of Witwarsrand in partial fulfilment of the requirements for the Master of Management degree in the field of Public and Development Management

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ABSTRACT

The School Health Policy in South Africa has evolved over the years in which the Department of Heath was the sole custodian; The Integrated School Health Policy (ISHP) emerged in 2012 as result of the evolvement. The ISHP is now in the responsibility of the Department of Heath, the Department of Basic Education and the Department of Social Department. This integration came as a result of a realisation that the heath of a child is not just physical but it is all encompassing and it requires the involvement of many actors and processes.

This study explored the implementation management of the ISHP in Gauteng. The research involved the investigation into internal and external factors that interfere with the implementation of the ISHP in Gauteng. A qualitative case study research was conducted. In-depth semi-structured interviews of key informants were used as primary data collection tools. This approach uncovered intricate relationships as well as complex and interrelated factors that have an influence on the implementation of the ISHP.

Results reflected an improvement from the previous school health policy. There are also factors that have been revealed that interfere with and are a hindrance to the implementation of the ISHP; the results revealed challenges that are related to the environment, technical and management capacity that are hindrances to implementation of the ISHP. These have led to loopholes that include inadequate participation of stakeholder in the implementation of the policy. This research provides the responsible Gauteng departments with recommendations for improving the implementation process of the ISHP in the immediate future. The conclusion of the study is that that there is no 'one way' of implementing policy but ways to remove some of the hindrances to implementation can be found.

Key words: Implementation, policy, school health, sustainability, communication strategy, human resources strategy, human capacity

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 (in the field of Public and Development Management) in the University of Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination in any other university.

_____

Nhlanhla Engetelo Shilubane

31 March 2015

DEDICATION

For all the children of South Africa, I pray that you will all reach and achieve your God given purposes in life. I dedicate this to my parents Masungi and Basani Shilubane for their matchless sacrifices toward my education, I love you very much and to my siblings, Nhlamulo and Nyiko, Nhlangano and Winnie, Nhlaluko you are my infinite support. To my nephews Nhlavutelo, Nhlalala and Vukona and my beautiful niece Vurhonga you are my inspiration.

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I am eternally grateful to my Lord Jesus Christ for His love and grace that enabled me to complete this research especially when I felt like giving up (many times).

My sincere gratitude to my supervisor Mr Thlotse Motswaledi for his guidance throughout the research process, without his assistance this research would not have been possible

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TABLE OF CONTENTS

ABSTRACT ii

DECLARATION iii

DEDICATION iv

ACKNOWLEDGEMENTS v

LIST OF FIGURES ix

LIST OF TABLES x

LIST OF ABBREVIATIONS xi

GLOSSARY OF TERMS xii

CHAPTER ONE 1

1 INTRODUCTION AND BACKGROUND 1

1.1 Introduction 1

1.1.1 Overview of the South African health System 1

1.1.2 The Integrated School Health Policy (ISHP) 4

1.1.3 Background to the Problem 9

1.1.4 Problem Statement 10

1.1.5 Purpose statement 11

1.1.6 Research question 11

1.1.7 The research 11

1.2 Conclusion 11

CHAPTER TWO 12

2 LITERATURE REVIEW 12

2.1 Introduction 12

2.2 Literature landscape 12

2.3 Policy 14

2.4 Policy and Implementation 14

2.4.1 Policy implementation within the school environment 17
2.4.2 Policy: Leadership and Management 19
2.5 Policy and Practice in School Health Programmes 20
2.6 School Health Programs 22
2.7 Barriers and Opportunities 25
2.8 International Context 27
2.9 South African Context 28
2.10 Conclusion 30
CHAPTER THREE 32
3 RESEARCH METHODOLOGY 32
3.1 Introduction 32
3.1.1 Research Philosophy/Paradigm 32
3.1.2 Research Strategy/ Approach 33
3.1.3 Type of Qualitative Research Design and Research Methods 33
3.1.4 Sample 34
3.1.5 Validity, Reliability and Ethics 35
3.2 Presentation of research data/ information 37
3.2.1 Data Analysis 37
3.3 Research Limitations 38
3.4 Conclusion 38
CHAPTER FOUR 39
4 PRESENTATION OF RESEARCH FINDINGS 39
4.1 Introduction 39
4.2 The Main Themes 39
4.2.1 Policy Content 41
4.2.2 Policy awareness and involvement 43
4.2.3 Policy implementation challenges 44

4.2.4 Implementation context and infrastructure 50
4.2.5 Relationships and implementation management 52
4.2.6 Implementation perceptions and opportunities 55
4.3 Field notes and observations 58
4.4 Conclusion 59
CHAPTER FIVE 60
5 DATA ANALYSIS 60
5.1 Introduction 60
5.1.1 Policy Content 61
5.1.2 Policy awareness and involvement 62
5.1.3 Policy implementation challenges 62
5.1.4 Implementation context and infrastructure 64
5.1.5 Relationships and implementation management 66
5.1.6 Implementation perceptions and opportunities 67
5.2 Field notes and Observations 68
5.3 Responding to the Research Question 68
5.4 CONCLUSION 70
CHAPTER SIX 71
6 CONCLUSIONS AND RECOMMENDATIONS 71
6.1 Conclusions 71
6.2 Recommendations 73
6.3 Further Research 77
REFERENCES 79
APPENDIX A: INTERVIEW SCHEDULE 83
APPENDIX B: CONCENT FORM 87

LIST OF FIGURES

Figure 1: a summary of accomplishments and shortcomings of the health system.....2

Figure 2: the relationship between top- down and bottom-up perspective on policy implementation.....14

Figure 3: illustration of four frame communication process for school health policy.....21

Figure 4: school health programme goals.....23

Figure 5: responses on content and focus of the ISHP.....42

Figure 6: research themes.....59

Figure 7: illustration of ways to improve ISHP implementation.....71

LIST OF TABLES

Table 1: school Health Services package.....6

Table 2: research respondent schedule.....39

LIST OF ABBREVIATIONS

Acronym	
AIDS	Acquired Immune Deficiency Syndrome
CSTL	Care and Support for Teaching and Learning Framework
DOH	Department of Health
DBE	Department of Basic Education
DSD	Department of Social Development
EPA	Environmental Protection Agency
FET	Further Education and Training
HIV	Human Immunodeficiency Virus
HCT	HIV and AIDS Counselling and Testing
NHI	National Health Insurance
NGOs	Non-Governmental Organisations
PMTCT	prevention of mother-to-child transmission
SBST	School Based Support Team
STI	Sexually Transmitted Infections
SWP	School Wellness Programme
TB	Tuberculosis
WOBT	Ward Outreach Based Teams

GLOSSARY OF TERMS

Term	Description
Communication Strategy	It is a plan for communicating information related to a specific issue, event, situation, or an audience. It serves serve as the blueprint for **communicating** with the public, stakeholders, or even colleagues. (EPA, n.d.)
Human Resources Strategy	A distinctive approach to employment management which seeks to achieve competitive advantage through the strategic deployment of a highly committed and capable workforce using an array of cultural, structural and personnel techniques. (Storey, 2001: 6)
Primary Health Care (PHC)	It is a conceptual model referring to processes and beliefs about the ways in which health care is structured. PHC encompasses primary care, disease prevention, health promotion, population health, and community development in one, aiming to provide essential community-focused health care (Thomas-MacLean, D. Tarlier, S. Ackroyd-Stolarz, M. Fortin, M. Stewart, 2003)
Sustainability	It is the ability or capacity of something to be maintained or to sustain itself. http://www.landlearnnsw.org.au/

CHAPTER ONE

1 INTRODUCTION AND BACKGROUND

1.1 Introduction

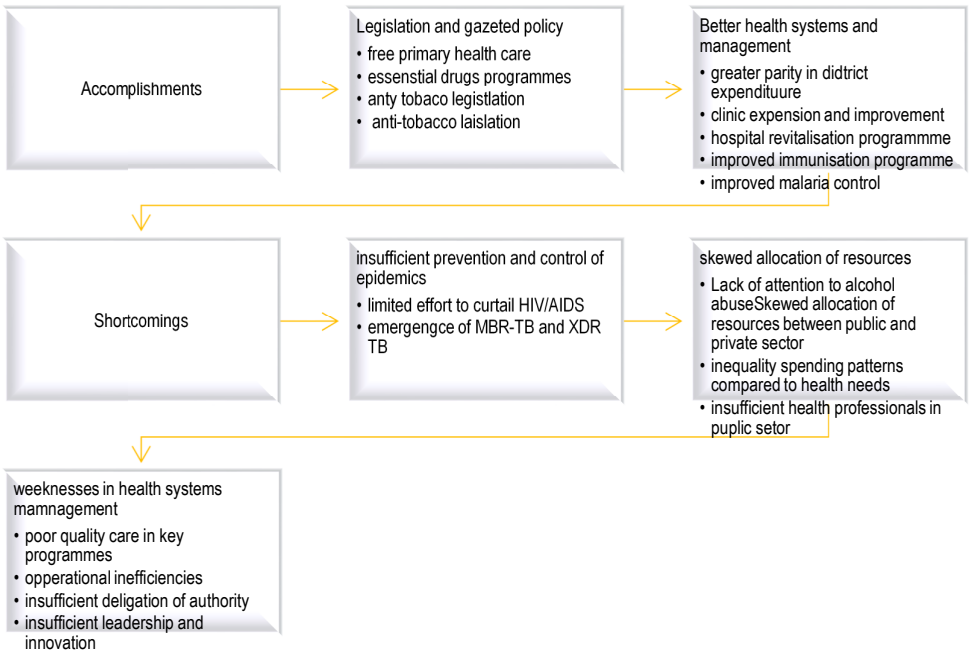
This chapter is an introduction into the case study; it gives background into the Integrated School Health Policy. It starts by offering an overview of the South African Health System, an overview of the South African Integrated School Heath Policy, the background to the problem, the problem statement, the purpose statement and the research question and then the conclusion.

1.1.1 Overview of the South African health System

The South African health system has vastly improved from post Apartheid 1994 when the first democratic government was formed. Since the restructuring of the public health sector after 1994 improvements that are substantial have been achieved, this in relation to access, rationalisation of health management and more equitable health expenditure. These achievements have however, been battered by an increased burden of disease related to HIV/AIDS, a generally weak health systems management as well as low staff morale (Harrison, 2009).

Harrison (2009) gives a summary of the accomplishments and as well as the shortcomings of the South African health systems. This is an indication of the great strides that South African has made after the fall of Apartheid in 1994, it also indicates the problems that the country is still facing in the currently, which is in many ways one of the legacies of Apartheid (Cullinan 2006).

Figure 1: A summary of accomplishments and shortcomings of the South African health system



(Source: Shilubane (2015), adapted from Harrison, 2009)

This summary gives an indication of the many disparities that are still evident in the South African health system.

South Africa has a parallel two-tire health system, one is the public sector which caters for the large percentage of the population and another which is the private sector of the country which is run commercially and attracts the middle to high income groups of the population who are mostly on medical aid plans (insurance).

The Department of Health of South Africa aims to improve and expand the public health care and the priorities currently are:

The National Health Insurance (NHI) – The NHI was introduced by the department of health in order to curb and address most of the shortcomings that have been identified above. This is a financing system that is intended to provide essential health care to all citizens including long-term residents of the South Africa, regardless of employment status and ability to make monetary contribution to the NHI Fund (DoH, 2012). There is an acknowledgement that the, the department is facing serious obstacles that are as a result of a distorted healthcare financing system.

The five year NHI implementation plan that that has been tabled which is said to include pilot studies and strengthening the health system in these highlighted areas: Management of health facilities and health districts; Quality improvement; Infrastructure development; Medical devices including equipment; Human Resources planning, development and management; Information management and systems support; Establishment of an NHI Fund (DoH, 2012).

HIV and AIDS-The department acknowledges that HIV and AIDS is a burden to the South African health system. Due to the burden of disease an effort is being made into addressing HIV and AIDS and TB in manner which is integrated. A strategy called HIV and AIDS Counselling and Testing (HCT) Campaign to prevent and manage the disease has been put in place and it is said to be based on behaviour change; use of barrier methods; providing medical male circumcision; scaling up syndrome management of STI; early prevention of mother-to-child transmission (PMTCT) (DOH, 2012)

Tuberculosis-TB contributes significantly to the burden of disease faced by South Africans like HIV Aids, the department uses the same strategy as HIV and AIDS to prevent and manage the disease.

Primary Health Care - The department of Health acknowledges the needs to undertake initiatives the will assist in the strengthening of the health system. The initiatives that will need to "change health service delivery from a curative model to one that promotes cost-effective primary healthcare (PHC) as close to the community and households as possible" (DoH, 2012). Strong enhancements in management and supervision of facilities are a must in order to accomplish the initiatives planned.

The department plans to develop and implement a model for delivering PHC services that gives incentives for health promotion and disease prevention at the household and community level. It also plans to decide the sphere of government that should be responsible for delivering PHC services and environmental health services at local level. There is a plan to go through quality assessments and accreditation processes for all PHC facilities (DoH, 2012).

Maternal and Child Health – The department plans to use "primary healthcare (PHC) approach to provide early and quality ante- and postnatal services as well as essential infant and child health services and nutritional advice" (DoH, 2012).. This in order to reduce the high maternal and child mortality rates in the country (DoH, 2012).

Malaria – there is a plan to prevent Malaria and manage the spread of Malaria in South Africa

Despite the many achievements that the country has accomplished, it is within reason to state that the South African public health system is under a lot of strain due to the burden of disease that as indicated above and although promising, still has a long way to get to its intended form.

1.1.2 The Integrated School Health Policy (ISHP)

Harrison (2009) contends that the challenge for policymakers in health care "is to demonstrate rapid improvements in the quality of care and service delivery indicators such as waiting time and patient satisfaction; while at the same time addressing the intractable health management issues that bedevil efficiency and drive up costs".

The ISHP was launched in 2012 at the backdrop of the of the previous school health policy which was launched in 2003. The previous policy and its programmes were had been incorporated into to the PHC Package, It was characterized by slow implementation in many areas, with low coverage at sub-district, school and learners' levels (DoH and DBE, 2012).

A range of sub-optimal factors are attributed to the previous policy and they include (DoH and DBE, 2012): managerial variation in the value attached to delivery of school health services; insufficient collaboration between DOH and DBE historically; inequitable distribution of resources in both urban and rural settings; the challenge of integrating previously vertical and fragmented services into comprehensive PHC services; competition for limited resources; the demand for curative services (aimed at short-term survival) outweighs the preventive and promotive services (aimed at long-term improvement in health and quality of life); poor data management impacts on the reporting of school health services

A number of issues that impact on the provision of quality services had been identified in the previous school health policy (DoH and DBE, 2012) and they included: Insufficient staff and infrequent visits to schools; this limits their ability to give children the time and attention that they need; Lack or insufficient basic equipment such as scales to weigh children; Lack of a conducive environment in classrooms for screening and examining children properly, including mental health assessment due to lack of privacy; Referral systems are not always available to respond to identified health needs; Follow-up is rarely conducted, as nurses generally visit schools once a year; Unavailability of transport, poor roads and infrastructure curtails access to hard to reach areas.

These factors have led to the introduction of the ISHP in order to curb the issues that have led to lack of implementation of the initial policy. The ISHP was introduced with the premise of putting the 'child first' because South Africa is a signatory to the United Nations Convention on the Rights of the Child and according to the Bill of Rights of the Constitution of South Africa.

In 2010 there were Twelve million learners were enrolled in public schools in South Africa according to the Department of Education (DBE, 2010). There is a commitment by the South African government to the health programmes in public schools which is on par with the aim of health sector to provide health services to all sections of the population though the primary health care (PHC).

The aim of the Integrated School Health Programme (ISHP) is to build on and strengthen existing school health services, with alterations that are critical (ISHP, 2012). The changes include: A commitment to close collaboration between all role-players, with the Departments of Health (DOH), Basic Education (DBE) and Social Development (DSD) taking joint responsibility for ensuring that the ISHP reaches all learners in all schools; Provision of services to learners in all educational phases. These include the foundation phase (Grades R-3); the intermediate phase (Grades 4-6); the senior phase (Grades 7-9); and the Further Education and Training (FET) phase (Grades 10-12); Provision of a more comprehensive package of services, which addresses not only barriers to learning, but also other conditions which contribute to morbidity and mortality amongst learners during both childhood and

adulthood; More emphasis being placed on provision of health services (as opposed to screening and referral) in schools, with a commitment to expanding the range of services provided over time. Mechanisms for ensuring that learners who are assessed as requiring additional services receive these services need to be in place; A more systematic approach to implementation. The phased approach in the 2003 School Health Policy focused on district level implementation, did not translate into adequate coverage at sub-district, school and learner levels. Although the ISHP will initially target the most disadvantaged schools, sequenced plans for progressive implementation aim to ensure that all learners are reached; Implemented within the Care and Support for Teaching and Learning Framework (CSTL) that is currently being used by the DBE to cohere all care and support initiatives implemented in and through schools including school health services.

The school service heath services package offered through the ISHP is laid out below.

Table 1: School Health Services package

(source: DoH and DBE, 2012)

Health Screening	On-site service	Health Education
Foundation phase (Gr R-3)		
.Oral health • **Vision** • **Hearing** • **Speech** • **Nutritional assessment** • **Physical assessment** **(Gross & fine motor)** • **Mental Health** • **Tuberculosis** • **Chronic illnesses**	.Parasite control: Deworming and bilharzias control (where appropriate) • Immunisation • Oral health (where available) • Minor ailments	Hand washing • Personal & environmental hygiene • Nutrition • Tuberculosis • Road safety • Poisoning • Know your body • Abuse (sexual, physical and emotional abuse)

• **Psychosocial Support**		
Intermediate phase (Gr 4-6)		
Oral health • **Vision** • **Hearing** • **Speech** • **Nutritional assessment** • **Physical assessment** • **Mental Health** • **Tuberculosis** • **Chronic illnesses** • **Psychosocial Support**	. Deworming • Minor ailments • Counselling regarding SRH (if indicated), and provision of and referral for services as needed	.Personal & environmental hygiene • Nutrition • Tuberculosis • Medical and Traditional Male circumcision • Abuse (sexual, physical and emotional abuse including bullying, violence) • Puberty (e.g. physical and emotional changes, menstruation & teenage pregnancy) • Drug & substance abuse
Senior phase (Gr 7-9)		
• **Oral health** • **Vision** • **Hearing** • **Speech** • **Nutritional assessment** • **Physical assessment incl. anaemia** • **Mental Health** • **Tuberculosis** • **Chronic illnesses** • **Psychosocial support**	• Minor ailments • Individual counselling regarding SRH, and provision of or referral for services as needed	• Personal & environmental hygiene • Nutrition • Tuberculosis • Abuse (sexual, physical and emotional abuse including bullying, violence) • Sexual & reproductive health • Menstruation • Contraception • STIs incl. HIV • MMC & Traditional • Teenage pregnancy, CTOP, PMTCT

		• HCT & stigma mitigation • Drug and substance abuse • Suicide
Further Education and Training (FET) (Gr 10-12)		
• **Oral health** • **Vision** • **Hearing** • **Speech** • **Nutritional assessment** • **Physical assessment incl. anaemia** • **Mental Health** • **Tuberculosis** • **Chronic illnesses** • **Psychosocial support**	• Minor ailments • Individual counselling regarding SRH needs, and provision of or referral for services as needed	• Personal & environmental hygiene • Nutrition • Tuberculosis • Abuse (sexual, physical and emotional abuse including bullying, violence) • Sexual & reproductive health • Menstruation • Contraception • STIs incl. HIV • MMC & Traditional • Teenage pregnancy, CTOP, PMTCT • HCT & stigma mitigation • Drug and substance abuse • Suicide
All schools		
	Environmental assessment • First aid kit • Water and sanitation • Cooking area • Physical safety • Ventilation (airborne infections) • Waste Disposal	

	• Food gardens • Recycling

1.1.3 Background to the Problem

South Africa has a long history of inequality in every respect along racial lines, schools are no different. South Africa introduced the National School Health Policy in 2003 in order to curb some of the inequality within schools; the policy was revised in 2011 and again it was launched by the President of South Africa in October 2012 as the Integrated School Health Policy (ISHP).

The ISHP appears to differ from the existing school health services in that it includes (but not limited to): a close collaboration between the Department of Health (DOH), Department of Basic Education (DBE) and the Department of Social Development (DSD) as well as all the other role players such as the school governing bodies; services will be provided to all learners at all educational phases; a provision of a more comprehensive package of services which addresses barriers to learning as well conditions that contribute to morbidity and mortality amongst learners in childhood and adulthood; emphasis on provision of health services instead of just screening and using the referral system as well as a commitment to expand health services in schools overtime (DoH and DBE, 2012).

The ISHP expects all stakeholders (other government departments, Non-Governmental Organisations (NGOs), School Governing Bodies (SGBs), teacher unions, learner organisations, academic institutions and civil society) to contribute towards its success and sustainability (DoH and DBE, 2012).

The policy was launched in order to assist school going children in accessing preventive health services and ensure that avoidable health problems are identified early. The biggest challenges since its inception have been implementation, monitoring and evaluation. The Integrated School Health Policy (ISHP) is based on the premise of building on and strengthening the existing school health services (DoH and DBE, 2012).

School health programs are central to cultivating specific health knowledge, behaviour and attitudes; and improving educational outcomes as well as improving social outcomes in young people (Kolbe, 2002). Consequently, schools play a vital role in shaping young people's lifetime health habits and behaviours, combating poor nutrition as well as physical inactivity (Kolbe, 2002).

The health of a child is all encompassing; it is related to all the environmental elements in which the child lives and learns (Kolbe, 2012).

Education is one of those environmental elements and it is integral to South Africa's long term development (National Planning Commission, 2011). It is considered one of the core elements that are vital in the fight against poverty, decreasing inequality as well as providing a basis for an equal society education; it is a developmental tool that sanctions people to define their own identity as well as enable them to carve their own paths in taking part in developing the society they live in (National Planning Commission, 2011). It is an indication that South Africa has placed education, health and social protection on its priority list through its budget allocation (The Mister of Finance, Pravhin Gordhan, 2013).

This study will explore factors that contribute negatively to the implementation of the ISHP amongst the policy experts and policy implementers within the Gauteng DOH, DBE and DSD.

1.1.4 Problem Statement

Implementation of school health services and programmes has been slow, showing very low coverage and below ideal provision standard has been experienced. Since 2003, when the then-Minister of Health at the time Dr MantoTshabalala-Msimang launched the National School Health Policy with the aim of providing a framework and implementation guidelines for provision of school health services to school children (Minister of health, Dr MantoTshabalala-Msimang, 2003) implementation has remained poor and below ideal (Mahlabi, Van Aswegen, Mokoena, 2010). The policy has been revised over the years under the Department of Health (DOH). A new revamped version of the policy titled the Integrated School Health Policy (ISHP) was launched in 2012 with the Departments of Basic Education (DBE) and Social Development (DSD) as co-custodians together with the Department of Health

(DOH). The factors contributing negatively to implementation of the policy within the three departments and extent to which the factors influence implementation of the ISHP are largely unknown. It is necessary to establish the impeding factors through the engagement of policy experts and policy implementers within the Gauteng DOH, DBE and DSD. The study which is based in Gauteng will assist in the implementation process of the throughout the country.

1.1.5 Purpose statement

The purpose of this research is to explore and establish factors that interfere with the implementation of integrated school health policy and the extent to which the factors influence its implementation from the policy experts and implementers within Gauteng DOH, DBE and DSD.

1.1.6 Research question

What are the factors that interfere with the implementation of the integrated school heath policy? And to what extent do the factors influence the implementation of Integrated School Health Policy (ISHP) amongst the policy experts and implementers within the Gauteng DOH, DBE and DSD?

1.1.7 The research

This research report is divided into six chapters, starting with the introduction and background as the first chapter, the literature review as chapter two, research methodology is chapter three, the forth chapter presents the research findings, and then followed by the data analysis of the research which is the fifth chapter and the last chapter is chapter six, it concludes the research and gives recommendations

1.2 Conclusion

This chapter looked at the overview of the South African Health System, the overview of the South African Integrated School Heath Policy, the background to the problem, the problem statement, the purpose statement and the research question.

The next chapter is the review of the relevant literature that highlights school health policies and their implementation.

CHAPTER TWO

2 LITERATURE REVIEW

2.1 Introduction

This chapter aims to give an appraisal on the literature related to the South African school heath policy implementation and the management thereof. It starts by offering an overview of policy, policy implementation, policy and practice in school health programs, then moves to an overview of school health programs and it subsequently looks at barriers and opportunities, as well as the international and South African contexts. This literature review has been conducted to provide insight into the international and local trends regarding school health policy implementation and its barriers.

The literature sourced was limited to the past decade; international literature is readily available as compared to the South African literature which is limited in terms of school health policy implementation issues and it is a fairly new literature. The literature search was limited to Google scholar and the University of Witwatersrand databases. The search strings were used to source articles that were dealing with 'policy', "policy implementation", 'health' and 'school health programs'.

2.2 Literature landscape

The articles in this literature are from academic and health professionals. The authors have an understanding and vested interest in policies related to the health of young people attending school. The literatures mostly come from international settings and experiences on policy and health. There is not much difference between the international articles and the South African articles as they all look at ways in which effective policy management and implementation can occur in school settings as well as barriers or hindrances to implementation. The only difference is that the international articles have a wealth of experience whereas the South African articles are quite recent as the school heath policy is a fairly new concept in South Africa.

There seems to be a consensus with the authors of the articles as to what the school health policies and programs should look like as well as consensus on the barriers to implementation. Contexts (that is country and environmental context), however differ. The consensus is around what programs should more or less look like, school health policy should have clear implementation guidelines, a commitment from authorities, training of staff, awareness campaigns and communication to all the stakeholders especially including, the young people, the teachers, parents and the community.

Theoretical framework

This study is based on public policy implementation theories. Literature distinguishes between **Top-down and bottom-up approaches** to implementation. The two approaches are differentiated in areas such as the role actors play, their relationships and the type of policies they can be applied to. The top-down approach seeks to develop policy advice that can be universal and apply consistency in behaviour patterns across different policy areas. Bottom-up approach's emphasise is on target groups and service deliverers, stating that policy is made at the local level. The bottom-up approach focuses on centrally located actors who formulate and implement government programmes, thus contextual factors within the implementing environment are important (Cerna, 2013),(Hill&Hupe, 2002).

There is recognition that writers of theory and public administrators may approach implementation from different points of views (Hill&Hupe, 2002) and (Raj Paudel, 2009). Implementations of policy differ in shapes and forms in different cultures and institutional settings ((Hill&Hupe, 2002), this view is echoed by Cerna (2013) stating that it is not easy to point out the factors or conditions that facilitate successful implementation, it is dependent on the political, economic and social context. Thus, no 'one-size–fits-all' policy is in existence at present.

Policy implementation takes in actions by individuals or groups aimed at achieving objectives that have been set at policy decisions (Raj Paudel, 2009). Raj Paudel (2009) further states that the way in which policy succeeds is dependent on two dynamics: local capacity and will and that "motivation and commitment (or will) reflect the implementer's assessment of the value of a policy or the appropriateness of a strategy".

Given the above, it is important for the study to follow similar perspectives in analysing and explaining fators that are a hinderance to the implementation of the Integrated School Health Policy.

2.3 Policy

Policy can be defined as a planned or unintended plan or course of action that is carried out in implementation practice or administration (Oxford dictionary, 2007, Parsons, 1995). A policy can also be seen as rules and resources that disallow and recommend actions as well as serving as means to achieve specific goals (LeGreco and Canary, 2011).

Ball, Hoskins, Maguire and Braun (2011:5), see policy as a merged set of "regulation imperatives, principles, multi-level and collective efforts of interpretation and translation"; it is further contended that policies come into being in settings with diverse resources and this relates to 'problems' that are made up nationally and locally. Polices are also set in the backdrop of commitments, values and forms of experience. They are also complex as they involve many actors in the their development and enactments (Ball, Hoskins, Maguire and Braun, 2011),

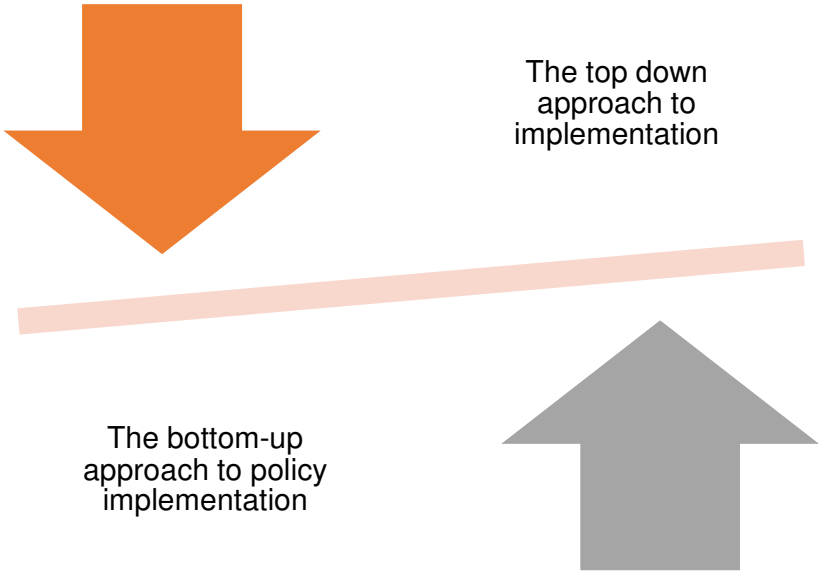
Policies do not normally prescribe what to do; they merely construct conditions where a number of options which are available are changed or narrowed when deciding what to do or setting goals and outcomes (Braun, Ball, Maguire, Hoskins, 2011).

2.4 Policy and Implementation

Policy implementation can refer to carrying out or fulfilling activities or actions in order to achieve goals or objectives that were set when policy decisions were being made; but as to when implementation begins or ends is still a debate (Brynard, 2000). Implementation is defined as a "deliberately initiated process, in which agents intend to bring into operation new or modified practices that are institutionally sanctioned, and are performed by themselves and other agents" (May, 2013).

Policies are meant to be agents of change which can be political, economic, social and/ institutional in nature; therefore if the policies are not implemented properly they remain just written intentions (van Baalen, 2002). The big debate is on the top-down verses the bottom-up policy implementation. The top-down approach is where it is suggested that implementation starts at the top level of government and it then trickles down to the implementers at the bottom. The bottom-up approach challenges the assumption of hierarchy in the top-down approach (Brynard, 2000). Top-down models consider policy designers to be the major actors. In contrast, bottom-up models recognise policy as it is delivered at the local level (Chunnu-Brayda, 2012). The figure below illustrate that there is no conclusion of the perspective or approach that a balance between the two approaches has to be struck as they both express strengths and weaknesses that could be exploited in policy implementation (Brynard, 2000; Chunnu-Brayda, 2012).

Figure 2: The relationship between top- down and bottom-up perspectives on policy implementation.



(Source: Shilubane, 2015)

There is an interaction that is multifaceted between policy and its institutional location in implementation, and this determines its success. The bottom-up approach

states that the ultimate implementation and policy outcome power lies with the local deliverers or " front-line workers" who operate at the lower level of implementation more than the policy makers because they are the ones who interact directly with the citizens or service users. There is a general consensus that implementation is a complex process that is influenced by the context and content of the policy that is being implemented, it involves many actors and many levels and it is also very dynamic (Brynard, 2000; Chunnu-Brayda, 2012; deLeon and deLeon, 2002).

Policy implementation is unique to each situation; five variables have been identified by Brynard (2000) that shape implementation direction and are considered essential to effective implementation. The variables are interlinked and interdependent; this however is dependent on the context. The variables are ***Content***; it refers to the mediation of choice of means and ends in the implementation process of setting of goals and actions to attain them. Policy can be characterised as *distributive* (the creation of public goods for the welfare of citizens), *regulatory* (these specify rules of conduct and sanctions) and *redistributive* (tries to change allocations of wealth or power from one group to the other). The second variable is ***Context***; which is the impact of context on implementation effectiveness; it may be shaped by a much larger context of the social, economic, political as well as legal truths or realities. The third variable is ***Commitment****;* it refers to the willingness of those responsible for implementation to carry out the tasks. All levels through which policy passes must be committed, commitment has the ability to influence and be influenced by all the other variables. The fourth variable is ***Capacity****;* this refers to access and availability of resources that are tangible such as human, financial, technological, logistical and material resources and so forth. Capacity also refers to the intangible resources that are needed to convert theory into action, such as leadership, motivation, commitment, courage, willingness and endurance. The fifth variable is ***Clients and Coalitions***; it refers to the coming together of interest groups, opinion leaders as well as those who actively support the implementation of a particular policy, consciously looking for and identifying relevant and key stakeholders is very critical in implementation as those who are affected by the implementation are usually larger than other stakeholders (Brynard, 2000).

It is asserted that policy implementation necessitates understanding from the outset as a process meaning a 'continuous and interactive accomplishment' instead of the

final product. 'Implementation' is not about a single thing is being implemented, is a complex process that involves many moving parts (May, 2013).

2.4.1 Policy implementation within the school environment

There are no "best possible" implementation environments; schools have their own capabilities and coping capacities when it comes to policy. Schools have their own way of looking at policy and this they draw on their own cultures and ethos as well inevitabilities of the circumstances within context possibilities as well as limitations (Braun *et.al*, 2011). In the process of implementation of the state-driven policies and initiatives targeted at children and young people, schools and educators play very significant roles (Leow, 2011)

Policy implementation requires creativity in contextualisation (interpretation and translation); this is the translation of policy ideas to practises that are contextualised. Policies within schools are interpreted and implemented are mediated by the factors that are determined by the institution itself. In schools, policy implementation extent and method is dependent on whether the policy is recommended strongly, delegated or advocated as well as the degree to which policies are "acceptable" to the culture and beliefs of the school. Due to the complexity of policy, individual school politics and its cultural practices mean that policies will be interpreted differently and will be differently incorporated into and against practices (Braun *et.al*, 2011).

Schools are different as they have particular histories, infrastructure and buildings, leadership experiences, budgetary state or position, staffing profiles, teaching and learning challenges, these issues must be put at the forefront before implementation takes place (Braun *et.al*, 2011). Power dynamics are highlighted by political perspectives where policy becomes the result of competing priorities that are based on interests, which means that they are negotiated, bargained and/or compromised (Braun *et.al*, 2011). Braun *et.al*, (2011), highlight the importance of context in policy implementation, they identify four of what they call the "contextual dimensions". The dimensions are *situated contexts*, which include things such as school histories, intakes, settings and locality; *professional contexts* include values, experiences,

teacher commitment; *material contexts* relate to budget, staffing buildings, technology and infrastructure, etc.; *eternal contexts* have to do with the quality and support of local authority as well as pressures and expectations form the broader policy context such as legalities and responsibilities.

Budd, Schwarz, Yount, Haire-Joshu (2009) found factors that characterize a supportive policy environment and their influence on the quality and effectiveness of School Wellness Programmes (SWP) implementation: development of organizational capacity to implement an SWP these include, developed administrative procedures, staff are made aware of SWP requirements, a wellness task force or committee has been set up; additional funds to schools have been allocated for actions to implement new nutritional standards, technical support, and training for food service providers; additional support is critical investment in support of action-oriented strategies necessary to ensure successful SWP implementation; SWP implementation is likely to have specific challenges and the sum effect of multiple challenges; challenges to SWP implementation may represent either a supportive (few challenges) or unsupportive (many challenges) policy environment and influence the dynamics of SWP implementation; actions to support organizational capacity may be critical in limiting challenges to effective SWP implementation; core domains of SWPs must be being implemented consistently and effectively; domains most likely to be implemented were those that were mandated or were associated with specific criteria for example physical activity, In contrast, the domains of evaluation and communication and promotion were least likely to be implemented; the authorization of funds to support objectives in the communication and promotion and evaluation domains may help ensure the consistency in the implementation of SWPs; Further work is needed to clarify the domains of evaluation and communication and promotion in a way that is easily definable, measurable, and affordable to schools; accountability plays a critical role has an effect on the quality of SWP implementation; accountability for SWP can be measured in terms of transparency, oversight, and systematic evaluation, that quality of implementation was affected by level of accountability, it could be a strategy to facilitate optimal policy implementation

2.4.2 Policy: Leadership and Management

Leaders of policy agendas (policy makers and implementers) are currently faced with challenges that vary in nature such as institutional complexity (globalisation, local and national interests that are new), technical complexity (working across supply chains and new innovations *etc.*), and an overabundance of knowledge that keeps evolving and the understanding of customers and individuals (Collinge and Gibney, 2010). These challenges have caused an emergent theory of 'place' in policy leadership, which states that place as in the geographical location is a unique entity and it is deferent from other places. 'Place' can also be understood as a produce of fundamental social processes as well as power relations across and a 'place' is a place of experience which means that it is subjective. This means that developments that are local must be understood by local social structures, political dynamics as well as local cultures, this goes beyond looking at just context (see Braun, Ball, Maguire, Hoskins, 2011 as discussed above), local processes and change (Collinge and Gibney, 2010). This theory about space and policy is echoed by Pike and Colquhoun (2009); saying that there is an interrelationship between space and people, therefore their 'mutually constitutive nature' cannot be ignored. This is to say that space and social context play a fundamental role given that it often overlooked in service delivery; policy intentions are mediated by contextual factors because individual behaviours are established by 'spaces' (Pike and Colquhoun, 2009).

The management of 'place' is determined by its leadership, planning through collaboration of stakeholders is more resourceful as it is much more politically legitimate and it means shared knowledge and understanding as well as capacity and interaction. Leadership starts to matter when there is an understanding of policy interventions through the examination of what can be termed "softer" interactions of relations in development and the "power of human agency" (Collinge and Gibney, 2010:387). Regional, local institutions as well as systems are stirred or driven by people together with leadership at all levels (Collinge and Gibney, 2010).

There is another view on leadership and public policy or service delivery which is of the view that leadership and listening correspond; these are both tasks of public service (Simmons, 2011). Listening (which is relative) to service users through

choice and voice (this relates to giving users a say in the direction of services that are to be provided). Listening refers to a process where a listener understands, construes and gauges what they have heard; this is an all important part in the effectiveness of leadership (Simmons, 2011).The voice of the user is usually as a result of what they have perceived and judged as poor or good public services. Different situations at different times call for different approaches to leadership; therefore there is no one leadership approach that will solve all public policy problems, thus listening becomes a critical tool to have in order to lead in policy matters (Simmons, 2011).

The difference between leadership and management seem to be a thin line. Berce (2012:298-299) identifies what he calls “eight principles” that should be applied by a leader and these principles are said to be independent of culture. *Control* is about creating an atmosphere that allows purpose clarity and a sense of unity; *Trust* is about the leader trusting the team members to do their work; *Stability* is about being focused, knowing one’s standing point as well as knowing what one’s supposed to be doing; *Adjustment* relates to being able to fine-tune to surroundings and opponents; *Responsiveness* is about responding to challenges in a calm and collected manner; *Steering* relates to integrating the capabilities and power of all the team members that is embracing other people’s knowledge, interests and abilities in order to mould and direct; *Responsibility* is another one of the principles and it is about a commitment to finish something without imposing own value system on others.

2.5 Policy and Practice in School Health Programmes

For child health to become a priority there is a need to recognize that there has to be a structure that will demonstrate steps in linking policies and programs to outcomes (Mistry, Minkovits, Riley, Johnson, Grason, Dubay, Guyer, 2003). This will enable stakeholders to come up with policies that will be applicable and sustainable in promoting public health objectives in early childhood health.

There are economic, social and cultural determinants such as poverty effects, education and discrimination that shape health in early childhood experiences as that is where foundation of lifelong health and development are being established.

Structures or systems that are not constructed properly have an impact on early childhood health. Establishing an effective and strong heath system in children by meeting basic needs may eliminate expensive solutions that do not work as required to reduce diseases in childhood (Mistry *et.al.*, 2003)

Mistry *et.al.* (2003) developed a framework that demonstrates a conduit through which policies as well as programs can encourage child health outcomes and have an impact on lifetime health. Policies and programs are there to promote family and community capacities, which in turn enable building of health foundations which are children's basic needs such as responsive care giving, safe and secure environments, adequate and appropriate nutrition as well as health promoting behaviours. These foundations then influence fundamental biological mechanisms that outline development and health across a child's lifespan. When developing health policies that relate to children there should be an intentional way by which the policies and programs build capacities of families and their communities. Capacities play a very important mediating role, ensuring that families and their communities have the correct tools necessary to make available the foundations of child health (Mistry *et.al.*, 2003).

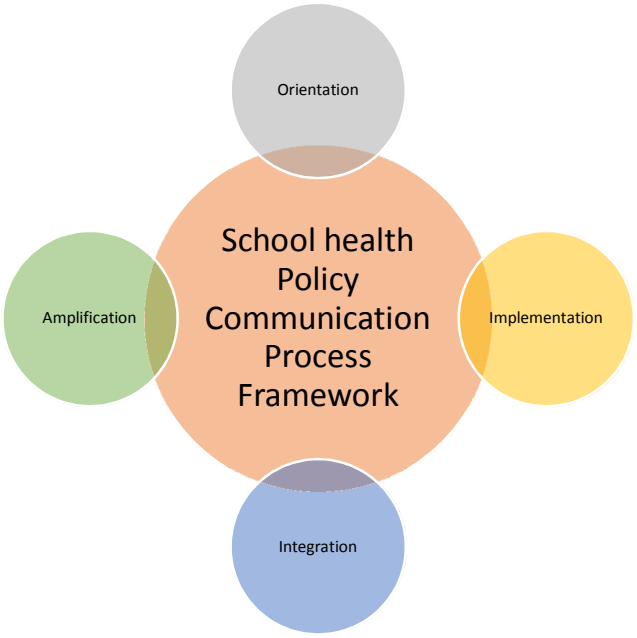
Sustainability is fundamental in school health policy initiatives and communication processes that enable this are vital. Communication is critical in policy formulation and practice, the kind of communication needed in policy is one that translates policies into practice. Policies can be seen as rules and resources that disallow and recommend actions as well as serving as means to achieve specific goals. Change to policies in terms of health practices is a process that involves coordinating the activities of stakeholders in different contexts (LeGreco and Canary, 2011).

LeGreco and Canary (2011), suggest a four frame communication process that assists in sustainable school healthy policy by engaging the parents, students and all the other stakeholders in health policy. *Orientation*, this is an introduction to policy issues as well as creating an awareness for all the stakeholders involved such as training meetings, information sessions, documentation, announcements and so forth; *amplification*, this involves creating detailed knowledge about policy delivery relating to practice in everyday use by stakeholders for example resources that translate written policy as practised; *implementation*, this is when stakeholders learn

policy by actual practice; *integration* is another frame of policy communication, this encompasses practices related to coordination through contexts, for example stakeholders can work to combine ideas, best practices and strategy sharing while showing togetherness in policy changes.

The figure below illustrates the four frame communication process for school health policy as suggested by LeGreco and Canary (2011).

Figure 3: illustration of four frame communication process for school health policy



(Source: Shilubane, 2015)

A review of health and education policies that are updated and coordinated to ensure that there is a strengthening of national efforts in the development and expansion of school health promotion programs are a necessity (Lankarani and Joulaei, 2011).

2.6 School Health Programs

Investing in the health and wellbeing of children from preschool through to the last high school grade is a very strategic enterprise as this can ensure a healthy labour

force and future leaders (Richardson, 2010). School health programs can be a vehicle to curb or reduce risky health behaviour while promoting healthy behaviour in young people. A comprehensive school health program would include health education, physical education, mental health and social services, health services, school environment, faculty and staff health promotion, food service as well as family and community involvement (Brener, Everett Jones, Kann, McManus, 2003; Micheal, Ditus and Epstein, 2007). There are many factors such as demographics, socio-economic status, politics that can affect or determine the type of health services required in the different schools (Brener *et. al*., 2003).

Therefore the school health policy cannot be a one-size-fits-all approach; getting a thorough understanding of the differences will ensure effective implementation. Students' needs, available resources in schools and the communities they are in, assist in dictating the type of services that can be provided as well as the method of delivering them. Having a school nurse is of vital importance in the implementation as well as the management of the school health programs regardless of the type of services offered. There is positive correlation between student health and their academic achievement; therefore it is imperative that health needs of children are effectively addressed within educational institutions (Brener, Wheeler, Wolfe, Vernon-Smiley, Caldart-Olson, 2007).

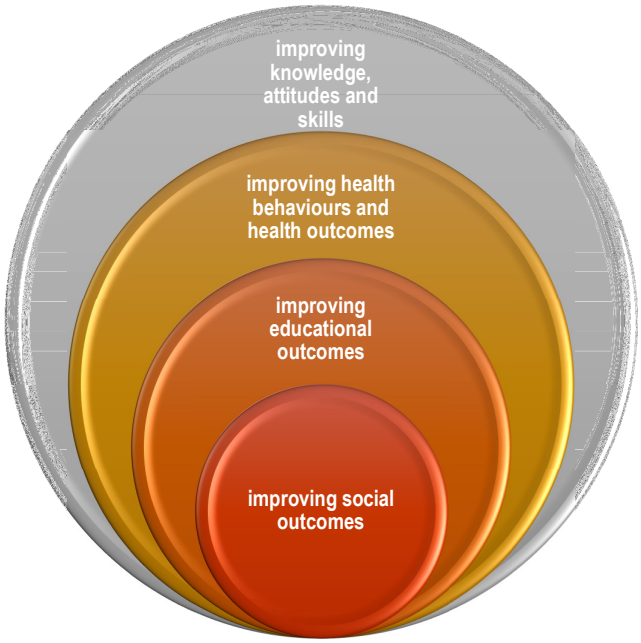
Awareness that health problems can negatively affect academic achievement negatively is of utmost importance. For school health policies to be improved there is an essential need of policy, legislative and fiscal support needed to make it a reality (Brener*et.al*, 2007).

School health programs ought to be designed in a way that helps in realizing a range of specific objectives within four related and interdependent goals for students (Kolbe, 2002). The first goal is **improving knowledge, attitudes and skills**, school health programs can improve knowledge and attitudes about health, the programs can be designed in such that they help students develop character by promoting values such as honesty, responsibility as well as respect for self and for others. The second goal is **improving health behaviours and health outcomes**, there are specific health outcomes and behaviours that school health programs can target such as alcohol, drug use, sexual risk behaviours as well as behaviours resulting in

injuries. These behaviours are interconnected and they cause health problems as well as educational and social problems and these behaviours become established in early in life. The third of these goals is **improving educational outcomes**, children who are healthy are more likely to learn and receive education and those who drop out of school tend to experience more health problems as well as poverty than those who remain in school. The forth of the goals is **improving social outcomes**, schools are places where young people spend their time the most, thus schools can influence psychological, emotional as well as social development (Kolbe, 2002). This requires community involvement and support for the school health programs to be effective.

Below is a figure that illustrates the interconnection of the goals of school health programmes as recommended by Kolbe (2002).

Figure 4: school health programme goals



(Source: Shilubane, 2015)

Schools as institutions of learning have the potential to play a very critical role in influencing lifestyles and health behaviours of students at an early age. It is a place where lifetime behaviours and habits are adopted. Schools can be a very valuable

connection between parents and the community, their involvement act as reinforcement and support for school health programs and strategies, this makes schools an ideal setting for health interventions targeted at school aged children. There should be health policies and supportive environments that encourage and enable children to make lifestyle changes that can improve their health (Lynagh, Schofield, Sanson-Fisher, 1997).

During the First International Health Conference on School Health which was held in October 2011, the schools that promoted health were described as environments where there is social and emotional well-being and a place where reproductive health and population education is being taught. The school health programs should be characterised by oral health promotion, HIV/AIDS and STD prevention, physical activity promotion, life-skills education and health that is skills based, a physical environment that is suitable and appropriate, as well as the prevention of tobacco and violence (Lankarani and Joulaei, 2011). School performance improvement or enhancements efforts that ignore health are not well thought out. There is an urgent need for a close collaboration between health and education authorities as this will ensure a full education for all children while eliminating gender inequalities (Lankarani and Joulaei, 2011).

2.7 Barriers and Opportunities

Implementing and evaluating school health programs and policies are vital in childhood health and disease prevention, schools play a big role in providing nutritional habits, opportunities for physical activity and contributing to a lifetime of habits (Agron, Berends, Ellis, Gonzales, 2010). A policy should have a plan for measuring the implementation of health policies this should include the designation of staff tasked with the responsibility for the implementation of the policy. There are barriers to effective and efficient implementation of school health programs or policies that Agron *et.al*. (2010) have identified.

All students and all educators must be enabled learn and to teach effectively respectively. School reforms must be designed for more than those students who are motivationally ready and able to profit from curricula and instruction. Schools have to ensure that they address the needs of those encountering external and internal

barriers that interfere with them from benefiting from instruction and these barriers are much more than just health concerns. They cover all the factors that interfere with the way educators teaching and the way in which students learn school. Approaches that address barriers are vital especially where large numbers of students are affected (Adelman and Tailor, 2000).

Adequate funding for the health programs is a challenge in policy implementation and monitoring; competing priorities/lack of time is another significant challenge as time that is enough is not allocated to health, nutrition and physical education in the school curriculums; the need to gain support and educate non staff stakeholders and this includes support from students, parents and the community can be a barrier; not having adequate tools to support the development of policy, implementation as well as monitoring and evaluation can be a major barrier in school health programs (Agron et.al., 2010).

There are opportunities that can be identified such as mobilizing student support as well as involvement; increasing awareness and understanding between good nutrition, physical activity, health and academic achievement; training of school governing bodies, teachers on developing, implementing and monitoring health programs; communicating the policy and partnership building; staff support and development; setting health, nutrition and physical education standards as well as introducing a school health committee or council (Agron et.al, 2010) this is collaboration as indicated above by (Brynard, 2000) .

There are key factors that can be effective in school health policy implementation. There is a need for top level and long-term commitment to school health programs from administrators and the powers that be; having a coordinator or any dedicated staff to guide the initiatives for school health and the implementation of the programs; there should be an approach that is data driven in decision making, program tracking and communications; a community environment that values health and wellness is invaluable; collaboration and the working together of government departments such as health, social development and basic education as well as leadership at government level and legislation that encourages and dictates positive change. All stakeholders must be made aware and clear that if there is no effective implementation and evaluation of school health policies, the prospective benefits of

the school health policy will never be realized (Agronet.al, 2010). The major challenges in school health are poverty, illiteracy, conflicts, emergencies, natural disasters, high school dropout, educational gaps, fast demographic and epidemiological shifts or changes and unemployment (Lankarani and Joulaei, 2011).

2.8 International Context

Internationally, in countries such as the United States of America, the implementation quality of school wellness policies differs across schools. Factors such as leadership, stakeholder buy-in, accountability systems, sufficient resources as well as effective feedback contribute to the implementation gaps across schools (Budd, Schwartz, Yount, Haire-Joshu, 2012).

In the United States of America (USA), when it comes to school wellness policies in public schools within states such as Alabama public schools there is a general compliance with wellness policies, however it was found that there are problems with integrating some health education into core subjects in the schools. Another challenge was that staff that are not qualified or offered training opportunities for development made creating infrastructure to support wellness policies very challenging. Wellness policies that comply with guidelines as in this case do not guarantee that effective policy of the implementation thereof. There is a need to translate policy into realistic and effective implementation procedures as well as the establishment of monitoring and evaluation systems (Gaines, Lonis-Shumate, Gropper, 2011)

In a country such as Uganda school health programs are still not prioritised due to lack of resources and other things that are deemed more important than school children's health such as political stabilisation, the school health policies are still in the draft stages (Acham, Kikafunda, Malde, Olderwage-Theron, Egal, 2012). One of the biggest barriers to realising and implementing the school health policies is lack of political will. Nutrition is an important factor when designing and evaluating school health programs, it was found that in Uganda absenteeism and drop-out from school was linked to poor nutrition. It has been found that a direct link exists between food and academic achievement. This shows that there is a critical link between children's

health, learning and nutrition; poor nutrition has an adverse effect on academic achievement and the health of a child (Acham *et al*, 2012).

There are African countries such as Botswana where government has put health including the health of children in its priority list; the School Health Policy has been introduced for health promotion in schools (Shaibu and Phaladze, 2010). It is comprehensive in nature, but implementation of the policy has proven to be a challenge. The challenges include delivery constraints such as health assessments for individual students are conducted in crowded classrooms; there is no privacy for pupils due to infrastructural shortages and challenges; there is a lack of age-appropriate teaching material and lack of space making it difficult for health education delivery; health assessment of the school environment is neglected even though it is specifies in the school heath policy, facilities for hand washing are not available in some instances, the school grounds were dirty and unhygienic toilet facilities (Shaibu and Phaladze, 2010).

The barriers to implementation in developing countries such as Botswana include differing implementation of the policy between districts and lack of awareness of the school health policy amongst teachers, parents and the community at large; health issues are left to the nurses another professions are not getting involved as they should therefore lack of collaboration between professions and departments; lack of heath knowledge amongst teachers is another barriers that makes it difficult to implement meaning there is a need for health education for teachers; nurses are overworked with little support from management, another problem is the lack of expertise amongst those who are tasked with the implementation (Shaibu and Phaladze, 2010).

2.9 South African Context

The South African landscape is unique; it has a long history of inequality and poverty due to apartheid; this has had impact on the current South Africa in that it stripped people of their assets such as land, social institutions and economic markets have been distorted through racial discrimination. The poverty is still continuing though there has been improvement since the democratic government came into power especially amongst the black population. South Africa is a middle income country but

for most households poverty is the order of the day, this is due to perpetual inequality (May, 2006). School health promoting initiative is a concept that is rather new in South Africa. There is no clear understanding of the concept and this has led to poor implementation of school health programs and services (Mahlabi, Van Aswegen, Mokoena, 2010).

Mahlabi, *et al* (2010), conducted a study in the Mpumalanga province of South Africa where they identified barriers to implementation on school health services. Governance is big barrier to implementation as active political will is not portrayed as all levels of government are not showing priority to school health programs, there are no clear policy guidelines to implementation, roles and scope of work were not clarified, there is a lack of commitment by government departments with regard to health of school children, government departments do not seem to have a shared vision when it come to the health of children in schools; school health program is another barrier in that there is no uniform implementation of the health programs as some districts implement health services and others did not.

Implementation of health services is not seen as a priority by those tasked to implement, lack of commitment by district health managers, inter-sectoral collaboration is not visible, poor roads in rural areas make it difficult for health programs to reach, lack of collaboration within the support services such as oral health nutrition programs, environmental health as well as nutrition, unequal distribution of resources “black schools” still getting less than their counterparts, school health programs centred around ‘screening’ while neglecting other health promoting activities (Mahlabi, *et al*., 2010).

Management of the school health services is a barrier as there are prevailing negative attitudes by health managers due to lack of understanding of what school health program is all about, shortage of qualified health personnel, there is no proper supervision of professional responsible for implementation, lack of understanding by school principles on the role of nurses and health professionals in schools, lack of managerial support; lack of community awareness is also a huge barrier to implementation of school health programs or services as communities have not been sensitized or have been excluded in the implementation processes, involvement of communities is vital to the survival of school health initiatives (Mahlabi, *et al*.,

2010).These barriers can be seen as a picture of the South African landscape in school health programs implementation currently.

In the KwaZulu Natal province of South Africa, there are hindrances to implementation of the National School health Policy (Shasha, Taylor, Dlamini, Aldous-Mycock, 2011). These hindrances include personnel issues with regards to long distance travel and hard to get places in rural areas, poor roads make it difficult for nurses and other health professionals to reach; transport is a problem for those responsible to implement health services in the school as access to vehicles is a problem, this means long travel distances and lateness (Shasha, et al., 2011).

There a great need for training of staff in order to implement the School Health Policy and there is a need for extra personnel and collaboration between departments; the screening for children should be taken seriously as children ought to be carefully examined before they enter formal school so that problems can be detected early and treated at an early stage of life; there is a need for teachers to be trained in health matters and first aid as they are usually the first point of contact with the pupils. Another major problem is the infrastructure as some schools still do not have the basics such as clean water and do not have satisfactory sanitation (Shasha*, et al*. 2011).

2.10 Conclusion

The purpose of the chapter on literature review was to give an appraisal on the literature related to school heath policy implementation and the management thereof. There is resonance of the need to have school health policies implemented properly and orderly within South Africa and the rest of the world. This literature review has provided insight into the international and local trends regarding school health policy implementation and its barriers. The key subjects in this literature review are policy structure, clear policy guidelines, governance, and sustainability, commitment by authority, training and development of staff as well as awareness of students, teachers, parents and the community at large.

The following chapter is the research methodology which was used for this study. It gives insight into the research approach, data collections tools, the philosophy, the research design and population sample used for the study.

CHAPTER THREE

3 RESEARCH METHODOLOGY

3.1 Introduction

This chapter is a section on research methodology which describes the philosophical orientation of the research and the research strategy that was selected to conduct the research. It also provides details of the sampling and considers the ethical questions relevant to the research. The primary research instrument was the semi-structured interview schedule.

3.1.1 Research Philosophy/Paradigm

The qualitative research is associated with inductive theory; the research assumes the implication of the study on the theory that encouraged the research exercise in the first place (Bryman, 2012). The epistemological orientation or position (*i.e.* what should be considered acceptable knowledge) of qualitative research is interpretivism which subsumes that the researcher's interpretations are critical in the application of the scientific model of studying the social world given that people and institutions are different from the natural sciences which follow the positivism epistemological approach to research. The difference therefore dictates a different logic in research procedure for social sciences that reflects the distinctiveness of humans as opposed to the natural order (Bryman, 2012).

Interpretivism is linked to hermeneutics philosophy, a term drawn in theology for the social sciences referring to the theory and method of interpretation of human actions (Bryman, 2012). Emphasis on human behaviour and its understanding of it is fundamental in the positivist approach to social science research; it is about the empathetic understanding of human action and not the forces that are deemed to act on the action (Bryman, 2012).

Phenomenology is another philosophy through which interpretivism is based; it studies the structures of the consciousness as experienced by the person who experienced it (Bryman, 2012).

The research position of interpretivism is appropriate for this study as it enabled me to interpret the design I have chosen for this research in terms of identifying factors that hinder or impede implementation of the Integrated School Health Policy in South Africa. Implementation of a policy is related to human behaviour and their understanding of the context or environment in which they operate.

3.1.2 Research Strategy/ Approach

A qualitative research approach is used for this study. There are different strategies that can be employed for social research such quantitative research, qualitative research and mixed method research (Bryman, 2012). Qualitative research has emphasis on words in collecting and analysing data, it is of the view that social reality is not static and it is created by individuals, it emphasise on the way individuals interpret their social world (Bryman, 2012). The quantitative research strategy is understood as one that stresses quantification when collecting and analysing data, it is deductive in its approach to the relationship between theory and research and emphasis is placed on testing theory (Bryman, 2012). The mixed method research is a combination of both quantitative and qualitative research strategies (Bryman, 2012).

This study assumes a qualitative research approach; it examines factors that hinder the implementation of the Integrated School Health Policy and how the these factors influence implementation of the Integrated School Health Policy implementation amongst policy experts and implementers.

3.1.3 Type of Qualitative Research Design and Research Methods

A research design offers a framework for data collection and analysis; a research method on the other hand can be denoted as a data collection technique (Bryman, 2012). A qualitative study is used; a case study research design has been used for this study/ research, it entails detailed and intensive analysis of the Integrated School Health Policy in Gauteng, the unit of analysis is the Integrated School Health Policy (ISHP) (Bryman, 2012).

The research methods that this study employed comprised of semi-structured interviews which were used as the primary research instruments or data collection techniques (Bryman, 2012).The interview process started in November 2014. The interviews began with unstructured questions (general questions about the individual or the environment they work in) which invited an occasional question for clarification from the participants. The target audience (the interviewees) talked about varied topics throughout interview (Bryman, 2012).

10 interviews (*i.e.* departments of health, basic education and social development, it include policy experts and policy implementers such as designated nurses, teachers, and designated social workers) were conducted and any obligatory additional interviews were conducted. In addition, follow-up clarifying interviews were conducted after data analysis had been completed, ensuring that an understanding of the findings has been grasped. The interviews were conducted in a way that is informal and open-ended, and carried out in a communication style that is conversational. All interviews were tape-recorded and they differ in length from one hour to two hours and additional minutes as it necessitated (Bryman, 2012).

Field notes were written, observations, and casual encounters with persons of interest were used in combination with the interviews. In addition other data such as on-going literature review, comments from public figures with authority and papers and so forth were used throughout the research study. Memoranda were written during the process of listening to taped interviews, typing transcripts, and reflecting upon a particular interview (Bryman, 2012).

3.1.4 Sample

Data was collected through semi-structured interviews from policy experts and implementers from the departments of Heath, Basic Education and Social Development in Gauteng. A non-probability purposive sampling method was used due to the nature, time and resource limitations of research. The sample size is 10 policy experts and implementers from the three Gauteng departments. The 10 participants were selected based on their relevance to the research questions that are being asked in this study as well as the locality of the research as it is based in Gauteng (Bryman, 2012). The three departments (health, basic education and social

development) have different mandates and focus; therefore the variations in terms of perceptions and the views on priorities ensued.

3.1.5 Validity, Reliability and Ethics

In qualitative research, a very key issue is trustworthiness of the study referring to a study doing what it was designed to do (Merriam, 1995, Bryman 2012). The question of reliability in qualitative research unlike quantitative is the amount of detail (the depth of understanding the subject reality) in the conclusion of the study that makes sense, it is about credibility, consistency and transferability and not what is true to many. It is about consistency of the results of the study with the data that are collected for the study (Merriam, 1995). In qualitative research, the key to understanding validity is through the concept of reality. It is about the similarity of one's findings to reality because qualitative research assumes that reality is constructed by the social actors, it has many dimensions and it is always changing, therefore there are more than one reality to be observed or measured (Merriam, 1995). There are strategies that can be employed to strengthen internal validity and reliability in qualitative research (Merriam, 1995). *Internal validity strategies* include: Triangulation: this refers to the use of multiple investigators, multiple sources of data or multiple methods to confirm emerging findings.

In the study, I have used the interviews, data sources as well as observation; Member checks: this refers to the collected data from the study participants and the researcher's interpretation of the data taken back to the participants to ask if the interpretations are plausible. In this study, I have done peer/ colleague examination: this refers to having peers or colleagues examine the data and comment on the plausibility or emerging findings; the statement of the researchers experiences, assumptions, biases from the onset of the study was also used. For this study, I have made statements on my biases about the implementation of the ISHP; Submersion/engagement in the research situation: refers to the collation of data over a long period of time to ensure in-depth understanding of the phenomenon or reality.

Reliability strategies include:

- Triangulation: this refers to the use of multiple investigators, multiple sources of data or multiple methods to confirm emerging findings.

- Peer/ colleague examination: this refers to having peers or colleagues examine the data and comment on the plausibility or emerging findings.
- Audit trail: the investigator describes in detail the way data were collected, the way categories were initiated as well as the way in which decisions were made.

To ensure internal validity and reliability as described above, this study assumed triangulation buy using different types of data sources which will include semi-structured interviews, Field notes that were written, follow-up interviews, observations, and casual encounters which reflect on the taped interviews and transcripts. Member checks and peer or colleague examination were employed to validate the plausibility of the interpretations of the study.

External Validity (the extent to which the findings can be applied to other situations) strategies include: Thick description: this involves providing enough information so that the readers will be able to determine the extent to which the research findings match their situations that is check whether the findings can be transferred; Multi-site designs: this involves using several sites, cases or situations especially those with variations which will allow the results to be applied to a broader range of other similar situations; Modal Comparison or typicality: this involves describing the typicality of the program or sample as compared to the majority of others in the same class.

In considering the extent to which the findings of this study can be applied to other situation, *i.e.* external validity, this study used thick description as a strategy to guarantee external validity. This study provides detailed description of the factors that impede/ hinder implementation of the Integrated School Health Policy in Gauteng and their effects on the implementation process. Thick descriptions are the strategy used for this study due to time constraints of the study period (October 2014 to end February 2015).

Ethical Requirements: Primary data that are trustworthy were required from the respondents' interview schedule responses. This study focused specifically on respondents who are of age and independent to participate in the study of their own free will (Bryman, 2012). The respondent's consent was requested, clear explanation was provided to all respondents that the research is conducted as a requirement of the Masters in Management in Public and Development Management

only (Bryman, 2012). Respondents were informed that their identities will remain confidential and that that the research findings will be shared with the respondents if they so wish.

3.2 Presentation of research data/ information

3.2.1 Data Analysis

Data analysis integrates a range of elements. It is an important stage of data research methodology (Bryman, 2012). This study analysed data, using transcribed data and the transcriptions were obtained from the semi- structured interviews that were audio recorded or taped, memoranda, and field notes. The transcribed data was coded by looking at things that the data represents such as events and behaviour; the coding includes the use colour pens to mark the margins with the appropriate numbers and letters as needed (Bryman, 2012).

Thematic analysis which is a common form of data analysis in qualitative research was used for this study, which identifies themes that emerge throughout the study that relate to the research questions. The themes for this study were searched for by looking out for things such as topic repetitions, local categories, metaphors and analogies, similarities, transitions, language connectors, missing data as well as material that is related to the theory, a framework in a form of a table that highlight the themes was used for this study (Bryman, 2012).

A range of numbers and letters and words were used to designate major categories and subcategories. This study had an on-going data analysis taking place throughout the research period. Connections between themes and categories were used to identify and to get understanding of the factors hindering the implementation of The Integrated School Health Policy. This identification and understanding were used to shape and bring understanding to the effects and influences on the implementation of the Integrated School Health Policy in Gauteng and be used as a picture that can be used as an example for learning (Bryman, 2012).

3.3 Research Limitations

There were limitations to the study, they included delays in securing approval from certain departments to conduct interviews with the relevant people, securing interviews with the School Governing Body members proved to be impossible due to time constraints. The time constraints for some of the participants made the time for interviews shorter than anticipated. The study cannot necessarily be generalised due to sample size. Therefore more research on the subject in South Africa is warranted.

3.4 Conclusion

This chapter looked at the research methodology which gave a description of the philosophical orientation of the research and the research strategy that was selected to conduct the research. It provided details of the sampling and considers the ethical questions relevant to the research and the primary research instrument that was used was the semi-structured interview schedule.

The next chapter is a presentation of the findings of the research study, it is the outcome of the data that was collected throughout the research using the research tools.

CHAPTER FOUR

4 PRESENTATION OF RESEARCH FINDINGS

4.1 Introduction

This chapter presents findings that resulted from data collected from field research. It presents the outcome of one on one interview with respondents as well as documents the field notes and observations of the researcher. The interviews were conducted as research tools data collection that would address the research question: What are the factors that interfere with the implementation of the integrated school heath policy? qualitative evidence stemming from the in-depth interviews is presented in this chapter.

The key informants in this case study included officials from the Gauteng Department of Health, Gauteng Departments of Education, The Gauteng Department of Social Development, Teachers from Swartkop Valley Primary School in the Westrand District and Hitekani Primary school in Soweto, Nurses from the Westrand District and Chiawelo Health Centre in Soweto. The data is presented in a way that aligns with the themes that have been identified in order to articulate and soundly synthesise data. All the statements made by the respondents of the research are highlighted in each theme that has been identified.

4.2 The Main Themes

The first theme dealt with the policy content, it explored the current focus of the ISHP. The objective was to find out whether the content of the ISHP meets its current objectives as well as map out the relevance of the policy to the school children and other stakeholders it aims to serve.

The second theme is stakeholder policy awareness; this theme strove to investigate the awareness of the ISHP by the stakeholders which have been identified in the ISHP as including the communities, the educators (teachers), the parents, the NGOs and other government departments. It is of great importance to for the stakeholders

to understand and be aware what the ISHP entails and what the benefits are in order for implementation to take place as intended. It must also be noted that the ISHP calls for stakeholder awareness of the ISHP for the implementation process to be enabled to take place.

The third theme explored the current challenges faced by the implementers of the ISHP. There can be challenges with implementation of any policy; it must therefore be born in mind that in order for the factors that cause hindrances to implementation to be identified, the challenges that are currently being faced by the implementers need to be recognized.

The fourth theme looked at the context and infrastructure in the implementation of the ISHP. The aim was to explore the roles that context or environment and infrastructure play in the implementation of the policy. In context, the focus was on whether the location and the environment of the schools determine the way implementation of the ISHP. In infrastructure, the focal point was in determining its importance in the implementation of ISHP within the schools.

The fifth theme determined the relationships between the responsible government departments as well as stakeholders and management of the implementation of the ISHP. The idea was to explore the relationship between the three departments (health, education and social development) who are the owners of the ISHP and the relation between stakeholders. Relationships can play a critical role in determining the success or failure of the of policy implementation.

The sixth and final theme looked at the perceptions of the implementation ISHP by the recipients (includes school children and the communities) of the programmes offered through the ISHP and the perceptions of all the stakeholders (includes other departments, teachers, NGOs). Perceptions determine the value of the policy programmes offered through the ISHP in the eyes of the recipients.

The views of the respondents gathered from the interviews differ; they however acknowledge the impact of the ISHP on the overall health of the school children who are direct recipients of the programmes offered through the ISHP.

The case study of the ISHP deliberated and set the ground on the selection of the respondents (see figure...below).

Table 2: research respondent schedule

Respondent Code	Respondent Title	Organisation
DH 1	Deputy Director: Child and School Health	Gauteng Department of Health
DH 2	Deputy Director: Health Promotions	Gauteng Department of Health
SD 3	Programme Manager: Sustainable livelihoods	Gauteng Department of Social Development
SW 4	Social Work Manager	Gauteng Department of Education
DE 5	Deputy Chief Education Specialist: School Health	Gauteng Department of Education
DE 6	Education Specialist: School Health	Gauteng Department of Education
ST 7	Educator: School Based Support Team coordinator	Swartkop Valley Primary School
SC 8	Deputy Principal: School health coordinator	Hitekani Primary School
SN 9	School Health Nurse	Westrand Health District
SN 10	School Health Nurse	Chiawelo Community Health Centre

4.2.1 Policy Content

The ISHP's main focus is on: Health education and promotion; Learner assessment and screening; Provision of onsite services, Follow-up and referral, Coordination and partnership, Community participation; Learner participation.

These form part of integrating school health in to the re-engineering of the South African primary health care (PHC).

The Integrated School Health Policy is in line with is in line with international school health policies and programmes. It is a well articulated policy that has properly laid out objectives and aims. It has the potential to be the best school health policy in South Africa, because it acknowledges that schools are institutions of learning that play a very critical role in influencing lifestyles and health behaviours of students at an early age. It is a place where lifetime behaviours and habits are adopted.

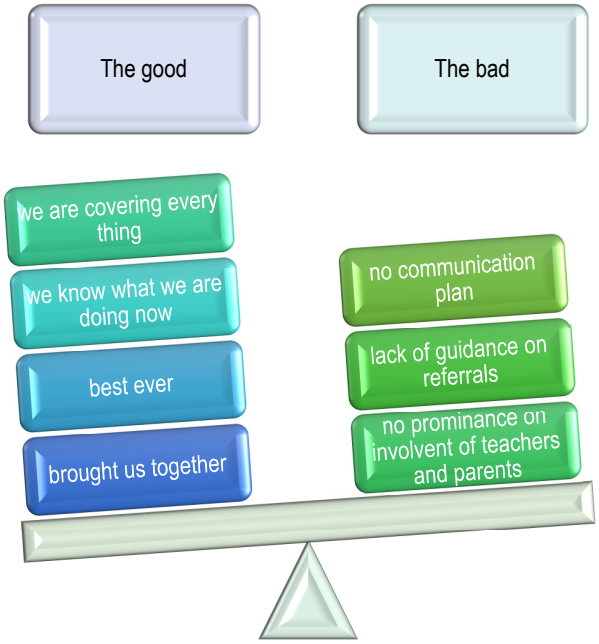
There was an excitement displayed by the respondents concerning the policy and its content. *"...I think it is the best thing that ever happened to schools...because some other learners are neglected, parents don't even take time to take their kids to the doctor. I think it is best that we have such a policy..."* one respondent said and another said *"I think we are covering everything so far, because the school nurse is doing almost everything you know...dental care, eye care etc and we are doing the screening of almost everything, TB like...the small kids, clinically we screen them for HIV and all the other things...yeah, I think we are covering everything so far"*

When asked about the focus of the ISHP, if the focus and content of the policy was enough to carry out the objectives of the ISHP. The respondents answered differently in that some are comfortable with the focus they would not add anything to it while others pointed to a few gaps that they feel should be addressed which include: Lack of a communication plan, lack of guidance in referrals saying that there is no clear guidance on how to go about doing referrals. Teacher and parent involvement should be prominent in the policy because if their involvement is lacking, the ISHP will never be implemented fully.

"My problem with the policy...um I think sometimes is that their approach is...well they are not working with people on the ground...I think that is the main problem...to prioritise actually their projects..." this was an answer to the question by one of the respondents.

The figure below gives an indication of how the participants responded to the content and focus of the ISHP. It gives an idea that the good of the policy content and focus outweighs the bad.

Figure 5: responses on content and focus of the ISHP



Source (Shilubane, 2015)

4.2.2 Policy awareness and involvement

The awareness of the ISHP by all the stakeholders was seen as lacking and very concerning. Most of the respondents felt that people who are meant to benefit from the ISHP such as school children, the community and other stakeholders such as NGOs do not really know much about the policy. Some are aware of the services that are offered through it but they do not really know that the policy exists. One responded said "*No I don't think they are aware of the policy, you know I don't think it is well articulated, I don't think many parents know about the ISHP per se....parents themselves don't know that we have a policy and this is what the policy says we must do...*"

Another respendent said *"I think that is another thing, normally a lot of projects from government, we start at the tail end. To implement without empowering people, or capacitating people, making people to understand what they need to do, making people aware what the project wants to achieve..."*

There were a few respondents who felt that the awareness is there have been

presentations made in some communities, meetings have been called for parents to be informed about the ISHP. This however they acknowledge that it is not enough as most people even stakeholders who are meant to be partners in implementation of the ISHP do not know about it. Due to lack of awareness of the ISHP there is no involvement by the stakeholders especially the parents and the communities at large in the implementation of the ISHP. This according to the respondents leads to gaps and delays in the implementation of the ISHP. *"...they don't know the policy and you find that sometimes they cause much damage because they do not know our guidelines...how we work, what are the parameters that govern the health services that we expect at school level..."* This was a statement highlighted by one of the respondents.

The reasons that were cites at the cause of this lack of awareness is sensitisation has not been done properly, the campaigns are not visible enough, lack of creativity especially with the community members.

4.2.3 Policy implementation challenges

The perceptions of the respondents on what the ISHP implementation challenges were varied but were similar in many ways. The following challenges were pointed out:

- Ownership

There is no ownership of ISHP by the stakeholders as well as the three responsible departments, that is, department of health, department of basic education and the department of social development. The respondents felt that all stakeholders and everyone involved should own the ISHP in order for it to be implemented properly; it should become everyone's business. It should be seen as something that will benefit and bring life to the communities at large as children are members of the community and when they grow up they could become members of the community who contribute positively to society as a whole. An example was given by some respondents about educators who at times become obstacles to the health of a child as a whole because most of them do not really know about the policy, in one school there will be a teacher (educator) who is appointed as responsible and should there be medical intervention needed at the school, some teachers will not allow their

pupils to leave their classroom for medical checkups as they do not see it as a priority and it is not really their responsibility to observe children whether they need medical attention or not.

- Responsibility/ Accountability

The three departments, health, education and social development have different priorities which the respondents felt maybe causing implementing of the ISHP not to happen as it should. Some respondents felt that in some departments such as Social Development, there are really no responsible persons for ISHP which makes accountability very hard. One responded said "...*for me if there is somebody who will say so and so you are dealing with children therefore as part of your performance this you need to deliver on, the problem is it will always be an add on and will be done as and when the person finds time to do it not necessarily be part of his performance or deliverables in terms of what the person need to be doing, therefore home bodies and allocation, that should be linked to your performance to make sure that you do it according the best of your ability because now you have a responsibility that is assigned to you to be reporting on it. For one within my department, there is nothing that I have to report on, it is a monthly report now that I have to give but nothing talks to ISHP*..." this indicates a huge accountability problem.

- Communication

Communication has been perceived as lacking and a big hindrance to the implementation of the ISHP by most of the respondents. There is a perception that communication between the three departments and other stakeholders is inadequate. This has led to some people working in silos; they felt that communication channels are skewed especially between the three departments, health, education and social development and this is mostly due unclear lines of communication. "...*there is no proper communication....it is there but it is lacking something because one department will come and the other will come and be shocked that the other is here*..." this was the view of one of the respondents and another view on communication was this "*...I'll start it from the partnership...in our partnership...the issue that I can highlight is the issue of communication because the other partner is complaining...like DoH is complaining about access into our schools*

and when they do get access you find that they are not expected, people are not ready because they cannot screen the children without the consent forms from the parents..." The respondents further say that the challenge is that sometimes there is no communication at district level whereas at provincial there is some communication in which there are agreements. But one would find that at district level the communication channels are closed. An example was given where the nurses will go and identify schools and visit them only to find that the schools are not ready and the principal will chase them away and say them that they have other programmes for the day. Communication from where it used to be has greatly improved but it is certainly not where they would want it to be.

- Planning /Team work

Planning together or working as teams were some of the things that respondents pointed out as challenges in trying to implement the ISHP or in making it work as it should. Most of the respondents complained about lack of proper collaboration with other departments, there is some collaboration they said but it is not enough to carry the mandate of the ISHP in totality. The respondents agree that the cause of this lack of collaboration is the fact that the three departments, health, education and social development all have different priorities and this at times makes it difficult to work together as a team or making the ISHP apriority. Departments of health and education seem to be planning working together but the department of social development is lagging behind according to the respondents. One responded said *"For me what is happening especially when it comes to school programmes, everything that is enlisted within the policy framework, it is things that are happening, it is just for us to work together not in isolation..."*

- Human resources/ capacity

All the respondents mentioned the problem of not having enough staff or capacity to carry out the implementation of the ISHP. The respondents say that there are not enough nurses, not enough health promoters; they claim that the shortage is great and it is a huge concern. All of them say that due to a lack of staff, the nurses and all those who are responsible end up doing a rushed job without really being thorough because they have to rush from one school to the next with limited time and skeletal staff. This causes important things to be missed as they try to meet the set targets.

Shortage of staff makes it difficult to do follow up and when it comes to school children if important things are missed at primary level, they in most cases become a bigger problem in high school or in the community in general especially with issues that can be prevented. Below are some of the comments made by the respondents on human resources:*"Currently working is the implementation of the programme itself, because the policy addresses the programme...it is doing very well...under challenging circumstances because there is a shortage of school health nurses...the shortage of ...the staffing in the department of health...the implementation part is coming okay...it is just that there is a shortage...they can't reach the targets that they set for themselves...you find that they can't reach every school..so it takes quite a while for them to reach other schools...you find that in some schools they have not even touched anything...this is a gap...a big one..."*

"Our main problem is employees who can help implement...inadequate health promoters, inadequate nurses, inadequate educators, inadequate coordinators...so in all department we are working on skeleton staff but if we were to get a full complement of staff...our policy would be well implemented and we would have a healthy society"

"*now our health promoters, we have got a less number of health promoters which do not cover the team, each team do not have a health promoter, so you would have a health promoter in a certain area divided among the number of teams and in some of the areas school health nurses will go without health promoters because there is a shortage, if there can be a number of health promoters according to those teams, at least, it can make the policy to be implementable, another thing is that you know health promoters are given topics, topics in that policy that they should adhere to, er... sometimes they do adhere to those but sometimes because of the shortage, they are not fully provided for because of the shortage of health promoters and it might not make, it will be like on the policy there is under performance"*

- Awareness

The respondents varied on awareness, most however agreed that the stakeholders particularly parents do not seem to know much about the policy which they saw as a big problem which is hindering the implementation of the ISHP fully. One respondent said *"so the challenge that I have picked up is that not much mediation has been*

done, people are given...because at head office we mediated into the district officials...we rely on the district officials that they mediate to their people and we are not sure if they have done that maybe the monitoring and follow system maybe are not strong enough to ensure that everyone...I cannot guarantee you that everybody knows this policy....my challenge is that we need to advocate until people know it by heart..."

- Transport and equipment

There is a shortage of transport especially for health nurses or the health teams assigned to go to school to provide school health services. This problem of transport makes it hard for the assigned teams to meet their school targets or targeted learners to receive the required health services. The problem is said to being worked on and it has improved it is however still a thorn on the side of the service providers. The issue is that the teams cannot get where when they need to and this leads to certain schools being neglected because teams cannot get there on time or at all. One responded said *"The issue of transport even though initially it was a real, managers at district level are now attending to it because there was a shortage of transport....they are addressing it in such a way that nurses are being dropped at schools some of the nurses are provided with a car to visit the schools but where there is a severe shortage of transport a dropping system is being utilised and they are dropped at school and when they are finished they phone the driver to pick them up..."* another responded said concerning transport *"Transport is an issue for us because we are not able to go when peach problem...it was difficult for me for to say give me the car today and tomorrow because I need to go and see the child....because if they give me the care on Monday, on Tuesday I am not going to have it, only on Tuesday...that creates a gap and it an issue..."*

Inadequate equipments have been a major problem in the past, but has improved in that the department of education has bought equipment such as scales for schools which make it is easier for nurses to check the weight and Body Mass Indexes (BMI) of the learners as required. The department of health has bought buses that are equipped as mobile clinics and are working well, there however glitches that have pointed out by the respondents such as *"department of health have come up with a project of mobile school health buses but now these mobile school health buses,*

they also have a problem in terms of the maintenance, who is supposed to maintain them? because from the budget that they are having, they did not cater for the maintenance of these buses because these buses...it is only a bus, it requires the very same staff that must go and be in the buses to provide health services with the buses...clearly they did not think of these underlying factors, they only saw...people can't reach the clinics...sometimes it is politically motivated, they want to bring the clinic to the people, now bringing the clinic to the people impacts on other people's budget because they only bring a bus, here is a bus...it looks good, it has everything it has top technology but now the maintenance...the people who have to manage, for the bus to be on the road they must apply for permission from the traffic department...there is nothing that they provide, they just bring the bus...the bus cannot travel without permission from the traffic department...you see there are all those underlying factors...it is a good service that we want but now people embrace the buses but once they receive the buses, all these challenges came up..."

- Budget

Budget constraint is one of the issues that came up as challenge to the implementation of the ISHP. The three main departments, health, education and social development have different priorities and they include budget priorities. This was perceived as a challenge by most of the respondents because the departments have other priorities that take precedent over ISHP which has become an implementation challenge. The department of health has decentralised the budget for school health services to the districts which is meant to make it easier because the districts will plan and buy whatever they need such as more staff and equipment but there is still a problem as one responded put it *"Budget can also be a problem, remember department of health has overspend in two consecutive years...so we were trying by all means to utilise... whatever budget that was there was taken to the department of health. So the Department of Education had to bail them out, so they had to prioritise...so they had to make do with whatever they have like the human resources..."*

4.2.4 Implementation context and infrastructure

The fourth theme that emerged was implementation context and infrastructure. When asked about the importance of context or environment in implementation of the ISHP, the respondents pointed to different aspects.

It was pointed out that in order for implementation of the ISHP to take place; the environmental context in which it is being implemented becomes a huge consideration because there are issues that are critical such as the historical and cultural contexts, the socio-economic status of the area in which the school is located as well as demographics of the school. Although these factors do not necessarily change what is being offered in terms of the health services but these do dictate the way in which the health teams offer services in the particular schools for example in rural school they in most cases take longer with explanations and the time spent there is longer due to the greater need of the health services in those areas.

There are things that are not available in some rural schools such as electricity which can make it hard to work for the health teams though not an impossible task as one participant commented *"The other thing that they have to acclimatise with is that in other rural schools is that previously there would be schools that do not have electricity so in such instances we even went to the extent of buying audio meters that use batteries but fortunately now most of the schools have electricity but as to rural and urban our nurses I must say they do adapt"*

Another respondent commented *"That is important not that because it is very different I mean if you present a programme..if the school health programme is in an area that is well resourced...the local clinic visits the school, some school have their own nurse...in such a school you are not going to have such a big intervention...you will still have to intervene but it will not be that much but if you go to a school in an area..or a more rural area...these children are waiting just for the service...the service is required and there you must also come with everything...you cannot give a watered down service...because it is far out so you need to understand where you are going to...context is very important...say for a social worker...and you find out that a child is being neglected and there must be some kind of intervention...if you*

are here in town or a city...it is easy to refer this as things are closer...but if it is far...you have to physically remove the child from home, the child must be taken where there are services which also has impact on the child...transport and emotional issues...so context is very important"

To address some of the contextual issues, the Department of Health at times requests the Department of Education to give them a list of schools which they think would better benefit from health services that are offered and they sometimes look at underperforming schools to check if health is related to the performance (or lack thereof) of the schools. One of the respondents said that *"each child has to be accommodated; because backgrounds differ...we must look at socio economic factors of each child not just the area and sometimes situations change overtime...you know a parent dying or something like that.."*

Infrastructure is a part of the forth theme that emerged; when respondents were asked about the importance of infrastructure in the implementation of the ISHP. The respondents were all in agreement that in order for the ISHP to be implementing fully within the Gauteng schools, infrastructure is a necessity. The respondents pointed to a few challenges that they are facing with infrastructure in trying to implement the ISHP. The challenges included: having no room or privacy within most schools for the health teams to work in; most schools do not have a sick room or a health room as others refer to it; inadequate toilet facilities within some schools, some schools have unhygienic toilet facilities for the learners; inadequate space for physical activities; some schools have no kitchen for school meals to be prepared

One respondent pointed out a concern she had *"You know we don't have a sickroom and this bothers me so much...because I would have a learner in class who is sick and he or she has to just sit there until we can get medical attention..."*

The respondents contended that the challenges above are some of the things that make it difficult for implementers of the ISHP to do or carry out the mandate of the policy. Most of the respondents said that for them to carry out what they are meant to do regarding the policy, the environment must also be conducive to the requirements of the policy and services offered through the policy. One responded remarked *"...we*

can make the environment suitable for the implementation of the policy that is how it should be..."

The reason behind these challenges of infrastructure still exit was perceived by some of the respondents as: red tape within departments which are responsible such as the infrastructure directorate of the department of education; communication problems within departments and other departments or other stakeholders which could in fact help the schools faster such as partnering with local municipalities or local environmental health officers; shortage of resources including human resources.

A responded said *"...like we have the infrastructure directorate within education department...so whatever challenge like blocked toilets we try to rope in whoever can assist but we do have our infrastructure directorate but in our case it take ages for the problem to be resolved, people are sitting with a lot of problems that we could have resolved as the department. We just refer those that cannot be solved to them, when it comes to infrastructure there is a directorate that is responsible for that...we write reports, I write reports and send it to my boss, he sends it to his boss and his boss to his boss etc., but then the follow up issue is a problem within the department because we need to follow up. This eventually de-motivates the schools, because we try by all means that all schools are health promoting schools, where healthy lifestyles are promoted in each and every school..."*

Some of these challenges are being mediated by the departments involved especially the department of basic education and the department of health. The department of education has bought screens for schools to for privacy of the learners when they are being examined. The department of health is said to be trying to liaise with the local municipalities so that they can work together and make the health of children everybody's business. These are however not enough to mediate for all the challenges faced due to infrastructural issues.

4.2.5 Relationships and implementation management

Relationships are the first part of the fifth theme of the findings. There are differing views or perceptions by the respondents on the dynamics of the relationship between the DOH, DBE and DSD in the implementation of the ISHP. The

relationship between these three departments is critical in ensuring the implementation of the ISHP as they are the main custodians of the ISHP.

One view from the majority of the respondents was that the relationship between the three departments is very good especially the relationship between DOH and DBE. The two departments are getting on well as they work together, most were grateful that ISHP was developed because now they can work towards a common goal as one respondent stated *"ISHP gave us direction, there is no more fighting for territories...yes we work for the common good now...to ensure that the learner gets all the services that are expected for them to get. Yes it has improved a lot it is only in the districts but we are trying our best..."*

They lamented however, over the lagging behind of the department of social development, saying it has not been really on board with the ISHP although they have started recently being involved *"You know now I think there is a good relationship between education and health, I think because of this policy and social development but with social development it is still moving slowly because of lack of social workers...but there is...a relationship is formed"* this is a commentary made by another respondent.

Another view on the relationships of the responsible departments by the rest of the respondents was different in that they felt that there is no integration between the departments, they still work in silos although they say things have improved. One responded said *"...but you know with health...it is a bit different because they are organised a certain way... they have such clear things...they don't do this, they don't do that....um really saying with this er...for I think for when things don't go well with departments is when it comes to budget remember each department has got its own budget...they have got their focus...so when we work together it is fine but as soon as you say you bring in money, that is when...we must ask higher up the ladder...that can hinder implementation..."*

Another responded mentioned that *" I think it is....you know...there is no integration, there is no proper communication...it is there but it lacks something because one department will come and the other will come and be shocked that the other is here...so there is no integration...one cannot do without the other because they are intertwined but we don't see that..."*

The management of implementation of the ISHP is the second part of the fifth theme.

The respondents raised a few concerns about the management of the implementation of the ISHP:

- Demarcations

The departments of health, education and social development have got differing demarcations. An example of this is that the GDOH has got five regions at district level and the DBE has got 15 regions at district level. This creates an overlap of regions where in some cases schools are left out in receiving health services because, one official from health will be dealing with certain schools in an area and told that other schools are not in his or her region another official would have to take over though they are in the same area. This creates a monitoring and evaluation 'nightmare'. A responded commented on this saying *"So you find that I as a district official in education I have got more than one health officials because our demarcations overlap. Sometimes my schools fall under another directorate, I will make an example like at Sedibeng and Ekudibeng the barriers that are there, some schools fall...for a health official, it will be his or her region, for me it might be I have to work with this one, work with this one and work with this one depending on my schools where are my demarcations..."*

- Involvement of other stakeholders

The involvement of other stakeholders in the implementation of the ISHP especially by the communities, other teachers and NGOs is perceived as lacking. Most respondents feel that the information about the ISHP has not really filtered to the communities in that they are not aware of it. Some maybe aware of the services offered through the ISHP but some of these respondents feel that if they don't know the policy and what it is trying to achieve. The communities especially the parents will not be able to enforce what has been done and learnt at school because ultimately the learners will value what is taught at home more that at school.

"... also the issue of...we have not much driven the issue of healthy lifestyles even to involve the community around the schools because for the child to learn the importance of healthy lifestyles and it's only in schools but when the go out it is two different worlds...whatever things they inculcate at schools they must be able to

implement them in their daily lives even at home...I think we are still lacking in roping in the entire school community...we are more focused on what is happening within the school premises forgetting that health issues impact even the environments that are surrounding the schools...the parent even the community at large that is surrounding the schools, so it is important to make sure that ISHP is extended to the school communities because they need to understand why is it important as parents that their children maintain a healthy lifestyle even at home..." this is a commentary from one of the respondents concerning community or stakeholder involvement.

- Clarity of roles

Most of the respondents felt that there are guidelines for implementation but the roles are unclear for some of the implementers of the ISHP. Some felt that they were not really sure what their role was and this makes it is difficult to implement all that is required.

- Monitoring and Evaluation (M&E)

Some of the respondents felt that there is a problem with monitoring and evaluation of the policy and the services offered through it. The respondents believed that the way they are chasing targets (trying to meet the numbers and deadlines) for learners and with the shortage of staff, monitoring and evaluating the policy is difficult because they are rushing through, leaving no time to reflect of what works and what does not work in order to take the lessons forward and learn from them. In the future, it will be even harder to monitor and evaluate the policy and the programmes offered through it because of some of these factors. Another one of the issues with monitoring and evaluation is that there seems to be confusion with reporting lines for the ISHP between the responsible departments, making it is a complicated issue to monitor and evaluate the progress of the policy implementation so far.

4.2.6 Implementation perceptions and opportunities

Perceptions about implementation of the ISHP by the stakeholders are the first part of the sixth theme. The way in which the stakeholders and the beneficiaries or recipients of the policy or services offered view the ISHP is very vital to the

implementation of the policy. Perceptions of the policy are also indicators of the value placed by the stakeholders on the policy.

Most respondents indicated that those community members and parents who know about the health services but not necessarily the policy are happy with the services offered; they see the value in it because their children benefit from it. The learners themselves are appreciate the services offered by the through the ISHP by the health teams.

A commentary by one of the respondents *"...they are seeing it positively, they see that we are not only coming there to provide health care, they see that this health care is there to assist learners to develop well or even to reach their goals of learning because if a child does not hear well, does not see well, is ill and is not attended to, he or she will not be able to pass or proceed well with the school, so they are taking it positively. Because even sometimes when our teams go to go to school, even some of the educators go to the nurses for some health advices or even the community because with school health services we are not only providing services to the learners only but also to the entire community, that is why we are linking it with the Ward Outreach Based Teams (WOBT) that is in Primary Health Care Re-engineering, to say when our school teams have visited the school and they have identified that there are several problems with the schools they have to link with the Ward Outreach Based Teams so that these teams can go in to the community to also inform the community members about health related issues that they need to be taking care of..."*

The perceptions about the policy are generally positive, but for lack of information and education about the ISHP some parents are said to be indifferent to the policy and the health services offered through it. In some cases the learners would be given medication and instructions for the parents by the nurses but only to find that the medication has not been administered on the learners by the parents even though the parents gave consent, they would rather give them 'traditional concoctions' that in most cases the conditions become worse than before. *"...for example you saw the learner with severe ringworms on his head...the parents are saying they use traditional medicine and it has not been working...if the parents are well informed...we have parents who allow their children to be treated by the nurses*

*but they will not use the medications given to the learne*r..." this was noted by a respondent.

There are opportunities that respondents felt were not being taken into consideration in the implementation of the ISHP that could be explored. The opportunities identified by the respondents included: 'school health services need to be decentralised even to the clinics', continuous collaboration between departments and all stakeholders, involve departments such the Department of Sports and Culture to assist with physical activities in schools, local municipalities to assist with things that can be fixed in schools quickly such as unblocking of toilets and environmental health without the red tape of going through other directorates such as the infrastructure directorate ; there are opportunities to bring awareness of the policy through local media, weather print or television, through community meetings, partner more NGOs as they are closer to the communities and will be able to bring awareness of the ISHP faster to the communities.

There is an opportunity to ensure that all educators know the policy not just about it and become involved in it, it must not be just for the health coordinator in schools. There is also an opportunity to bring in retired nurses to work as school health nurses and recruiting new staff to close the staff shortage gap in order for full coverage of the ISHP to happen in all corners of Gauteng.

One responded stated *"....we are looking at opportunities such as job creation....for me I think we have got a lot of people who could assist in terms of driving this because some of the things that have been highlighted is issues of resources, limited resources and limited capacity in terms of having the nurses that will reach all these learners but I must say that we have go a lot of pensioners....the nurses that could be utilised to be school nurses because of the limited number that we have they are not able to reach out with the schools, hence we have a target...we do school A, school B... the third school we cannot reach it because of the number that we have....therefore it is an opportunity of creating jobs for the people..."* it was also pointed out there is an opportunity to create jobs within the departments where specialists can be appointed and their focus would be on children's programs. The specialists would ensure that they own the program and run with it as fully as possible rather having people who have to set things on the side in order to attend to

the ISHP duties. The respondents noted that it is also about empowering r communities because one talks about children, one cannot leave out the parents and creating sustainability *"..what are doing with the parents of those children....we will vaccinate now but who then follows up after..."* a remark from one of the respondents.

4.3 Field notes and observations

As the researcher of this study there are things that I noted and observed during my time at the two schools that I visited with the purpose of doing this research study.

I visited two different schools in two different districts within Gauteng. One school was in a rural area whereas the other one was in an urban township. I noted a few similarities as well as a few differences with regard to the environment and the ISHP implementation.

The similarities were as follow: they were both very neat schools in previously disadvantaged areas; the urban school was larger than the rural school but they both did not have much space for physical activities, no play areas for the learners; overcrowded classes but they made do with what they had; they had helpers from their communities.

The differences were as follows: the rural school had a kitchen to prepare meals for the learners whereas the urban school had no kitchen, they use the caretaker's small kitchen; the rural school had a functioning food garden whereas the urban school used to have but not fully functional anymore; in the rural school the parents are mostly illiterate from a previously farming community, the urban school had a mixture of backgrounds from very poor and illiterate to middle class; the rural school is a fully functional health promoting school with full awareness of the ISHP, the urban school was not a fully functional health promoting school and had less awareness of the ISHP; the rural school has an educator who is a coordinator for School Based Support Team (SBST) which is an ISHP implementation support team in the schools, the urban school has a health coordinator who is not part or even aware of the SBST

During one of my visits to the rural school, there was a mobile clinic present. What I observe was that the learners were excited about the clinic being at school as they

had been expecting it. The educators were supportive of the learners in going for their health assessment especially the SBST coordinator; she was very passionate about her duties as a coordinator. There were only two people within the mobile clinic as part of the health team, the school nurse and the administrator who was also the driver of the mobile clinic.

This was an indication the shortage of staff as lamented by all the respondents. They were a lot of learners as well as some teachers who went in for assessments but the staff was not enough to cater the need which made them overwhelmed and tired and were rushing through the work so as to reach the targeted learners. This then confirmed also what the other respondents were saying about having to rush through the services and having no time to reflect and monitor and evaluate the health services that have been offered and the impact thereof.

While visiting the rural school, I had an opportunity to speak to some of the parents who were waiting for their children while the mobile clinic was stationed at the school. They indicated that they do not know about the policy but they are aware of the health services offered at the school and they appreciated the services offered to their children. They said they would like to be a part of the ISHP and they would like to know what it is and what their role in implementing it would be.

4.4 Conclusion

This chapter presented findings that resulted from data collected from field research. It presented the outcome of one on one interviews with respondents as well as documentation of the field notes and observations of the researcher.

The next chapter is an analysis of the collected data that was presented in this chapter.

CHAPTER FIVE

5 DATA ANALYSIS

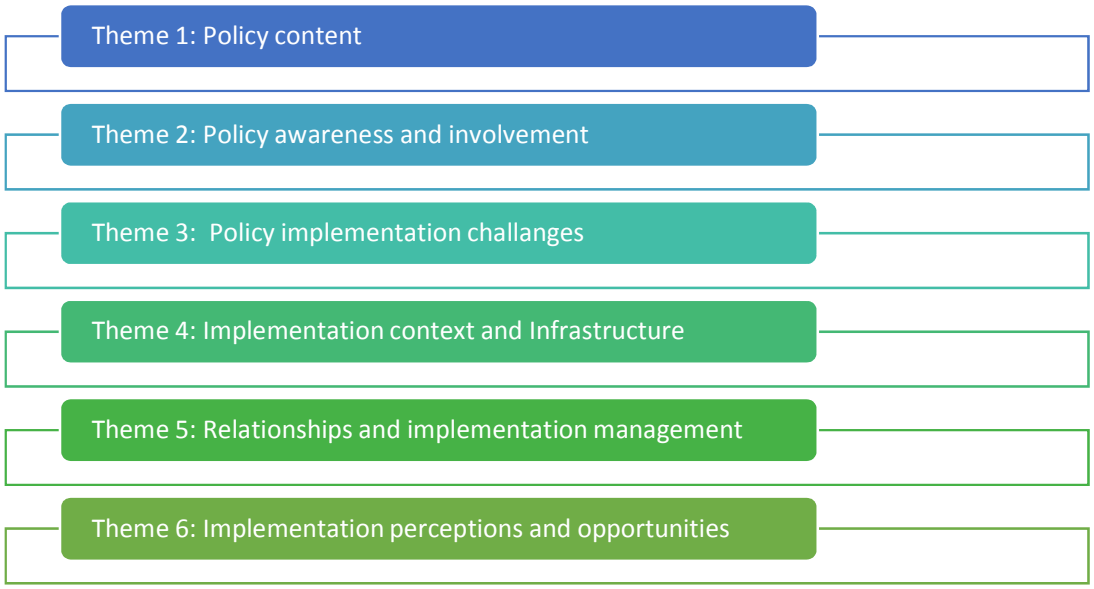
5.1 Introduction

This chapter is taken from the case study findings as depicted in the preceding chapter (chapter 4). This chapter first analyses, discusses and interprets the findings from the responses, field notes and observations as well as reflecting on the theoretical framework that emerged from the literature review.

The findings are interpreted around the key themes that came from the findings and the literature review.

The chapter concludes with a synthesis of the key issues that lead to answering the main research question of the study and in the processes reflecting on the sub questions that support the research question. The case study was based on the following themes:

Figure 6: Themes of the case study



(Source: Shilubane, 2015)

5.1.1 Policy Content

Considerable strides have been made by the responsible departments, especially the Department of Health in developing the Integrated School Health Policy which is an upgrade from the previous School Health Policy. A lot of effort had been put into the development of policy by ensuring inclusiveness of other stakeholders. Unlike the previous school health policy, there is consensus on the need for this policy by all the stakeholders and the schooling community and communities at large. There appears to be political willingness to make the ISHP work as evident by the coming together of the three ministers of the departments of health, education and social development to make this an inclusive policy with the aim of making it work for the sake of the 'South African child'.

School health is relatively new in South Africa as compared to the developed world. The introduction of the ISHP is a step in the right direction; the Gauteng departments which are key role players (Health, Basic Education and Social Development) in implementation of the ISHP have in a way embraced the policy and are well intent on making sure that it is implemented and that the learners as well as the communities benefit from it. The championing of the ISHP implementation process by the three key role players is a political mandate.

There should be an intentional way by which the policies and programs build capacities of families and their communities in the development of health policies that relate to children is what the literature suggests. The policy programmes must be intent on improving knowledge, attitudes and skills, improving health behaviours and health outcomes, improving educational outcomes goals is improving social outcomes (Mistry *et.al.*, 2003; Kolbe 2002). The ISHP clearly covers what the literature suggests.

The literature on policy implementation suggests that there are multiple ways in which policy can be implemented. Implementation of policy involves many actors and it is unique to each situation (Brynard, 2000). The most argued ways of implementing policy is the bottom up and top down approaches to policy implementation. The implementation process of the ISHP was intended to be a bottom up approach, however so far within Gauteng the impression of the implementation approach has been that of top down approach rather that the bottom-up approach. The lack of

consultation and involvement of other stakeholders gives an impression that it is from the top down. The current focus of the ISHP has been well received in Gauteng there are however suggestions that there has not been much consultation with people on the ground when the 'powers that be' of what the focus of implementation should be and this has created an impression there the implementers do not have much of a say on how implementation of the ISHP should be done.

5.1.2 Policy awareness and involvement

Awareness of policy by all stakeholders is critical to implementation. In the case of ISHP, there is a large gap in raising awareness by the responsible departments to all the stakeholders. This gap in awareness has created a vacuum that can only be filled by the involvement of the relevant stakeholders in the implementation of the ISHP.

Stakeholders such as parents and their communities can play a very large role in ensuring the maintenance and sustenance of health and healthy lifestyles of their children who will in turn become responsible members of their communities. Having children that are healthy reduces the stress on the health system of the country or in this case the province of Gauteng. The health resources of the country are already in distress as it is due to limited resources and budget. This is supported by LeGreco and Canary (2011) that in order for school health policy to be sustainable, engaging the parents, students and all the other stakeholders is important, communication to these parties is critical

5.1.3 Policy implementation challenges

It is the prerogative of government to make decisions and to manage resources in order to achieve goals that have been set out. This is case of the Gauteng provincial departments of Health, Basic Education and Social Development regarding the ISHP. There has been good progress made and good practices that are being carried out in the implementation of the ISHP within the province currently. As literature contends, there is no one particular way of implementing policy, as to where policy implementation starts or ends, the debate is still on (Brynard, 2000) and likely to continue for a long time.

Bearing in mind that policy implementation is unique to each situation, Brynard (2000) says that there five variables that shape implementation direction and are fundamental to effectiveness of policy implementation. The variables include ***Content***; and in this case study the policy is *distributive* (the creation of public goods for the welfare of citizens), ***Context***; ***Commitment***; ***Capacity***;* as well ***Clients and Coalitions***. These variables are said to be interlinked and interdependent, meaning one cannot be there without the other. ISHP can only be effectively implemented if the above variables are present.

Great steps and leaps have been made toward the implementation of the ISHP since its inception in 2012. Like any other policy, there are implementation issues and challenges that are causing impediments in the implementation process. The impeding factors that must be taken into to account are not limited to but include:

Ownership- there is a lack ownership of the policy or programme by most of the stakeholders including the responsible departments. ISHP must become everybody's business.

Responsibility/ Accountability - there is a shifting of responsibility that is evident, the departments have reporting line issues that make it easy for people to shift responsibility thus leaving no one accountable for the implementation of the ISHP in certain departments and their districts.

Communication - there are no proper channels/processes of communication or strategies that have been established in order to fulfil the implementation mandate of the ISHP. Literature on school health policies suggests an open communication process due to the intricacies of school health policies programmes as they involve many role players. LeGreco and Canary (2011), suggest a four frame communication process that assists in sustainable school healthy policy by engaging the parents, students and all the other stakeholders in health policy. The four frames are orientation, amplification, implementation and integration

Planning /Team work - Although work is being carried out, health services are being rendered in the schools; there is still an issue of lack of collaboration between the departments and within as well as between stakeholders. Districts and other departments are still working in silos, making it difficult to share best practices as

well as resources and working together to achieve common goals. Collaboration is what literature suggests; this enables resources to be optimally used and to share what works and what does not in implementation.

Human resources/capacity - there is a shortage of human resources to carry out the implementation of the ISHP, this makes coverage of the ISHP throughout the entire Gauteng close to impossible. This has also created loopholes for the school health teams to rush trough their work in order to get to the next school which leaves less than desirable results in the work that has been carried out. Some schools and learners are being skipped which is creating a vicious cycle of unhealthy learners as they are being left behind and because of the targets, for some of these learners will be out of school by the time the school health teams return to the schools. Although training of implementers is happening is some areas, there is a capacity gap that need to be bridged.

Awareness - without awareness and knowledge of the policy a big gap that can actually be easily filled is being opened. Awareness of the ISHP is not enough especially amongst the parents and the communities at large. Involvement of stakeholders is vital to the sustainability of the policy and its programmes.

Transport and Equipment – transport for the health teams is still a problem although there has been progress made. The procurement of equipment is happening but at a slow pace due to budgetary constraints.

Budget – The competing priorities of the three main departments have a major impact on the ISHP budget, the Department of Health is a major contributor to the ISHP budget followed by the Department of Basic Education. Due to constraints on the budget, ISHP implementation is taking a strain,

Monitoring and evaluation – there is no monitoring and evaluation that is visible currently with the implementation of the ISHP.

5.1.4 Implementation context and infrastructure

Implementation of the ISHP is carried out within the restrictive structural environment of the South African schools and health centres. It appears that the context in which the implementation of the ISHP is taking place plays a role in the effectiveness of the

policy implementation. The three responsible departments are doing a good job in identifying school or learners that need the health services offered through the ISHP the most.

Literature supports the importance of contexts when implementing policy, there are that Braun *et.al. (*2011) argues must be put at the forefront before implementation takes place. These issues are termed 'contextual dimensions' and they include school histories, intakes, settings and locality; values, experiences, teacher commitment; budget, staffing buildings, technology and infrastructure; the quality and support of local authority as well as pressures and expectations form the broader policy context such as legalities and responsibilities.

There is some indication that the cultural and historical contexts are being taken into consideration when implementing the ISHP. For example schools have been divided into quintiles, quintile one being the least resourced or poorest schools and quintile five being the most well resources school, for now the focus of the ISHP is on quintile one and two schools without completely removing the focus on quintile three to five schools. The division of schools was done based on the history of South Africa of segregation based on the skin colour of learners, the historical 'black schools' were the least developed with least resources whereas the historical 'white schools' were the most well resourced schools with good infrastructure. So in trying to mediate and close the gap, the schools have been divided into quintiles by the department of Basic Education.

There three responsible departments are struggling when it comes to infrastructure this is a dilemma mostly for the Department of Basic Education. Lack of infrastructure does not necessarily prevent health services to be provided within school through the ISHP, it does however cause challenges in delivering of the services and sustaining the health promotion education. Where there is no adequate infrastructure, more resources are required to be brought into the schools by the school health teams, such as mobile units and screens for learner privacy. Whereas where there is infrastructure there is no need to bring all the extras because there is room to conduct medical assessments.

Space for physical exercise is a challenge when they are trying to encourage and promote physical health and exercise for the learners. There are issues of toilets that

are inadequate within schools or just not up to standard as there are schools that do not have flush toilets and schools that do not have running water. These are issues that make it is difficult for health promoters to educate learners about hygiene and for the health and healthy lifestyles education to be sustainable. The infrastructure some cases does not support what the ISHP is trying to achieve through the services and health education being offered. There a problem of disconnect within departments such as the DBE's infrastructure directorate and the other directorates in providing and this is due to red tape which delays requests by the schools and school health specialists. Conditions and the environments have to be conducive for the ISHP to be implemented as set out in the policy itself.

The responsible departments have tried to mediate by bringing mobile clinics to the schools, buying screens for privacy and other equipment to carry out what the ISHP dictates. This is however not enough as it is not sustainable due to budget constraints.

5.1.5 Relationships and implementation management

Relationships between the three responsible departments have improved since the inception of the ISHP. However, there are communication and collaboration problems that are still evident between the departments which are a hindrance to implementation of the ISHP. The relationship between the departments and other stakeholders such as NGOs, local municipalities and other departments such the Department of Sports and Culture regarding the implementation of the ISHP is either shaky or non-existent at the moment. These relationship dynamics are in opposition to what Lankarani and Joulaei (2011) support that "*There is an urgent need for a close collaboration between health and education authorities as this will ensure a full education for all children...*"

There are gaps that are evident in the management of policy (ISHP) implementation in Gauteng. The gaps include lack of clarity of roles for some of the implementers within the three departments such as health promoters and social workers and stakeholders such as NGOs in relation to the ISHP. Some of the implementers do not really know what their role is in the implementation of the ISHP. This is caused by unclear communication channels, and reporting lines. Another gap in managing the implementation of the ISHP is the lack of involvement by stakeholders such as

parents and the communities. Without the involvement of parents and their communities, school health programs or policies cannot be effective as learners are part of the community and their parents or guardians have the ability to enforce what has been taught at school in terms of heath and health lifestyles. If they are not aware and have no input or contribution in how the ISHP is being implemented, they will not encourage their children to see health and healthy lifestyles as vital to their well being. The literature states that different situations at different times call for different approaches to leadership; thus there is no one leadership approach that will solve all public policy. Literature supports that stating that planning which involves collaboration of stakeholders is more resourceful and it is politically sound as it means shared knowledge and understanding including capacity and interaction.

5.1.6 Implementation perceptions and opportunities

Perceptions of implementation of the ISHP by the stakeholders and all beneficiaries are important. It is evident that some of the stakeholders, who have a vested interest in the ISHP, appreciated the services offered through the ISHP. They do not necessarily know what the policy entails, therefore their involvement ends in perceiving what is being offered through schools but they do not understand their role in implementation of the ISHP. Their contribution is therefore not really being put to the forefront; it therefore seems not to be valued in practice though in theory the policy acknowledges the valuable contribution of the stakeholders. This stands in contrast to what the literature advocates for, that a community environment that values health and wellness is invaluable. Simmons (2011) says that the voice of the user is usually as a result of what they have perceived and judged as poor or good public services.

There are opportunities that can be explored to ensure that implementation of the ISHP takes place in Gauteng to capacity. Noting that the three responsible departments have made great strides in implementing the ISHP, there are still problems that can be mediated by some of the opportunities that have been identified. The departments have so far not taken advantage of the opportunities such as hiring retiring nurses, which is subject to budgetary constraints. There are however other opportunities such as bringing awareness and ensure involvement of parents and communities in the implementation of the ISHP by being part of

community meetings where the ISHP can be brought to the fore in educating the community about it. Making use of available resources such as the services of the local municipalities is an advantageous opportunity to push forward the implementation of the ISHP. The fact that there are opportunities; it shows that it is never too late to make changes that will effect implementation positively. Agron *et.al* (2010) and Brynard (2000), support the mobilisation of student support as well as involvement; increasing awareness, training of school governing bodies, teachers on developing, implementing and monitoring health programs; communicating the policy and partnership building as opportunities that should be pursued.

5.2 Field notes and Observations

There is an understanding and an appreciation that the health of children is fundamental the holistic development of a child both in the school environment and in the communities in which they live. The schools visited are neat and the educators ensure that the environment in which the learners obtain their education is clean regardless of the infrastructure that is there.

Despite the fact that both schools have school health coordinators, knowledge of the ISHP is limited, there is a need to educate all the teachers on the ISHP ensuring understanding. If teacher or educators know about the ISHP it will be easier to transfer the ISHP knowledge to the learners and the communities, knowledge of the ISHP should not be limited to one particular teacher because the burden becomes too much on that educator.

There schools would be better served if the infrastures could be improved and health promoting education would be done in an environment that is conducive to the demands of the ISHP.

5.3 Responding to the Research Question

The purpose of this research study was to explore and establish factors that interfere with the implementation of integrated school health policy; and investigate the extent to which the factors influence its implementation from the policy experts and implementers within Gauteng DOH, DBE and DSD.

In order to achieve these objectives, the internal and external elements which are present in the implementation ISHP had to be ascertained. This was done through and examination of the literature that related to the ISHP and its implementation as well as in-depth interviews with the relevant respondents and field observations.

What transpired during the study was as follows:

There is no denying that the ISHP has brought about change in school health, it is one of the greatest things that could have ever been done for the South African school health system. It is different from the previous school health policies or programmes because it is inclusive and accommodating of different departments and stakeholders. There is a realisation that heath of a child is all encompassing, and that a child is a member of a community; therefore healthy communities contribute toward a healthy nation and a positive outlook.

Implementation of policy does not happen in isolation. There are so many factors that must be considered when implementing policy. It involves many actors and many levels that must always be considered. The ISHP is no different, it is an intricate policy that requires many role players in order to make it work and ensure that it is implementable and sustainable.

Effective implementation of policy can only happen in an environment that is conducive and supportive. While the departments that are the main custodians of the ISHP have made great leaps in the creation of environments that support the implementation of the ISHP. There is optimism about the policy itself and the future it has if implemented properly as well as the benefits it will bring.

The ISHP has created a platform in which departments and other stakeholders can interact and work together for a common goal. ISHP has created a way in which learners and the communities in which they reside or a part of can benefit and encourage healthy behaviours and lifestyles.

Analysing and interpreting the data enabled the conclusion that environmental and contextual, technical and managerial elements which include lack of communication are the major inhibitors of the implementation of the ISHP and they have an influence on the direction of the implementation of the ISHP. In this, the key objectives of the research were met.

5.4 CONCLUSION

This chapter gave a depiction of the research findings through the analysis, discussion and interpretation of the findings from the responses, field notes and observations as well as reflecting on the literature review. It also looked at key issues that lead to answering the main research question of the study and in the processes reflecting on the sub questions that support the research question.

The next chapter concludes the research study and gives recommendations.

CHAPTER SIX

6 CONCLUSIONS AND RECOMMENDATIONS

This chapter presents the conclusions and recommendations of the case study; it also suggests areas of research.

The recommendations will focus on areas where positive change and difference can be made as well as areas of possible influence.

6.1 Conclusions

This case study's purpose statement was to explore and establish factors that interfere with the implementation of integrated school health policy; and investigate the extent to which the factors influence its implementation from the policy experts and implementers within Gauteng DOH, DBE and DSD.

The study consists of Six (6) chapters that have been presented with the aim of answering the research questions and realising the purpose statement. The chapters were presented as follows: Chapter One (1) looked at the overview of the South African Health System, the overview of the South African Integrated School Heath Policy, the background to the problem, the problem statement, the purpose statement and the research question. Chapter Two (2) which was the literature review was to give an appraisal on the literature related to school heath policy implementation and the management thereof. The key concepts that emerged from the literature were policy structure, clear policy guidelines, governance, and sustainability, commitment by authority, training and development of staff as well as awareness of students, teachers, parents and the community at large. Chapter Three (3) was the research methodology which gave a description of the philosophical orientation of the research and the research strategy that was selected to conduct the research. It provided details of the sampling and considers the ethical questions relevant to the research and the primary research instrument that was used was the semi-structured interview schedule. Chapter Four (4) gave

presentation of findings that resulted from data collected from field research. It presented the outcome of one on one interviews with respondents as well as documentation of the field notes and observations of the researcher. Chapter Five (5) gave a depiction of the research findings through the analysis, discussion and interpretation of the findings from the responses, field notes and observations as well as reflecting on the literature review. It also looked at key issues that lead to answering the main research question of the study and in the processes reflecting on the sub questions that support the research question. Chapter Six (6) concludes the research and offers recommendations.

The Integrated School Health Policy is a policy that South Africa can be proud of. It offers opportunities to improve services delivery to young South Africans who are often overlooked when it comes to service delivery. This study explored the implementation management of the ISHP in Gauteng. The research involved the investigation into internal and external factors that interfere with the implementation of the ISHP in Gauteng. A qualitative case study research was conducted. In-depth semi-structured interviews of key informants were used as primary data collection tools. This approach uncovered intricate relationships as well as complex and interrelated factors that have an influence on the implementation of the ISHP.

Results reflected that there has been an improvement from the previous school health policy. There are factors that interfere with and are a hindrance to the implementation of the ISHP; the results revealed challenges that are related to the environment, technical and management capacity that are hindrances to implementation of the ISHP. These have led to loopholes that include inadequate participation of stakeholder in the implementation of the policy. The factors that have been identified were present in the previous school health policy, they are not particularly a new phenomenon.

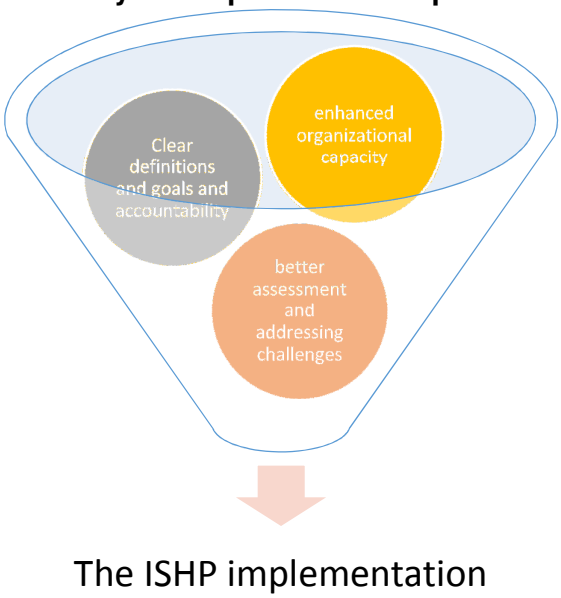
This research provides the responsible Gauteng departments with recommendations for improving the implementation process of the ISHP in the immediate future. The conclusion of the study is that that there is no ‘one way’ of implementing policy but ways to remove or bypass some of the hindrances to implementation can be found.

The ways to improve implementation of the ISHP must include as illustrated in the figure below: the enhanced organizational capacity; clear definitions and goals and

accountability; better assessment and addressing challenges of the ISHP implementation

This study could help the identified departments in planning the implementation and coming up with solutions to curb the barriers, change some of the perceptions and make use of the opportunities that present themselves during policy implementation

Figure 7: illustration of ways to improve ISHP implementation



6.2 Recommendations

The following recommendations are proposed:

Policy content

The content of the policy is on par with the world standards for school health policies but it would be advisable to continuously involve all the stakeholders as there are school no policies or programmes that are 'one size fits all'. The implementation variables that are suggested in the literature review (chapter two) and highlighted chapter five of this case study are a must for implementation of school health policies

and programs to take place and they must be taken into account in the ISHP implementation.

Policy awareness and involvement

The campaign to bring awareness of the Integrated School Health Policy (ISHP) to the stakeholders and all the beneficiaries should be led by the executives or management of the three main departments (Health, Education and Social Development). This will enable those who are at the forefront of implementation to see the commitment by management and the importance of the policy and the health services offered through it. The broad terms of reference to the awareness campaign should include: taking stock of what has been done so far must be taken and do an analysis of the awareness needs; the development of a plan of action for the awareness campaign that will involve all stakeholders to get views and contribution; a deliberate and continuous involvement of all the stakeholders especially parents, all teachers and the community at large as well as learners.

Due to the nature of the policy, that is, being about health and lifestyle changes, knowledge and awareness of the policy by all stakeholders is imperative. The awareness and knowledge distribution of and about the policy must be continuous it order for it to be sustainable; it cannot be a once off campaign. Cost effective ways of campaigning such as educating parents and the communities during school meeting and community meetings without having to print or distribute material is one way of involving the stakeholders.

Policy implementation challenges

The challenges of the ISHP are interconnected and interrelated and cannot be separated in trying to address them. There are suggestions that could help eliminate some of these challenges:

A *communication strategy* development by all three ISHP custodial departments is recommended, this strategy should include information sharing. A strategy of this kind would encourage policy dialogue between stakeholders, the policy would be advocated for, and it could encourage and bring about innovation. Stakeholder participation would be more evident if encouraged to be part of the decision making.

As it is perceptible through the study that there are communication channel blockages, a communication strategy that encourages participation by stakeholders will clear up most of the blockages that have been identified.

The need for more staff or human resources is obvious. The shortage of human resources to cover the required targets for the ISHP is a huge issue for all three main departments. A *human resources strategy* should be developed specifically for the ISHP with the participation of all stakeholders. The strategy should bear in mind the budgetary constraints that all three main departments are faced with. Innovative ways that will increase the capacities of the current staff without necessarily increasing the number of staff is more sustainable and should be considered in the strategy.

Build capacity of the staff that is already in the front line is necessary; the human resources strategy should include training interventions such as formal training, in-house training and education actions.

Hiring staff on a part-time basis as the need arises could be another way of cutting costs but still getting the best possible work for the time that is needed.

Hiring new staff including retired nurses, retire social workers and the like is an option that can be considered and would create employment and increase capacity.

Continuous monitoring and evaluation plan, the challenges that are currently being faced in the implementation of the ISHP are not new to the South African school health programmes. Therefore a well thought out deliberate and continuous M&E plan that involves various stakeholders would be worthwhile if adopted in the implementation of the ISHP as it would give an indication and a picture of where the implementation is currently at and would help eliminate some of the challenges from the onset instead of waiting for years before it happens. This would allow the implementers and all the other stakeholders to share best practices and learn from each other.

Implementation context and Infrastructure

School infrastructure of most of the South African schools stem from Apartheid South Africa pre-1994, Gauteng is no different. There have been improvements

since then but the disparities are still evident especially the 'former black schools'. The development of infrastructures and environments that are conducive to the aim of the ISHP of changing health behaviours and lifestyles is of vital to the sustainability of the ISHP and behaviour changes.

There ways in which some of the infrastructure disparities such as not having room to conduct health assessments in schools are being mediated for by the departments especially Basic Education. The ways include buying screens to create privacy *etc.*, for the learners.

The mediation is not enough because in most cases they are not sustainable. Privacy screens will eventually wear out; mobile clinics already have sustainability issues such as maintenance and so forth and at the end money would have been wasted.

There has to be a deliberate investment in the school infrastructures such as proper toilets, rooms for health assessments to take place, proper kitchens for school feeding schemes, space and equipments for physical exercise. Investing in infrastructure is a sustainable way in which the health education can also be sustained and in the long run, the costs of maintains will be less compared to the cost of buying things that will not last.

This will create an environment that is conducive and will enable the school health teams to do their work well.

Relationships and implementation management

It is apparent that there are implementation management challenges with ISHP in Gauteng. It would be advisable for the revision of management roles to be had, a team of three people (it does not have to be new staff) should be put together from the three departments, that is Health, Education, and Social Development, these will be solely responsible for the management of the implementation and evaluation of the ISHP as well as reporting on it, they would work directly with the district officials. This would clear up some of the reporting channels issues; it would ensure that people are accountable. The roles of some of the first line implementers such as

health promoters, teachers and Social Workers as well as some district officials should be clarified.

The three departments should collaborate together to revise their respective demarcations that are causing confusion and leaving some learners not attended to thus causing more harm. The revision of demarcations would help with the implantation of the ISHP and other services that are interdepartmental.

As much as budget for the school health services is being centralised to the districts, there are still competing priorities for all departments involved with the ISHP. A budget should be set aside by each department and put together with the purpose of implementing the ISHP instead of having a budget that also has to cater for other departmental priorities.

Monitoring and evaluation should be done at an ongoing basis rather that than waiting for a later stage to do it. This will help counter some the problems that were experiences in the previous school health policy. Monitoring and evaluation of the ISHP should be done in a deliberate and calculated manner.

Implementation perceptions and opportunities

Perceptions of the beneficiaries and stakeholders bring about weight and value to what is being implemented (the ISHP). Perceptions play a large role in implementation because they are linked to the sustainability of the objectives of the policy and its programmes. It is therefore imperative for the beneficiaries to know and understand what the policy is all about, to be sensitised to it and be involved in the implementation as this will bring the policy into practice. It would be advisable to utilise the opportunities that have been identified in Chapters four and five to help with the implementation of the policy.

6.3 Further Research

Further research into the Integrated School Health Policy (ISHP) is recommended. The objectives for further research should seek to include: the role infrastructure plays in implementation of the policy; the relationships between stakeholders and the impact it has on the implementation of the policy; exploring the interdepartmental

relationships in implementation; investigating the impact of context in implementation of the policy; exploration and investigation into the role of accountability in the implementation of the ISHP; systematic assessment, prevention, and address challenges in the school environment.

This research report was divided into six chapters, starting with the introduction and background as the first chapter, the literature review as chapter two, research methodology was chapter three, the forth chapter presented the research findings, and then followed by the data analysis of the research which was the fifth chapter and the last chapter was chapter six, it concluded the research and gave recommendations.

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APPENDIX A: INTERVIEW SCHEDULE

Introduction

My name is Nhlanhla Shilubane; I am a student studying for a Master of Management at in Public and Development Management (MM P&DM) at the University of Witwatersrand. The research that I am conducting is for the partial fulfilment of my Master degree. You have been identified as a policy expert or policy implementer within one of the three departments identified; hence you have been selected for this study. Please assist me by answering questions that I will be asking shortly. The interview should take about two hours. Please note and be assured that your responses will be treated as confidential and used solely for the purpose of this research. Should you require feedback, please contact Nhlanhla Shilubane at this email address nhlanhlashilubane@gmail.com and the results will be made available to you.

I would like to thank you in advance for taking your valuable time to complete this questionnaire.

Section 1: Interviewee Biography

Name	
Profession	
Organisation	

1. What position do you hold within DOH/DSD/DBE/ School?

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2. What are your main responsibilities?

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3. When did you start working in the department/ position?

Section 2: About the Policy

4. What is your understanding of the integrated school health policy?

- **Probe:** What are the main focus issues that the ISHP should be focusing on?

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5. What would you consider to be very important in ensuring the policy gets fully implemented?

- **Probe:** In your view, what do you think is currently working in the implementation of the policy?

- **Probe:** Has the policy been published enough that all stakeholders are well acquainted with it?

Section 3: Policy Implementation Challenges

(With any policy comes implementation challenges)

6. In your view, what do you think are the major impediments (hindrances) to the implementation of what has been set out in the ISHP?

- **Probe:** How are these hindrances affecting or influencing the implementation?

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7. What do you believe are the causes of these hindrances?

- **Probe:** Are there guidelines for the ISHP implementation?

- **Probe:** How important is guideline uniformity when implementing the ISHP?

Section 4: Implementation Context and Infrastructure

8. How important do you think the context of location is when implementing the as school health policy?

- **Probe:** Is the environment of where the ISHP is being implemented critical in ensuring that proper implementation is taking?

- **Probe:** Is there a difference in how implementation takes place based on the environment of the recipients of the ISHP?

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9. How important is infrastructure in ensuring that the ISHP does actually get implemented?

- **Probe:** If there is a gap in infrastructure, how is it currently being addressed?

Section 5: Relationships and Implementation perception

10. Now that the ISHP is now the responsibility of three departments, how is the relationship between DOH, DSD and DBE?

- **Probe:** What are the dynamics for consideration in the implementation of the ISHP

- **Probe:** What are the perceptions of the ISHP by the recipients and those at the forefront of the implementation?

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11. Are there any opportunities (gaps that can be filled) that should be considered in the implementation the ISHP?

- **Probe:** What can be done to improve implementation?

APPENDIX B: CONCENT FORM



Consent Form for Participation in a Research Study

Study: .....

Title of Study: Factors impacting negatively to the implementation of the Integrated School health policy in Gauteng

Description of the research and your participation

You are invited to participate in a research study conducted by Nhlanhla E. Shilubane which is for the partial fulfilment of a Masters of Management degree in Public and Development Management (MM P&DM) at Wits University. The purpose of this research is to establish the factors that interfere with the implementation of the Integrated School Heath Policy (ISHP). Your participation will involve an interview / focus group / consultation being audio recorded.

Risks and discomforts

There are no known risks associated with this research.

Potential benefits

There are no known benefits to you that would result from your participation in this research. This research may help us to understand the factors that interfere with ISHP implementation.

Protection of confidentiality

Any study records that identify you will be kept confidential. The records from your participation may be reviewed by people responsible for making sure that research is done properly, including the ethics committee of the University of the Witwatersrand. (All these people are required to keep your identity confidential). In other words, records that identify you will only be available to me, my research supervisor and the Wits ethics committee, unless you give permission for other people to see the records

Voluntary participation

Your participation in this research study is voluntary. You may choose not to participate and you may withdraw your consent to participate at any time. You will not be penalised in any way should you decide not to participate or to withdraw from this study.

Who to contact if you have been harmed or have any concerns

This research has been approved by the University of the Witwatersrand Ethics Committee and the Wits Graduate School of Public & Development Management (P&DM). If you have any complaints about ethical aspect of the research or feel you have been harmed in any way by participating in this study, you may contact the P&DM Academic Delivery Unit manager Helen Mzileni on 011 717 3562 or e-mail to Helen.Mzileni@wits.ac.za.

If you have concerns or questions about the research, you may contact my research supervisor Thlotse Motswaledi on 011 717 or e-mail to Thlotse.Motswaledi@wits.ac.za

CONSENT

I have read this consent form and hereby agree to participate in this study. I understand that I am participating freely, without being forced in any way to do so and I have also been given the opportunity to ask questions. I also understand that I can stop participating at any point should I not want to continue and that this decision will not affect me negatively in any way. I understand that this is an academic research project whose purpose is not necessarily to benefit me. I understand that my participation will remain confidential I give my consent to participate in this study.

.....

Participant's Name

Date…….

……..

Signature of participant

I hereby agree to the tape recording of my participation in the study

……..

Signature of participant **Date…….**