https://dspace.org/

Evaluation of the implementation of the School Health Policy in two schools in Cape Town

Ramma, Lebogang

2010-09-03
http://hdl.handle.net/10539/8596

Downloaded from a DSpace repository. https://dspace.org/

EVALUATION OF THE IMPLEMENTATION OF THE SCHOOL HEALTH POLICY IN TWO SCHOOLS IN CAPE TOWN

Lebogang Ramma

A research report submitted to the Faculty of Health Sciences, University of the Witwatersrand, in partial fulfilment of the requirements for the degree of Master of Public Health

Johannesburg, 2010

DECLARATION

I Lebogang Ramma declare that this research report is my own work. It is being submitted for the degree of Master of Public Health at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other University.

……
12 May 2010

DEDICATION

I dedicate this work to:

My fiancé Zandi, for her understanding, support, advice and encouragement throughout this research project. I can never find words to thank you enough for your patience and tolerance during my studies. You are the best.

I also wish to express my gratitude to my parents and my brothers and sisters for their unconditional support even during times when they did not exactly know what I was doing during my studies.

ABSTRACT

Introduction

School-going children have unique health challenges that deserve a focused attention from policy makers, commonly done through the provision of school health programmes. The education system provides the most comprehensive existing infrastructure for reaching school-going children and school health programmes enable health problems to be addressed at relatively low cost. The 2003 South African National School Health Policy (NSHP) aims to deliver equitable and focused health services to school-going children in order to safeguard their right to optimal health and development. There is currently limited information on the process of implementation of the NSHP, implementation context at different schools, as well as facilitating and constraining factors that impact on the implementation of this policy.

Aim: The main aim of this study was to evaluate the implementation of the 2003 National School Health Policy in two primary schools in Cape Town.

Methods: This was a process evaluation that used qualitative methods primarily. Two schools located in different education districts were selected via convenient sampling for an in-depth study. Within each school, participants were purposively selected based on their potential to provide relevant information. The final sample consisted of seven individuals; five educators and two school health nurses. Data collection tools included an in-depth semi structured interview schedule, self-administered questionnaire and document review. Interviews were recorded, transcribed and later analysed to obtain key themes.

Results: The evaluation found that the NSHP has been implemented in a phased manner, disadvantaged areas were prioritized, different staff-mix with regards to the composition of the school health team was used and the minimum requirements in terms of health assessment for Grades R and 1 learners (Phase 1 services) were met. Educators and school health nurses did not have the same level of knowledge and understanding of the NSHP, and educators were less informed about this policy than nurses. The policy context influenced working relationships between different actors or stakeholders. Challenges or constraints to policy implementation included broad systemic problems such as poverty and staff shortages, lack of dedicated budget for school health services and insufficient prioritisation of school health services by senior departmental managers, all which constrained effective policy implementation.

Although findings of this study cannot be generalized to other schools, they give important insights into the current implementation process of the NSHP. It is one of the few studies focusing on the process of policy implementation in recent years and the in-depth qualitative methods allowed the researcher to explore the complexities and contradictions of policy implementation in post-apartheid South Africa.

Conclusion: This policy has for the most part been implemented according to specified policy implementation guidelines and minimum requirements for implementing phase 1 services were met. It is recommended that a dedicated budget should be allocated to school health services and existing structures within the school system such as School Governing Bodies be utilized effectively to encourage parental involvement in school health. Nurses should advocate for increased support for these services among all stakeholders, including managers in the Department of Health.

ACKNOWLEDGEMENTS

1. Professor Laetitia Rispel, this project would not have been possible without your insightful advice, guidance and encouragement. I consider it a privilege for having had this opportunity to work under your guidance. I learnt a lot from you.

2. All the participants who volunteered to take part in this study, without you, this project would have not been possible. Your insightful comments during our discussions are highly valued.

3. I also wish to express my sincere gratitude to my colleagues in the Department of Communication Disorders at the University of Cape Town, more especially Associate Professor Shajila Singh who was always willing to allow me to attend my MPH meetings and Ms. Gillian Ferguson for all her help and support during this project-thank you all.

TABLE OF CONTENTS

DECLARATION ii
DEDICATION iii
ABSTRACT iv
ACKNOWLEDGEMENTS vi
LIST OF TABLES ix
LIST OF BOXES x
LIST OF ABBREVIATIONS xi
1 Chapter 1: Introduction 1
1.1 Global and National Context 1
1.2 South African Context 2
1.3 Literature Review 3
1.3.1 School Health Programmes: An overview 3
1.3.2 School Health Programmes in South Africa 4
1.4 Evolution of the South African 2003 National School Health Policy 6
1.5 National School Health Policy Content 7
1.5.1 Goals and Objectives of the NSHP 7
1.5.2 Package of Services to be Provided According to the NSHP. 8
1.6 Proposed policy implementation strategy 10
1.7 Evaluation of policy implementation 12
1.8 Studies evaluating school health programmes 14
1.9 Summary of the Chapter 17
1.10 Rationale for the Study 18
2 Chapter 2: Methodology 19
2.1 Study Aim 19
2.2 Specific Objectives 19
2.3 Study Setting 19
2.4 Scope of the Study 22
2.5 Research Methods 22
2.5.1 Study design 22
2.5.2 Study Population 23
2.5.3 Study Sample 23
2.5.4 Sampling Strategy 23
2.6 Procedure 23
2.7 Data Collection 24
2.8 Pilot Study 26
2.9 Data Processing Methods and Analysis 27
2.10 Reliability and Validity 28
2.11 Ethical Considerations 28
2.12 Limitations of the Study 29
3 Chapter 3: Results 30
3.1 Description of the Two Participating Schools 30
3.1.1 Historically Advantaged School. 30
3.1.2 Historically Disadvantaged School 31
3.2 Meeting Minimum Implementation Requirements 32
3.3 Implementation of the School Health Policy 34
3.4 Successes Attributed to Policy Implementation 39

3.5 Challenges and or Constraints Faced by Implementers 42
3.6 Comparing Policy Implementation to Guidelines Provided 46
3.7 Summary of Chapter 48
4 Chapter 4: Discussion 50
4.1 Introduction 50
4.2 Policy Implementation Process 52
4.3 Was the Policy Implemented According to the Guidelines? 63
4.4 Are the Minimum Requirements for Policy Implementation Met? 64
5 Chapter 5: Conclusion and Recommendations 66
5.1 Recommendations 67
5.2 Suggestions for Further Research 68
REFERENCES 70
GLOSSARY OF TERMS 78
APPENDICES 79
Appendix A: Interview Schedule for Key Informants 79
Appendix B: Self-Administered Questionnaire 82
Appendix C: Information sheet 83
Appendix D: Interview consent form 84
Appendix E: Consent for audio taping the interview 85
Appendix F: Ethics Clearance Certificate encl. 86
Appendix G: Permission Letter from the WCED encl. 86
Appendix H: Approval of title letter encl. 86

LIST OF TABLES

Tables		Page
1	Significant Dates and Events Relevant to the 2003 NSHP	7
2	Socioeconomic Profiles of the Participating Schools' Communities	21
3	Summary of Data Collection Approaches, Participants and Measurement Tools	25
4	Minimum Requirements for Implementing Phase 1 Level of School Health Services	33

LIST OF BOXES

Boxes		Page
1	Key results on implementation of school health policy	34
2	Success attributed to policy implementation	40
3	Challenges and or constraints faced by implementers on implementing this policy	42
4	Comparing NSHP implementation to guidelines	46

LIST OF ABBREVIATIONS

ADD	Attention Deficit Disorder
AIDS	Acquired Immune Deficiency Syndrome
CI	Children's Institute
DOE	Department of Education
DOH	Department of Health
EST	Educator Support Team
ENHPS	European Network of Health Promoting Schools
HIV	Human Immunodeficiency Virus
HPS	Health Promoting School
HPSI	Health Promoting Schools Initiative
ISRDP	Integrated Sustainable Rural Development Programme
MCHW	Mother Child Health Welfare
MDGs	Millennium Development Goals
NSHP	National School Health Policy
NHSS	National Healthy School Standard
PHC	Primary Health Care
PSNP	Primary Schools Nutrition Programme
SGB	School Governing Body
UCT	University of Cape Town
UNICEF	United Nations Children's Fund
URP	Urban Renewal Programme
UWC	University of the Western Cape
WCED	Western Cape Education Department
WCDOH	Western Cape Department of Health
WHO	World Health Organization

1 Chapter 1: Introduction

The purpose of this study was to evaluate the implementation of the 2003 National School Health Policy (NSHP) in two primary schools in Cape Town, Western Cape Province. This chapter sets the scene for the research report by: presenting issues relevant to international and national efforts to prioritize child health; providing an overview of school health programmes in South Africa; and reviewing the literature pertinent to school health programmes and their evaluation.

1.1 Global and National Context

Children represent the future of a nation, and their healthy growth and development should be a priority for all nations. In recognition of this, 189 member states of the United Nations (including South Africa) met in 2000 for the millennium summit, and unanimously adopted the Millennium Declaration (Fay, Leipziger, Wodon & Yepes, 2005). One of the principles outlined in this declaration was a pledge by the member states reaffirming their commitment to the welfare of children:

> "*As leaders we have a duty therefore to all the world's people, especially the most vulnerable and, in particular, the children of the world, to whom the future belongs*." (United Nations General Assembly, 2000).

One of the outcomes of this declaration was the eight Millennium Development Goals (MDGs) which address the following broad areas: poverty, education, gender equality, child mortality, maternal health, disease, environment and development (UNICEF, 2008). UNICEF (2008) has argued that the primary focus of the MDGs is children and the goals are one way in which the global community signalled their commitment towards the welfare of children, especially their health.

1.2 South African Context

In line with this global trend, the South African government has shown commitment towards improving the welfare of its children. A pledge by the South African government to *"put children's first"* when signing the Convention on the Rights of the Child (United Nations, 1989) and giving children a special recognition in the Bill of Rights of the South African Constitution (Government of the Republic of South Africa, 1996) are further indications that the welfare of children is considered a priority. Other government initiatives include the establishment of the South African Social Security Agency (Government of the Republic of South Africa, 2004), the increased disbursement of social support grants (e.g. child support grant), (Mantu, 2005) as well as developing a separate policy, the NSHP to address the health needs of school-going children (Department of Health [DoH], 2003).

School-going children have unique health challenges that deserve a focused attention from policy makers. For instance, ill-health and malnutrition remain prevalent in school-going children and a significant proportion of children continue to face health problems that compromise their physical development, their school attendance and their ability to learn (Bundy & Guyatt, 1996). In South Africa, the main health problems among school-going children include the following:

1. Nutritional Deficiency: Stunting is the most common nutritional disorder, affecting 20% of 1-9 year olds;
2. Trauma, Violence and Mental Health: injury is the leading cause of death in the 5-14 years, and teenage suicide is in on the rise in South Africa;
3. Substance Abuse and Risk Taking Behaviour: The following prevalence rates were reported amongst South African adolescents: smoking (42%); alcohol use (43.8 %) and drug use (12.4 %);

4. Hearing, Vision and Speech Impairment: Prevalence of vision impairment amongst pre-school and school-going children is between 2.4% and 6%, while that of hearing impairment is between 4.5% and 6%;
5. HIV and AIDS: 4.8% of 15-19 year olds were HIV positive in 2001. The HIV epidemic has a profound impact on children who are infected and affected (Program for Health and Development in South Africa, 2004; Henry J. Kaiser Family Foundation, 2001; Guthrie, Shung-King, Steyn & Mathambo, 2000).

Empirical evidence shows that good health and nutrition are prerequisites for effective learning, hence health problems among school-going children need a special and focused attention from national ministries of health in the form of dedicated school health programs (Bundy et al. 2006).

1.3 Literature Review

1.3.1 School Health Programmes: An overview

School health programmes describe a set of policies, procedures (or protocols) aimed at protecting and promoting the health and well-being of the entire school community (Wiley, James, Jonas & Crosman, 1991). Classical models of school health programmes include a triad of health services, health education and a healthy environment (Resnicow & Allensworth, 1996). However, modern day school health programmes have extended this classic model to include five additional and interactive components: Opportunities for physical education and recreation, counselling, psychology and social services, nutrition and food safety, staff wellness, as well as family/community involvement (WHO/AFRO, 2002).

One of the advantages of school health programmes is that most of the health problems prevalent amongst school-going children can be addressed at low cost (Bundy & Guyatt, 1996). The education system also provides the most comprehensive existing infrastructure for reaching school-going children (Bundy et al. 2006). Furthermore, in most countries there are more teachers than nurses, and there are more schools than clinics (Bundy & Guyatt, 1996). Because of this potential of the school setting to be a health delivery environment, school health programmes were identified in the 1993 World Development Report as some of the most cost-effective public health interventions (World Bank, 1993).

Effectiveness of school health programmes largely depends on the roles played by educators and parents, i.e. the broader school community (Leger, 1998; Ahmed et al. 2006; Al-Amari, 2007). These programmes require educators to function in a number of areas that are not necessarily their core function e.g. enhancing social environment of the school and linkages with relevant stakeholders (Leger, 1998). Success of school health programmes therefore depends on educators' understanding of these areas that are essential to these programmes (Leger, 1998). Parent involvement is also a crucial factor for the success of school health programmes (Perry, et al. 1988). Parents can act as role models and teachers for teaching and maintenance of new health behaviours in young children (Perry, et al. 1988). Involving parents, care-givers and local community members in school health can act as strong reinforcement and support for these programmes (Lynagh, Schofield & Sanson-Fisher, 1997).

1.3.2 School Health Programmes in South Africa

South Africa has a long history of school health services, with early documentation of the existence of these services dating back to 1914 (Venter, 1997). However, given the

history of apartheid and segregation policies, there were marked inequities in the availability and provision of school health services (Shung-King, 2006). For instance, school health services were provided effectively to all schools in white areas several times a year, while schools in the disadvantaged, mainly former homeland areas, got school health services once every two to three years or none at all (Shung-King, 2006).

Inequities in the provision of school health services persisted even after democracy, and in some provinces, until the late nineties. This was revealed by the findings of a school health services survey conducted in all the nine provinces by the then Child Health Policy Institute (now Children's Institute) in 1997. The survey results showed that there were significant variations in the way in which these services were delivered throughout the country (Shung-King, 2006). Often these services were delivered as vertical services with dedicated school health personnel (Child Health Unit, 1998) and in the majority of the cases, protocols, instruments, assessment procedures and monitoring systems varied according to geographical areas (Shung-King, 2006).

Variations in the provision of school health services in South African schools could also be attributed to the gaps in health policies and programmes that targeted children, specifically school-going children before 1994 (Shung-King, 2006). However, significant transformation has occurred since 1994 within the South African Health and Education sectors with regards to learners' health. There are now several Department of Health (DOH) and Department of Education (DOE) policies that are aimed at addressing children's health needs among other things. Most notable of these are the following three policies: The Health Promoting School Initiative (HPSI), originally a World Heath Organisation (WHO) initiative, (Onya, 2007; WHO, 2009); the National Policy on HIV/AIDS for learners in public schools, and students and educators in further education

and training institutions of 1999 (DOE, 1999), The Youth and Adolescent Health Policy of 2001, (DOH, 2001) and now The National School Health Policy of 2003 (DOH, 2003).

1.4 Evolution of the South African 2003 National School Health Policy

The need for a specific school health policy was identified by the Maternal Child and Woman's Health (MCWH) divisions, both nationally and in the provinces (Shung-King, 2006). The plan was to have a separate policy that will deliver equitable and focused health services to school-going children in order to safeguard their right to optimal health and development (DOH, 2003). Interestingly, one of the key objectives of this proposed policy was "to support the school community in creating health promoting schools," that is school health services should be established within the HPSI framework (DOH, 2003). The policy development process or events leading to the development of this policy started in mid-1996. Table 1 on the next page gives a brief summary of key events and timelines relevant to the formulation of the South African NSHP of 2003.

Table 1: Significant Dates and Events Relevant to the 2003 NSHP

YEAR	ACTIVITY	ACTORS/STAKEHOLDERS
1996	• Children's Institute (CI) conducted needs analysis regarding school health • HPSI piloted in selected Western Cape Primary schools	Provincial Maternal Child and Women's Health Managers, CI, Child Health Unit (UWC)
1997	• CI convened a national roundtable discussion on school health in Cape Town	National and provincial departments of health and education, Child Health Unit (UWC) and other academic institutions
1999	• DOH commissioned CI to lead the process of development of national school health policy (NSHP) and write the policy	DOH & CI
	• Consultative workshops were held (1 per province) over three months	DOH, DOE & relevant NGOs, Dept. of social development
	• Development of Implementation guidelines and costing of the implementation process	CI and Economist employed by WCDOH
	• Official launch of HPSI	DOH
	• Launch of the National HIV/AIDS policy for learners and educators by the Minister of Education	DOE
2002	• Launch of the Youth and Adolescent Health policy Guidelines by Minister of Health	DOH
2003	• Approval of the NSHP and implementation guidelines	DOH, CI
2004	• Launch of the NSHP and implementation guidelines by the Minister of Health	DOH , CI
2006	• Preliminary survey in 9 provinces to check on progress with policy implementation	CI staff member

1.5 National School Health Policy Content

*1.5.1 **Goals and Objectives of the NSHP***

The main goal behind the introduction of the South African National School Health Policy was to provide a policy that will guide the development of a comprehensive school

health service that functions within the framework of Health Promoting Schools. Specific objectives as outlined in the policy were as follows:

- Support the school community to create a Health Promoting School
- Address health barriers to learning
- Provide preventative and promotive services that address the health needs of school going children, as well as;
- Support educators in their school health activities in the classroom and the in the curriculum (DOH, 2003).

Some of the key principles underpinning this policy are that it should be established within the framework of health promoting schools, uphold PHC principles, and that school health services should be an integrated and not a vertical service (DOH, 2003). The primary target population specified in the policy is all children and youth, irrespective of age, attending learning sites. This includes grade R (where it is attached to formal learning sites) and extends right up to grade 12. However, other members of the school community (i.e. school staff, and parents and care-givers of the learners), are also meant to benefit from the services provided under this policy (DOH, 2003).

1.5.2 Package of Services to be Provided According to the NSHP.

The services provided under the school health package were selected to address some of the pervasive health issues among South African school learners. The specified services in terms of the policy could be divided into two broad categories; preventive and promotive interventions. Preventive services included main health assessments of all grade R and 1 learners, and constitute the core of the services that are provided at phase 1 of policy implementation (DOH, 2003). The focus of health assessments are to identify barriers to learning. The following is a list of health assessment specified in the policy:

- Hearing screening

- Vision screening
- Screening for speech impairment
- Physical examination for gross loco motor dysfunction
- Oral health checks
- Anthropometric assessment

Additional health assessments that may be required include: mental health assessment and identifying and responding to internal injuries and child abuse (DOH, 2003). It was quite surprising to note that these services are considered "additional services that may be added" in spite of the fact that they have been noted as health issues that are on the rise among 5-14 year olds in South Africa (DOH, 2003).

Health promotion and health education, which were to be provided at Phase 2 (health assessments and some of the health promotion activities) and phase 3 (health assessments and all of the health promotion activities) were identified as the most crucial aspect of the school health activities (DOH, 2003). This was partly because these services provide the best opportunity for impacting on the immediate and long-term health behaviour of children and youth. Furthermore, in contrast to the health assessments which are labour intensive and may need specialized equipment and professionally skilled personnel, health promotion services could be provided by non-professional personnel (e.g. Community Health Workers) to many children in one instance. Even more important was the idea that these services should ideally be incorporated into the school curriculum to ensure continuity in their delivery throughout the child's school year (DOH, 2003). Issues that were specified to be covered as part of health promotion and health education included:

- Lifeskills education
- Child abuse

- High risk behaviours, including substance abuse and violence
- Road safety and overall safety within homes and communities
- Environmental health including water and sanitation
- Healthy Lifestyles
- Reproductive health, including promoting healthy sexuality
- Self-care for learners with chronic non-communicable disease

As it can be seen from the goal and the objectives as well as the underpinning principles for this policy stated above, this was meant to be a broad and comprehensive policy that encompasses not only the learner, but the entire school community. Even more important was the recognition of the need to integrate the school health activities with curriculum activities. Incorporating the school health services in the curriculum has an added benefit of potentially bringing the health care workers and educators on a single platform for promoting the health of the learners.

Therefore, in its broad sense NSHP was meant to provide enabling conditions to make schools health promoting environments. That is, while the HSPI was mainly aimed at all aspects of creating a healthy school environment, the NSHP was meant to provide a roadmap of the steps and activities that should be followed by the school to become health promoting schools. As outlined in the earlier sections, those steps include: tackling health barriers to learning and development, as well as teaching and promoting the necessary knowledge to optimize healthy growth and development (DOH, 2003).

1.6 Proposed policy implementation strategy

The school health policy was developed with a set of implementation guidelines and the DOH was given the task of being the key driver in the policy implementation process (Shung-King, 2006). This is in contrast to international approaches for implementing

school health programmes, where the DOE, and not the DOH, is the lead implementation agency (Bundy, et al. 2006).

The implementation guidelines proposed that school health services be developed in three phases over a 10-year period (DOH, 2003), with a recommendation that Phase 1 services be prioritized for implementation. All education districts were required to implement phase 1 services by the end of 2007. Phase 1 is the minimum level of school health services which include Grades R and 1 learners' health assessments and health promotion activities in these grades. Phase 2 is the next level of service provision, while Phase 3 is the "ideal" service which includes a complete physical examination of the learners, as well as a full range of health promotion activities to the entire school community (DOH, 2003). Schools districts with phase 1 services in place were required to proceed with implementation of phase 2 and 3 services immediately (DOH, 2003).

The guidelines specify that priority policy implementation should be given to the most disadvantaged areas such as areas in the Integrated Sustainable Rural Development Programme (ISRDP) and the Urban Renewal Programme (URP) (DOH, 2003). The policy also allowed for different staffing options for the delivery of school health activities as a consideration in areas where primary level health facilities are currently under-resourced (DOH, 2003).

The policy guidelines also specified minimum criteria for its implementation at different phases that include; personnel to perform Grades R and 1 health assessments, access to referral facilities to manage identified problems, health promotion activities to grades R and 1 learners at least once a year, and school health team comprising ideally a professional nurse plus one nursing assistant (varied according to context). Lastly, a school health team to learner ratio of 1:5000 (for health assessments) and 1: 20, 000 for

health promotion activities and a minimum number of 1 school visits per year was recommended (DOH, 2003).

The policy and implementation guidelines acknowledge good coordination, and regular communication between DOH and DOE as a "critical success factors" (DOH, 2003) for the implementation of this policy. However, these guidelines do not clearly specify the exact role that the DOE is expected to play when it comes to the policy implementation. This was pointed out as a potential weakness of this policy by Shung-King (2006):

> *" ...the glaring weakness of the process* [the policy formulation] *was the absence of a structured relationship between the national Departments of Health and Education. This severely affected the potential to integrate the policy into the Department of Education process."*

This also led to minimal contribution by the DoE to policy content, and consequently led to a missed "window of opportunity" to have school health services integrated within the school curriculum and relevant education initiatives as envisioned by this policy (Shung-King, 2006).

1.7 Evaluation of policy implementation

The primary aim of most policy implementation studies is to evaluate a policy project or programme performance (Mazmanian & Sabatier, 1989), so as to determine whether to continue with the implementation of a policy or programme, or curtail, terminate or expand it (Cloete, 2006). While they may differ significantly in the kind of evaluation criteria used, or the focus of the evaluation (i.e. policy outputs or eventual outcomes or both), most implementation studies begin with a view of formal objectives stated in the

policy, and then proceed to evaluate the extent to which those objectives were attained as well as analyze the reasons for the failure to achieve the stated objectives (Mazmanian & Sabatier, 1989).

A common error in evaluation studies, is to separate the policy formulation process from the implementation process (Turok, 1991). According to Walt & Gilson (1994), this separation is rather problematic because policy making is interactive, with the formulation and implementation of the policy being two elements in a continuous loop. It therefore follows that policy evaluation studies that separate policy formulation from implementation may lead to failure in understanding the apparent mismatch between what the policy objectives are and what the policy actually achieves. Furthermore, studies that compartmentalize evaluation, separating it from policy-making and implementation risk becoming "marginalized and academic", and their conclusions may not carry much substance to influence policy in a major way (Turok, 1991).

1.6.1 Focus of Policy Evaluation and Implementation context

When evaluating policy implementation, the focus can either be to determine whether the policy was implemented as intended to the target population (process evaluation) or attempt to measure the impact the implementation of the policy has had on defined outcome measures (impact evaluation) (Purdon, Lessof, Woodfield, and Bryson, 2001). A comprehensive evaluation should focus on both process and impact of policy implementation. Since it is not always possible to focus on these two aspects simultaneously, the focus of this study was on process evaluation of the implementation of the 2003 NSHP in two primary schools in Cape Town. Process evaluation is a measure of the degree or the extent of the implementation of the policy (Owen & Rogers, 1999). It verifies details of the programme and whether it is delivered as intended to the target

population (Scheirer, 1994). This aspect of policy evaluation provides the most information on how the policy should be managed or how it should be re-formulated or developed in future (Purdon et. al. 2001). Without a careful process evaluation, it is difficult to explain why the policy was not implemented as intended (Mukoma & Flisher, 2004).

The context under which the policy is being implemented can influence the manner of implementation, and consequently the outcomes of policy implementation (Creese, 1991; Walt & Gilson, 1994). It is therefore important that studies that evaluate policy implementation do so while taking into account the context under which the policy was implemented (Creese, 1991). At the time of implementing this policy, many parts of the country did not have school health services (DoH, 2003). The policy was also implemented during a time when there was a shortage of trained nursing personnel in South Africa, and most of the areas were under-resourced to provide these services (DoH, 2003). Availability of resources (including personnel to implement the policy) is a crucial requirement that can lead to the success of a policy implementation (Hildebrand & Grindle, 1994). In the case of personnel to implement the policy, it is also important to ensure that implementers have the skills to carry out policy implementation (Labadarios, Steyn, Mgijima, and Dladla, 2005).

1.8 Studies evaluating school health programmes

School health programmes hold the greatest potential in facilitating delivery of health services to school-going children. However, like other programmes aimed at improving health, the continued support and strengthening of these programmes can only be done if there is evidence that they do in fact impact positively on the school environment and on the health of school community (Mukoma & Flisher, 2004). This statement makes a

strong case for the need to evaluate the impact of these programmes. Further calls for evaluating and establishing the effectiveness of school health programmes came from Veugelers & Fitzgerald (2005).

There are no published studies that formally evaluate the *implementation* of the 2003 NSHP in South Africa. However, there are a number of studies done both in South Africa and elsewhere that evaluated other school-based health programmes. The findings of these evaluation studies vary considerably. While some studies showed that these programmes do have significant impact in the health outcomes of learners (Wang, et al, 2008; Veugelers & Fitzgerald, 2005; Durlak & Wells, 1997; Manios, Kafatos & Mamalakis, 1998), other evaluation studies reported only modest impact made by these programmes in terms of the health outcomes hoped for (Schagen et al. 2005; Kingsman, et al, 2001; Magnani, MacIntyre, Mehyrar, Lisanne & Hutchison, 2005; Labadarios et al, 2005 and James, Reddy, Ruiter, McCauley & van den Borne, 2006). Some studies were inconclusive regarding the impact of these programmes on learners' health. For example the evaluation of European Network of Health Promoting Schools (ENHPS) and HPSI showed that both these programmes have the potential to, but do not necessarily contribute to health-related outcomes among learners and staff (Hamilton & Saunders, 1997; Mukoma & Flisher, 2004).

These variations in the outcomes of studies evaluating school health programmes could in part be attributed to the complexities associated with evaluating such programmes. School health programmes are typically multi-dimensional, and the complexity associated with evaluating such a wide range of intervention activities can present methodological challenges (Mukoma & Flisher, 2004). Because of these challenges, some evaluations of these programmes end up using methodologies that may not allow confident attribution of the observed outcomes to these interventions (Mukoma & Flisher,

2004). It is for these reasons that, there has been a call to identify suitable methods and materials, and use well-designed studies involving large number of participants in appropriate settings when evaluating effectiveness of these programmes (Centre for Disease Control & Prevention, 1996; Wilson, O'Meara, & Summerbell, 2003). Even in instances where methodological issues are not of concern, some of the outcomes attributed to these programmes are not easy to measure. For instance, in a study evaluating the impact of National Healthy School Standard (NHSS) in England, teachers reported changes brought about by these programmes that were hard to quantify. For example, they reported changes that relate to the "feel" of the school, learners "listening more," improved attention as well as learners "looking forward" to events (Warwick, et al. 2005) as outcomes of implementing this programme.

In some of the studies that have been reviewed thus far (e.g. Schagen et al, 2005; Warwick, et al, 2005, Magnani, et al, 2005) the focus of the evaluation tend to be on the outcome of the policy programmes, with little attention given to the implementation of the programme itself. The weakness of this approach to policies or programmes evaluation is that it may not be possible to understand why the outcome of the programme turned out the way they did (Walt & Gilson, 1994). This makes a strong case for the need to also evaluate the policy implementation process. Evaluation of the implementation process is important because it gives a clear account of what was done, and why, provides evidence on whether the policy or programmes were implemented as intended and informs the evaluation outcomes (Mukoma & Flisher, 2004). In other words, a policy or programme may fail, not because it was weak or improperly formulated, but because it was not implemented properly. Without a detailed process evaluation, we can only "infer that perhaps the implementation did not occur as expected" (Mukoma & Flisher, 2004).

Most of the evaluation studies on school health reviewed here also tend to be done within a very short period of time. For instance, a study by Magnani et al. (2005) evaluated the impact of life skills education on adolescent sexual risk behaviours in KZN after the programme had been implemented for only two years, A similar study done by James et al. (2006) evaluated the impact within a year. Likewise, Kingsman et al. (2001) evaluated the impact of comprehensive school-based AIDS education program in rural Masaka, Uganda within a 2 year period. These time frames are not adequate to give a good indication of the impact of the programme.

Evaluation studies that focus on outcome or impact of the policy programme require that the policy be in operation for a longer period before evaluating its outcomes or impacts (Owen & Rogers, 1999). Given the fact that the school health policy has only been implemented in the past 5 years, it is appropriate to do a process evaluation, before evaluating the impact, hence the reason for this study.

1.9 Summary of the Chapter

School health programmes hold the greatest potential to improve learners' health. There are generally very few studies that have been conducted over the years that specifically evaluated health programmes in schools in South Africa. Most of the studies that have been conducted thus far tend to evaluate certain aspects or components of a school based health programme; Kuhn, Steinberg & Mathews, (1994); Mbananga, (2004); Magnani et al. (2005); Labadarios, et al. (2005); James et al. (2006). None of these studies were comprehensive evaluation of a broad-based school health programme or the entire policy process. Even for a programme such as HPSI which commenced before the implementation of the school health policy, a literature review by Mukoma & Flisher

(2004) found that there was no available published study on its implementation in South Africa.

1.10 Rationale for the Study

There is currently limited amount of information on the process of and actual implementation of the NSHP, the context of implementation at different schools, as well as the facilitating and constraining factors that impact on the implementation of this policy. This study is a process evaluation of how this NSHP has been implemented in two selected primary schools. The information obtained through this study could inform both methodological approaches and future studies evaluating the implementation of the NSHP.

2 Chapter 2: Methodology

The research methodology employed in this study was guided by the study aims and objectives. This chapter therefore describes the study aims, objectives, the study setting, scope, study design, the research tools, data collection approaches and analysis of results.

2.1 Study Aim

The aim of this study was to evaluate the implementation of the school health policy in two primary schools located in two separate education districts in Cape Town.

2.2 Specific Objectives

1. Determine whether the minimum requirements set out in the Policy implementation guidelines in terms of phase 1 level services have been met.
2. Describe and document how the school health policy has been implemented in the selected schools
3. Determine whether the school health policy has been implemented according to the implementation guidelines specified in the policy
4.

2.3 Study Setting

This study was conducted in Cape Town, the provincial capital of the Western Cape Province and the legislative capital of South Africa. The Western Cape Education Department (WCED) consists of eight education districts, with around 1460 schools and 976,647 learners (WECD, 2008). The districts include four urban education districts; Metro Central, Metro North, Metro East and Metro South, and four rural education districts; Cape Winelands, Eden & Central Karoo, Overberg and West Coast (WCED, 2008).

For the purpose of this study, two urban education districts; Metro Central and Metro South school districts were selected. The Metro Central school district is home to most of the historically advantaged schools in Cape Town. The Metro South school district on the other hand, has more historically disadvantaged schools when compared to the Metro central district. In this study, the phrase "historically disadvantaged school" is used to refer to any school that was disadvantaged by unfair discrimination before the Constitution of the Republic of South Africa came into operation (Government of the Republic of South Africa, 2000).

The two education districts chosen for this study were selected to represent two contrasting school districts in the Cape Metropolis in terms of the demographics socio-economic profile, as well as the availability of school health services in these areas prior to the introduction of the national school health policy in 2003. The Metro Central school district, had a predominance of historically advantaged public schools. This education sub-district had publicly provided school services until the early 90s, but after 1994 school health services in this education district started to decline. Therefore, schools in this education district did not have DOH publicly provided school health services when the NSHP was implemented in 2003.

The Metro South education district, although located in a non-affluent area of Cape Town, is home to several historically disadvantaged schools. This education district has a history of functional public provided school health services dating back more than two decades. Schools in this education district continued to have public provided school health services even after 1994. Therefore, when the school health policy was introduced in 2003, several schools in this historically disadvantaged school district already had some functional school health services in place. It also important to note here that this historically disadvantaged school district was one of the first school districts in the

country to participate in the HPSI back in 1994/95. As it was later discovered during the study, the participating school from this district was one of the pilot schools for the HPSI.

The Metro South education district is also located within an area that has been designated an urban renewal programme (URP) focus area in the Western Cape. URP is part of the urban renewal strategy announced by President Mbeki in 2001 which focuses on areas of greatest socioeconomic deprivation (City of Cape Town, 2008).

As stated earlier, these two education districts were purposively selected to represent two contrasting school districts in the Cape Metropolis in terms of socio-economic profile. One school was selected from each district to take part in this study to enable the researcher to compare schools from two different socioeconomic and geographical contexts with regards to the implementation of the NSHP. Table 2 below shows the socioeconomic profiles of the communities from which the two schools were selected.

Table 2: Socioeconomic Profiles of the Participating Schools' Communities

FACTOR	METRO CENTRAL SCHOOL	METRO SOUTH SCHOOL
Ethnic composition:	78% White, 10% Black African 8% Coloured and 4% Asian/Indian	96% Coloured, 3.5% Black African and 0.5% White
Unemployment Rate:	3%	57%
Average annual household income	R76 801-R307 200	R19 200 -R76 800
Type of Dwelling	House/Brick structure 35.46%, Flat in block of flats 48.39%	House/Brick structure 7.10%, Informal Dwelling/shack 8%,

Source: Census 2001 Statistics South Africa,

2.4 Scope of the Study

This study was a process evaluation and set out to investigate how the 2003 NSHP and the implementation guidelines have been implemented in two different public primary schools within the Cape Town metropolitan area. The focus of this study was a process evaluation of the implementation of Phase I services. The implementation guidelines for the NSHP proposed that it be implemented in a phased manner, with a recommendation that Phase I services be "prioritized for implementation" (DOH, 2003. According to the implementation guidelines, Phase I services were supposed to be provided in all school districts by the end of 2007. Since this study was conducted during 2008, one year after the implementation of phase I should have been completed, it made sense to focus on the aspect of the policy that was in place (or supposed to be in place) at the time of the study. Otherwise, an evaluation of higher phases (phases 2 and 3) would have potentially raised issues that could not have been answered at the time when the study was being conducted.

2.5 Research Methods

A qualitative research methodology was chosen for this particular study because it allowed for in-depth collection of information from participants via conversation and observation (Skinner and van der Walt, 1997). Furthermore, qualitative research studies allow the researcher to describe the nature of certain situations, processes and relationships, as well as to evaluate the implementation process of particular policies, practices, or innovations (Leedy & Ormrod, 2005).

2.5.1 Study design

The study design was a descriptive cross-sectional, process evaluation to determine the implementation of the school health policy in two primary schools from two different education districts in Cape Town.

2.5.2 Study Population

The study population were school health nurses, educators and learners from the two school districts.

2.5.3 Study Sample

The study sample was made up of all individuals who were directly involved in the delivery of school health services at the time of the study. Those included two school health nurses and five educators from the two schools.

2.5.4 Sampling Strategy

The two education districts were purposively selected to allow for comparisons, as highlighted above. Within each school district, the names of the schools were listed in alphabetically (from A-Z) in the WECD schools directory. Starting with the first school on the list, the principals were contacted consecutively to invite the schools to participate in this study. The first principal to accept the invitation to participate in this study became the participating school. A written invitation to participate in the study and a request for an interview with the relevant individuals was then faxed to the school. At school level, participants for this study were purposively selected based on their potential to provide relevant and important information (i.e. information rich) to answer the research question and because they were directly involved in the delivery of school health services at the two schools.

2.6 Procedure

Permission was first requested from the Western Cape Education Department (WCED) to conduct the study. Once the permission was granted, two education districts and the participating school within the district were selected as described above (see section 2.5.4 above). The first person contacted at the school was the principal. Permission was then

requested from the principal to contact Grade R and Grade 1 teacher to invite them to participate in this study. A total of five (5) educators consisting of: 2 school principals (1 from each school), 1 Grade one teacher and a Grade R teacher (from Metro South district or the historically disadvantaged school), a teacher who served as a Health Coordinator (from the Metro Central district or the suburban school) were selected and included in the study.

Two school health nurses working in the education district from which the historically disadvantaged school was based participated in this study. The first nurse was contacted via the school's administrative assistant to invite her to participate in this study. The second nurse who participated in this study was recommended by a colleague from the Child Institute because she was one of the people involved in the formulation of the NHSP. The suburban school district did not have a school health nurse at the time of the study. Therefore, seven people in all: five educators and two school health nurses were interviewed for this study.

2.7 Data Collection

The following methods were used for data collection in this study:

a. In-depth interviews with key informants (Appendix A)
b. A review of statistical summary of records kept by the school health nurse reporting: percentage of Grade R and 1 learners assessed, percentage of learners with identified problems followed up at least once, and duration between identification of health problem and follow up etc.
c. A self-administered questionnaire (see Appendix B).

Table 3: Summary of Data Collection Approaches, Participants and Measurement Tools.

OBJECTIVE	APPROACH	TARGET SAMPLE	MEASUREMENT TOOL
1. To determine whether the minimum requirements for the implementation of this policy have been met	Self-administered questionnaire	School health nurses (n = 2)	Questionnaire
2. To describe and document how the policy has been implemented in the selected school	Key informants Interview	School Principal (n = 2) Grade R teacher (n = 1) Grade 1 teacher (n = 1) Health Coordinator (n = 1) School health nurse (n = 2)	Semi-Structured Interview
3. To determine whether the policy has been implemented according to the policy implementation guidelines	Key Informants interviews	School health nurses (n = 2) Educators (n = 5)	Semi-structured Interview Record Review

A semi-structured interview covering key themes linked to the study objectives was conducted with each one of the key informants. Respondents were asked during the interview to talk about the implementation of the NSHP in their schools. The interview schedule was constructed such that it addressed the following broad categories of issues:

- Description of the implementation of this policy in their school;
- Roles played by each participants in the implementation of this policy;
- Description of how school health services are organized in their school;
- Successes that can be attributed to the implementation of this policy, and;
- Challenges or constraints encountered by respondents with regards to the implementation of this policy.

All interviews were tape recorded for transcription and analysis.

A review of records kept by the school health nurse depicting statistical summary of services performed (mainly health assessments for Grades R and 1) was done. Information obtained from the record review plus the information reported by participants during the interviews was compared to what is specified in the implementation guidelines with respect to the implementation of this policy to evaluate whether the policy has been implemented according to the guidelines.

Finally, school health nurses were asked to complete a self-administered questionnaire to establish whether minimum implementation requirements specified in the guidelines with respect to phase 1 level services were in place. The questionnaire was developed by reviewing all activities specified in school health package for phase 1 level of school health services (e.g. Grades R and 1 assessment, number of school visits per year, etc). It allowed the respondents to indicate what was happening with regards to specified activities by marking YES (if that activity was currently being done), NO (if it is not being done) or NOT SURE if that applied. There was also a section in the questionnaire that allowed respondents to provide information that could not simply be answered by a yes/no/not sure (e.g. number of visits per year).

2.8 Pilot Study

The interview schedule was piloted on two educators in a primary school in Gugulethu, Cape Town, to test the feasibility of the interview schedule. The school was selected because it has similarities to one of the participating school i.e. they are both from historically disadvantaged areas.

The findings of the pilot study revealed that educators were not aware of the specific name of the policy that guides the provision of health services in schools. They were however, aware of the activities of school health nurses in their school. A decision was therefore made that, in instances where educators were not aware of the NSHP of 2003, the first question in the interview schedule would be modified to allow for educators to talk about school health services in their school. It was also found during the piloting of the interview schedule that questions (f) and (g) of the interview schedule (refer to appendix A) were not appropriate for the educators. So those questions were only posed to the nurses.

2.9 Data Processing Methods and Analysis

According to Leedy & Ormrod (2005), there is usually no single "right" way to analyze qualitative data. However, one approach for analyzing qualitative data is the one described by Creswell (1998), the "data analysis spiral." When using this approach, data is reviewed several times using the following steps; organizing the data, reviewing the data to get an overall idea of the data, identifying general categories or themes and classifying accordingly (Cresswell, 1998). The final step is to integrate and summarize the data (synthesis) for the readers (Cresswell, 1998).

Consistent with Cresswell (1998) approach for analysing qualitative data, audio recorded interviews were first transcribed and saved as a word document. The transcripts were then read and re-read several times to identify common or dominant themes. The themes were coded according to the broad categories outlined in the interview schedule: Description of the implementation of this policy, roles played by the different respondents in the implementation of this policy, description of how school health services are organized in their schools, successes attributed to the implementation of this

policy, as well as challenges or constraints encountered by respondents with regards to the implementation of this policy. The themes were then integrated and summarized into a report.

2.10 Reliability and Validity

Validity and reliability of information obtained was enhanced by interviewing several people who are involved in different aspects of the implementation of this policy, representing different perspectives (i.e. educators and health workers working in the same education district). Furthermore, information from the interviews was compared to the information obtained from document review to ensure the cross-checking of the information obtained through the interview.

2.11 Ethical Considerations

The study was approved by the University of the Witwatersrand Committee for Research on Human Subjects (Medical) and postgraduate committee (R14/49, Appendix F). Authorization to conduct this study was also granted by the Western Cape provincial education department (Appendix G).

Informed consent was obtained from the participants prior to taking part in this study. They were also informed about the nature, scope and purpose of the study. Participants were also informed that their participation in this study is voluntary and that there were no material benefits for them associated with taking part in the study. They were further informed that they have the right to stop participating in this study at any time if they want without any negative consequences to them. Confidentiality and anonymity of the participants was guaranteed by making sure that no identifying information; their names or the names of the school they worked for, was used anywhere in this report.

Participants were identified only through their interviewing sequence (e.g. Key informant 1, Key informant 2, etc).

2.12 Limitations of the Study

Limitations of this study include the fact that the school districts were selected purposively and the schools through convenient sampling. These schools might differ in important aspects from other primary schools in South Africa, and are not representative of South African primary schools. This means that the findings of this study cannot be generalised to other South African schools. Great care was taken to design the data collection instruments and to ensure that quality information was obtained. However, the study relies on participants' self-reported and hence based on their perceptions. Nevertheless, the information obtained from key informants gives important insight into some of the key policy implementation issues and can be used as pilot study for the design of similar studies.

3 Chapter 3: Results

This chapter presents the results of the study as follows: description of the two schools; whether the minimum requirements with regards to implementation of phase 1 level of services have been met; description of the implementation of the school health policy in the two schools; and whether the policy has been implemented according to the policy implementation guidelines;.

3.1 Description of the Two Participating Schools

3.1.1 Historically Advantaged School.

This school is located in one of the affluent suburbs of Cape Town and it has been in existence since 1954. According to the school Principal, the school currently (2009) has a learner population of 776 (grade 1-12) and 26 teachers (excluding support personnel such as remedial teachers and the school's own two psychologists). The school is surrounded by a secure perimeter fence, with a strict control access into the school i.e. the entrance is manned by a security guard. The school building is a long, well maintained face brick structure that spreads across the school yard with a tiled roof. All the windows and doors were intact (i.e. no broken windows) and the building appeared to receive routine maintenance to keep it in a good state. About one third of the school premises (grounds) was paved with grey paving bricks, and the remaining two thirds was covered with green well trimmed lawn. The school grounds were very tidy and free of litter and rubbish

At the back of the school buildings were school sports grounds. The school boasts the following sports facilities; a neat soccer field, a cricket field, a hockey pitch, a double tennis court, as well as a well maintained swimming pool. Other facilities in the

playground include a jungle gym with monkey bars. Furthermore, each grade has a physical education period timetabled into their school timetable and there are scheduled extracurricular activities in the school timetable throughout the week.

Walking around the school gives a sense of order and security; there were no children loitering around unattended, except during recess times (school has two recess times during the day). At the end of the school day, parents park their cars at a designated area, and walk over to the gate to fetch their children. The school also has an after care facilities for parents who cannot pick their children at designated times.

3.1.2 Historically Disadvantaged School

This school, unlike the other school was located in the less affluent part of the Cape Town metro. The school has been around since 1985. It currently has a learner population of 1098 (grade 1-12) and 32 teachers (2009 statistic provided by the school Principal). The school buildings are surrounded by a 6 foot welded wire mesh perimeter fence with a razor wire for extra security. There are two front gate entrances to the school, one was locked and the other one was unlocked, controlled access into the school premises. The school buildings comprise of four two-storey buildings, located alongside each other that appeared to have been long overdue for maintenance work. Several windows were broken, and there were several broken pieces of furniture (e.g. chairs) around the school. The front of the school yard had a hard concrete paving, and the rest of the school grounds were bare earth with no paving or grass. There was some litter and rubbish were scattered in the school yard.

There were literally no recreational facilities in the school premises. The only forms of sporting activity offered in the school were soccer and cricket. The makeshift

playgrounds for both cricket and soccer were an open piece of bare and uneven ground with no facilities (e.g. goal posts for soccer). There was however, a well looked after community vegetable garden (with vegetables growing in it) in the school premises. During the researcher's walks around the school premises, there were several learners who were walking around unattended during teaching time. At the end of the school day, learners loitered around the school (mainly in front of the school yard) without any adult supervision. There was no after care facility at this school. Overall, walking around this school gave did not give a sense of order.

3.2 Meeting Minimum Implementation Requirements

The minimum requirements for the implementation of the school health activities at each phase of implementation were specified with regards to the following areas:

- Grade R/1 assessments;
- Referral facilities required;
- Health promotion;
- Staff mix;
- School Health team to Learner ratio;
- Number of school visits per annum.

School health nurses were requested to complete a self-administered questionnaire to determine whether the minimum requirements for implementing phase 1 level services were met. Their responses are displayed in Table 4. on the following page.

Table 4: Minimum Requirements for Implementing Phase 1 level of School Health Services.

Activity outlined in the policy	Policy Recommendation	Historically disadvantaged school	Suburban School
Grade R/ 1 assessment	The following assessments should be done: ● Hearing ● Vision ● Gross Motor Impairments ● Anthropometric	All assessments are currently being done	All assessments are currently being done, plus: ● educational psychology ● occupational therapy and ● speech therapy services)
Referral facilities or agents required	School health team should be able to access: ● Primary level facility ● Audiologist ● Opthalmologist ● And Optometrists	Nurses have access to these referral facilities/agents Referrals are done immediately after assessment	Services are provided by resident professionals (some based on the school premises)
Health promotion	Schools should have: Well maintained first aid box ● At least 1 staff member trained in the first aid ● Health promotion activities for grade ones	● There are several staff members trained in first aid ● There is a well replenished first aid box at the school	● There are several staff members trained in first aid ● There is a well replenished first aid box <u>in each</u> classroom ● <u>All</u> learners undergo a basic first aid course
Staff mix	● Professional nurses ● Nursing assistant (or a person able to conduct health promotion activities)	● Professional nurse ● Nursing assistant and/or ● Community health worker	● Psychologist ● Occupational Therapist ● Speech Pathologist ● Audiologist ● Learning Support Educator
School health team to Learner ratio	● 1 team: 5000 Grade one learners ● 1 team: 20-25000 learners for health promotion activities	● 1 team: 3 000 Grade R/1 learners ● 1 team: 16 400 learners (Grade R-12)	● 1 team: 150 Grade R/1 learners ● 1 team: 1000 learners (Grade R-12)
Number of school visits per annum	● 1 visit for Grade R/1 assessments ● With follow-up within 6 months	● 1 visit per year ● Follow-up within 6 months or less	● Present at the school throughout the school year to attend to problems as they come up

3.3 Implementation of the School Health Policy

The key results emerging from key informant interviews are listed in Box 1 below, and elaborated on below:

Box 1: Key results on implementation of school health policy

- There is lack of a common understanding of the 2003 NSHP among implementers.
- Educators serve largely a coordinating role between different stakeholders
- Comprehensive range of school health services are currently provided
- The context influences working relationships among different actors or stakeholders involved in implementation of this policy, and ultimately influences implementation

3.1.1 Lack of a common understanding of the 2003 NSHP

One of the key findings of this study was the fact that educators responsible for the implementation of this policy had different levels of awareness and there was no common understanding of the NSHP. In the suburban school, the 2003 NSHP has **not** been implemented. However, educators in this school were aware of the NSHP, as revealed by the following excerpt from an interview with an educator in this school:

> "No *we have it* [referring to the NSHP], *but we also have our own, the HIV and the school health policy."* – **(Key informant 5).**

The provision of school health services in this school was therefore not done according to NSHP guidelines, but according to the school's own internal school health policies. Nevertheless, the provision of school health services in the suburban school, provided insights into the contrast and variation in the provision of school health services within different public primary schools at a time when there is a national framework for the provision of school health services i.e. the 2003 NSHP.

Some educators from the historically disadvantaged school were not even aware of the existence of this policy until the date of the interview:

> *"I tried to find out what school health policy you were referring to on the phone, but I couldn't get anything…we are a health promoting school, therefore what we use here is the health promoting school policy*."**-(Key informant 1).**

School health nurses generally had a better knowledge and understanding of this policy compared to the educators. They understood that the two (school health policy and HPSI) were related and complementary:

> "*…What we do here is the school health policy, the school health policy guides me how to do my work as a school health professional, whereas it takes hands with a health promoting school we work with the educators and the whole school community so at the same time while I am doing my work, I'm promoting health…*"**-(Key informant 7).**

3.1.2 Educators serve mainly a coordinating role between different stakeholders

In the historically disadvantaged school, there are representatives who represent school in several health forums (e.g. Health Promoting Schools forum etc) within the education district. These representatives also coordinate health activities within their schools:

> "*I am an HPS representative …which means that I go to the meetings that are held and whatever information they have there then I have to bring it back…"*-**(Key informant 2).**

Educators also liaise with the parents, and sometimes the health care professionals in matters relating to learners' health. However, the context under which school health services are provided influences educators' level of involvement in school health services. For example, educators from the historically disadvantaged school tend to be more involved in the entire process from identification of a learner who needs assistance to further follow up:

"*I have a learner in my class who doesn't speak and the learner has been with me since last year already. I approached the sister and then she had the speech therapist come to….,. and then I think its from X [institution where the child was referred] and then the child went there and it was discovered that she has selective mutism and we had the child, then sister also went to visit the home."*-**(Key informant 2).**

Educators from the suburban school, on the other hand tend to leave most of the responsibilities for matters pertaining to the learner's health to their parents:

"We don't deal with major health problems here at our school. When a learner is sick, we call the parent or the guardian of the child, and they take them to seek the appropriate care. Then the parent has to inform the school after the child has received treatment…Fortunately, most parents are good about following up on their children's health…"-**(Key informant 5).**

School health nurses who participated in this study reported that their core function is to perform learners' health assessments, but they also recognize that their roles extend beyond just the health assessment of learners:

"*Ok, basically first of all we work in the school environment there's communities involved so we also work with our communities. For instance we have parent interviews so should there be any other social issues coming out of that then we do the necessary referrals. So our work is not only to examine children, although that is our core function …"*-**(Key informant 7).**

3.1.3 A comprehensive range of school health services is provided.

At phase 1 level of service delivery, nurses are expected to provide mainly health assessments for grade R and 1 learners and health promotion services. The study found that a comprehensive range of services is currently provided by the school health nurse as well as a team of health professionals assembled through the health promoting schools

forum for the Metro South education district. Services provided include health assessments, health promotion, health education, social and medical support and dealing with special requests, as can be seen from the quotes below:

a. *Health Assessments*

"...So if there is any sickness, like the Sister was here, so she took our learners in and she checked all of them ... So we could alert things like a hearing problem, a speech problem and we could refer these learners, through their parents to the local clinic and from there they will bring us letters saying they've been to the clinic and this is the letter…"**-(Key informant 3).**

b. *Health Promotion*

"*…and now every year we have health promoting week so all the school that are health promoting school participate and this year you know we were so blessed, the schools got each R1000 from the department of health for health promoting schools week which was in August from the 18th to the 22nd and that is the first time that we really got such a lot of money… they can do whatever they want with the money at the school for the kids, if they buy toothpaste, nail clippers or some even bought skipping ropes and things like that."*-**(Key informant 7).**

For the suburban school, in addition to other health promotion activities provided throughout the year, the there is a basic first aid course offered to all learners:

"*But then also during the course of the year every class has a basic first aid class.*" **-(Key informant 4).**

c. *Health Education*

"*... If I have a Grade 5 and they are busy with the reproductive whatever and then I will give my health education around whatever she is doing in the class ... most of the time I have to offer my health education for the need of the school*." -(**Key informant 7).**

d. *Social and Medical Support Services*

"*At the moment we have sister X (name withheld), that is our [her role in the HPS forum] And there is the nurses and social workers of the department [DOE] So they call a meeting and we have to go there and see what's, you know… what are the burning issues. We also have a doctor there, Dr. Y (name withheld] and if we have learners that are ADD then we have access to her, and quickly also."*-**(Key informant 2**).

e. *Responding to Special Requests*

There are also occasional special requests from the national DOH that are provided through school health services.

" *We do get special requests coming up from national health or sister or health sectors. Like now they must request for us to assist in the vitamin A campaign, so you adjust your school health schedule and you go…"* -(**Key informant 6).**

3.1.4 The context influences working relationships among different stakeholders

There were some reported relationship problems between educators and parents from the historically disadvantaged school:

"Parents involvement in school health is generally poor. We sometimes get a learner showing up at school, telling you that 'Mr Z [name withheld], Mommy said I should tell you that I am sick'…" - **(Key informant 1).**

However, educators from the suburban school were generally happy about their relationship with the parents in their school:

"…fortunately, [in this school] most parents are good about following up on their children's health …" **-(Key informant 5).**

School health nurses working in the historically disadvantaged school generally appeared to enjoy good working relationship with parents in their school district:

> *"...I don't have a problem working with the parents. You have the odd occasion you know the mentality where they want to make a scene but it all depends on you how you are going to react to that person's attitude."* **-(Key informant 7).**

In general, the study found that there is generally a good relationship between educators and nurses:

> "*…okay we have a very good working relationship. If we do have a problem we call sister F and she attends , she is very prompt, you know especially with an emergency or something like that and then if she is unable to help then she will ask Dr Y you can also go directly to her."* **-(Key informant 2).**

The suburban school did not have a school health nurse working there at the time of this study, but utilises a number of private professionals that come to the school to provide different services to the learners. Educators interviewed reported that they enjoy a good working relationship with these professionals.

> "*They also are really regarded as part of the staff uhm they're not on their own. If any staff member wants some advice, they are happy to come down.* "**-(Key informant 4).**

3.4 Successes Attributed to Policy Implementation

As stated earlier, the 2003 NSHP was not yet implemented in the suburban school. The findings reported in this section will therefore apply only to the historically disadvantaged school. Key points identified by implementers as successes of implementing this policy are listed in Box 2 in the next page, and will be elaborated thereafter:

Box 2: Success Attributed to Policy Implementation

- NSHP provides a safety net for some learners
- The NSHP facilitates early detection, diagnosis and intervention for childhood illnesses
- The policy extends educators' influence on external factors that can compromise the learner's ability to learn (e.g. abuse, parental neglect and health problems)

In general, both educators and health workers expressed some appreciation for the value of school health services. The following are some of the responses from the interviews regarding what respondents thought to be the success of these services:

a. Safety net

"…to catch those children that fell through the cracks because a lot of our children in the pre-school age go to the clinic for the first injections and then you never see them again. And when we see them in grade 1, the child doesn't have language, doesn't have the hearing, the vision, the development, the brain development." **-(Key informant 6).**

b. Early detection, diagnosis and intervention

"…you can detect, prevent problems when they are like 11 years old, you can find scoliosis and you can do something about the problem which is why we examine that in a phase 3…..Once they older there is not so much that we can do about the problem." **- (Key informant 2)**

c. Extends educators' influence

"…it enables educators to address factors that are outside of the school systems' inner circle such as abuse." **-(Key informant 1)**

3.2.1 Reasons for the observed successes

Participants were also asked to identify factors that they feel contributed to the success that they reported were brought about by implementing this policy. Educators identified leadership in the school environment as a key factor, while nurses felt that the right attitude for the person rendering the services, as well as passion for school health services as important factors.

a. School principals' leadership

Principals who are supportive to their teaching staff and "hands-on" in school health matters were found to increase the likelihood of success with implementing this policy:

"I will never ask one of my teachers to do something that I am not prepared to do…In some cases, I personally follow-up on a case without the teacher's knowledge and come and update the teacher on the outcome or progress."-**(Key informant 1).**

b. The right attitude

Respondents also reported that success of implementing this policy relies on implementers with the right attitude:

"…but the person who renders the service if that person do everything that the policy says, but that person's attitude is not right, you wont do your job the way… you understand, it all depends, you must have the right people in the right positions and doing the right things…."**-(Key informant 7).**

c. Being passionate about school health

A passion for school health services was also identified as a factor that led to the successful implementation of this policy:

"That is, I am very passionate, I believe in the service and that's why I do whatever I can."- **(Key informant 6).**

3.5 Challenges and or Constraints Faced by Implementers

Implementers of this policy also reported a number of challenges or constraints associated with the implementation of this policy. A brief summary of the challenges or constraints encountered is presented in Box 3 on below:

Box 3: Challenges and or constraints faced by implementers in implementing this policy

- Systemic challenges (e.g. long waiting times; staff shortages, poverty, large class sizes etc) requiring intervention at national government level
- Lack of parental involvement in school health matters
- Ideological differences amongst actors/stakeholders regarding the value of school health services
- Lack of a dedicated budget for school health services

A. Systemic problems that require the intervention at national government level

These were the challenges that could not be addressed effectively at district level, as highlighted in the box 3 above. Comments from key informants are shared below:

i. Long waiting times at the health facility

"Most of our learners don't have medical aid, so when they need medical attention, they have to go and wait in long lines at the clinic…" -**(Key informant 1).**

ii. Poverty and other social problems amongst the school community members

"Most of our parents here will tell you that we are not working, we don't have the money to take the child here and there, we are unemployed. That is our main concern, unemployment of our parents in this area." -**(Key informant 3)**.

"For instance there's such a lot of social problems and when I get to the school it's as if I am the social worker.." - **(Key informant 7).**

iii. Large class sizes, therefore making educators job challenging

"You see we all sit with classes 40+ children in our classes, at the end of the day the curriculum does come first."- (**Key informant 2).**

iv. Shortage of nursing personnel

"We are supposed to be 5 teams in X (name withheld), we are 4 teams. Because of the other uncovered areas, Y and Z (names withheld), we divided those schools amongst us, so we both got extra schools…" -**(Key Informant 7).**

B. Lack of parent's involvement in their children's health matters

Lack of parental involvement in school health matters was cited by educators as one of the key challenges:

"You see we can set the appointment also but if the parent does not follow up…, a lot of them are unemployed, but some of them do work and their bosses may not allow them time off." -**(Key informant 2).**

C. Ideological difference amongst stakeholders regarding the value of school health and implementation of the school health policy

Some implementers pointed out that there are still some managers in the DOH who are opposed to the idea of having school health services:

"There's a lot of people within the department, top managers that believe that school health service should not exist. And I'm not talking here middle management level, I'm also talking top management level where people see this as a service that's wasting the health department's budget on healthy children."-**(Key Informant 6).**

Key informants reported that the DOH has started to put some pressure on nurses to see more children. School health nurses reported feeling this pressure:

"...as I said the only thing is I don't like this rush, I don't like this pressure, we have to see this amount of learners and then we have to move onto the next school. Because they want us by this year July to reach the target and I don't know if we'll reach the target." - **(Key informant 7)**

D. No dedicated budget to provide school health services

There are several costs associated with the provision of school health services that schools have to bear. These costs may include procuring and maintaining a well replenished first aid box, paying for staff members to be trained on first aid, and so on. With the exception of a once off sum of R1000 for the 2008 school year from the DOH, schools do not get a dedicated budget from either the DOE or the DOH for expenses:

"*We don't get money from the department [DOE], within our own budget we see what we are able to provid .."* **–Key informant 2**

"*No, we don't, from the DOH side, the facility like X, gets a budget and whatever budget facility X have we are included in that budget, but there is not a budget that says, this money is allocated to school health..*" – **(Key informant 7).**

While the historically disadvantaged school relies on nurses from DOH to provide services, the suburban school has found some innovative ways of providing high quality school health services in their school. This is done by making parents pay a special fee, called a testing fee:

"*What we do is the parents pay an additional sum, say it's like R300, its not a deposit for entrance, it's for a testing fee …and during the course of the year, while they are in Grade R, they will have, all the children will have: ears tested, eyes tested etc, just basic tests…."- (***Key informant 4).**

This school also make arrangements with different health professionals or organisations to provide services to the learners at a discounted fee:

> *…, because we are finding more and more children require things like occupational therapy.... about 8 or 9 years ago an occupational therapy practice, the lady approached me and asked if we would have accommodation for that practice at the school. And so they have been with us for about 8 years. But they're private; we give them sort of board and lodging so the fees are low."* **(Key informant 4).**

> *And also in addition to that, we employed a part-time psychologist originally she shared between another school and ourselves for three days; we now have her 5 days a week 'til 12 o'clock. I don't know what we would do without her; she actually does a lot of additional work. We now have a second psychologist that comes in twice a week. We also have a speech and language therapist who started three years ago … our speech and language therapist is an audiologist as well, also private practice."* **(Key informant 4).**

3.3.1 Suggestions for Improving Implementation Process

When participants were asked to give suggestions on how could the implementation of this policy be improved, almost all of them felt that provision of these services will be better if they were provided by resident professionals. That is, nurses and other professionals who provide these services should be based at their respective schools:

> *"I would love to work at the school to be employed…..to be placed in the school and then I would sustain health in the school because if you try to maintain, I must be honest we try to maintain health in the schools with what we are doing as far as this policy is concerned. To maintain health not sustaining health ,and the only way to sustain it is to be there constantly."- **(Key informant 7).***

"Ideally, each school should have its own school health nurse, psychologist, social worker, and community health worker." **(Key informant 1).**

3.6 Comparing Policy Implementation to Guidelines Provided

A set of guidelines accompanied the NSHP to provide an implementation framework for provincial health authorities (DoH, 2003). According to these guidelines, the school health policy should be implemented as follows:

- Phased implementation over 10 year period with more focus on implementing phase 1 level services for all schools in the country;
- Prioritizing most disadvantaged areas such as areas in the ISRDP & URP;
- 100% of school districts should provide at least phase 1 services by 2007;
- Districts that already have phase 1 services in place should proceed with the implementation of Phase 2 and 3 with immediate effect;
- Consideration for different staffing options for the delivery of the school health activities.

A summary of the findings from this study regarding policy implementation, compared to available guidelines is presented in Box 4 and elaborated on thereafter.

Box 4: Comparing NSHP implementation to guidelines

- Policy was implemented in a phased manner with more emphasis given to implementing phase 1 level services
- Disadvantaged areas were prioritised in the implementation of the policy
- Although there is flexibility in team composition regarding the provision of these services, financial constraints necessitate training nursing assistants
- Key informants reported that some schools are still not covered by school health services, and districts with phase 1 level service have not been able to move to higher phases *

[*] = and aspect that deviates from stated implementation guidelines

The implementation guidelines for this policy recommend a phased implementation, starting with Phase 1 level services until all schools are covered. The findings of this study suggest that this was mostly the case:

> *"... we have to examine the Grade R and 1 learners, supposed to be in a phase 3, ...but since last year the DOH said we must up our numbers, they want all the children in the Western Cape to be seen, to be at least screened...*- (**Key informant 7).**

Similarly, implementation prioritised the most disadvantaged areas, in this case the school in the URP focal area. As indicated already, the NSHP was not implemented in the suburban school.

The study found that different staffing options were used as indicated in the Guidelines. In this implementing school district, professional nurses, enrolled nursing assistants and community health workers were all part of a school health team:

> *"A team is a professional nurse and a sub-professional person. Previously it was a staff nurse because a staff nurse has a bit more advanced training but now it has moved to enrolled nursing assistants because of financial problems." -(***Key informant 7).**

Although the NSHP was implemented in all the eight WCED districts, key informants reported that there were still some schools that were not covered by school health services as can be seen from the following:

> *"If you look at it, by 2007 we should have had all schools covered with school health services. But it's not happening…. because the people who are supposed to do the tracking,.. they don't do it."* -**(Key Informant 6).**

A review of documentation kept by the school health nurse showed that of the 976, 647 learners registered in the WCED for the 2007/8 school year, about 127, 573 (13%) of

them were in Grade R and 1 (WCED, 2008). The total number of grade R and 1 learners who had health assessment during the 2007/8 school year was 97, 233 (76% of Grade R and learners) (WCDOH, 2008).

According to the guidelines, districts with phase 1 services should proceed with Phase 2 and 3 implementation, but this has not yet happened. Schools that already had phase 1 level of services are still providing these services at present. Key informants reported that school districts that attempted to proceed to phases 2 and 3 were asked to go back to phase 1 until all schools in the district are covered at phase 1, which was not the case at the time of the study:

> *"...supposed to be in a phase 3, we have worked in a phase 3 that means we do a full examination of the child, take their clothes off, test their eyes, listen to their hearts, we do a full examination. A thorough examination in a phase 3 but since last year the department of health said we must up our numbers, they want all the children in the Western Cape to be seen, to be at least screened and when we say screened that excludes a phase 3 because they want the numbers to go up. You see so we have to work in a phase 1 and 2 since last year..."* **(Key Informant 7).**

3.7 Summary of Chapter

The findings of this study revealed that actors charged with the implementation of the school health policy have different levels of awareness and understanding of this policy. Despite the policy being implemented in all WCED education districts, not all public schools were covered by these services as initially planned, and there in no dedicated budget from DOH or DOE for the implementation of this policy. While both implementers (educators and school health nurses) generally reported appreciation for the value of school health services, they also pointed to key challenges such as broad

systemic aspects, lack of parental involvement and lack of buy-in or prioritisation of school health services by senior DOH managers, that constrain their policy implementation efforts. Some aspects of this policy (e.g. phased implementation) were done according to policy guidelines, while other such as transition to higher phases of service provision did not go as stipulated. Lastly, for the school that implemented this policy, all the minimum requirements for the implementation of Phase 1 of this policy were met.

4 Chapter 4: Discussion

4.1 Introduction

This study was a process evaluation of the implementation of 2003 NSHP in two primary schools in Cape Town. The results of this small study should be interpreted in the light of its methodological limitations. The study findings cannot be generalized to other schools, education districts or provinces as it was not a representative sample of schools. Most of the information was self-reported by key informants and hence based on their perceptions of policy implementation. The findings contained in this report therefore reflect mostly the perspective of front-line implementers (nurses and educators) and there was no input from other key stakeholders or actors such as decision-makers (senior managers) from DOH and DOE as well as the learners' parents. The evaluation did not measure, and was not intended to measure, the impact of the policy on its intended beneficiaries.

Despite these study limitations, the findings of this study provide important insights into the current implementation process of this policy. It is one of the few policy implementation studies done in recent years and the in-depth qualitative methods allowed the researcher to explore the complexities and contradictions of policy implementation in post-apartheid South Africa. This study makes an important contribution to process evaluation of a major policy initiative and to documenting the perspectives of front-line implementers.

The evaluation found that by and large the policy has been implemented according to the guidelines and basic requirements for the implementation of this policy were met in the one school that implemented the policy. There was also a good working relationship between the educators and the nurses regarding the NSHP implementation. Parental involvement however, varied mostly according to context, with educators from the

historically disadvantaged school reporting minimal parental involvement while their counterparts from the suburban school reported maximal parental involvement. Nurses were also satisfied with the level of parental involvement, but this could be shaped by the school context.

Although this study was not an impact evaluation, both participating educators and school health nurses expressed appreciation for school health services. The most cited success of this policy was the fact that it acts as a safety net for children who may have otherwise been lost to the health system (especially for learners from the historically disadvantaged school). Through the health assessments for grade R and 1, nurses are able to detect learning barriers earlier and appropriate interventions can be put in place for learners who need it. When detected, these problems can be treated early and this gives the child a chance for normal development (Venter, 1997).

Educators also reported that school health services allow them to influence issues that are outside of their core functions as educators e.g. it is now easy for them to address issues such as child abuse in the learner's home environment. Good leadership in a school environment, the right attitude and passion for school health services by the nurse, were identified as essential factors for successful provision of these services.

Various weaknesses relating to implementation of this policy were identified, and these are discussed below. These weaknesses include differences in awareness and understanding of the policy between educators and nurses, reported shortage of nursing personnel, reported lack of coverage by school health services in some areas, and no dedicated budget for school health services.

4.2 Policy Implementation Process

Key informant responses indicated a dissonance between educators and nurses in terms of their awareness and understanding regarding the implementation of this policy. Some educators from the historically disadvantaged school were not even aware of the existence of the 2003 NSHP. This lack of awareness and understanding observed in some educators was seen as a major area of concern and a potential weakness in this policy implementation process as pointed out earlier by Shung-King (2006) because educators, as key stakeholders in school health services, were expected to be aware and familiar with this policy. Otherwise, how could they be expected to participate in the implementation of a policy programme that they are not even aware of? According to Ahmed et al. (2006), for school-based programmes, it is important to equip educators with appropriate skills (including awareness and understanding of a policy programme) before the programme is implemented. Success of implementation of these programmes also depends on educator's understanding of their role in their implementation (Leger, 1998).

However, as stated in the earlier section (section 2.3) of this research report, the historically disadvantaged school was one of the pilot sites for the HPSI in the Western Cape, and consequently one of the first schools in the district to adopt the HPS philosophy. Educators from this school were therefore more aware and familiar with the HPSI than the NSHP. School health services in this school were organized according to HPSI guidelines and not NSHP guidelines. As a result, educators in this school tended to describe their roles with regards to school health in line with the HPSI activities. It appears from this observation that for educators, the most important thing is to subscribe to the HPS philosophy, as opposed to knowing the more intimate details of the NHSP.

This is because, despite not knowing anything about the NSHP, this school was already a health promoting school.

Educators from the suburban school were aware of this policy, but this policy was not yet implemented in their school because this school was not initially prioritized for NSHP implementation. However, despite the NSHP approval six years ago, this suburban school saw school health services outside the broader NSHP framework.

Nurses who participated in this study were well informed about the national school health policy and understood this policy well within the context of HPSI. Their understanding of the NSHP was that it provided them with guidelines to make schools health promoting environments, which is consistent with one of the objectives of this policy i.e. *"to support educators and the entire school community by creating health promoting schools." (DoH, 2003)*.

A possible explanation for this apparent lack of common understanding and awareness of the policy can be attributed to some of the events that occurred during the formulation of this policy. These include lack of significant contribution to the policy formulation discourse by DOE as well as failure by policy formulators to state explicitly the role and or input expected from the DOE with regards to the implementation of this policy (Shung-King, 2006; DOH, 2003). Given that this policy is external to the DOE, and the fact that it does not specify the role of educators for its implementation, educators are less likely to be familiar with it when compared to school health nurses who have to undergo training and orientation on implementing the NSHP.

Another reason that could have led to this differences in awareness and understanding of this policy between educators and nurses was the fact that, around the time that this

policy was implemented there were a number of other prominent health policies aimed at school-going children that were also being implemented, including the National HIV/AIDS policy for the education sector, the Youth and Adolescent Health Policy, and HPSI.

Regarding HPSI, this initiative was launched in 1999, around the same time when the initial work for the formulation of the national school health policy was initiated. The end goal of this initiative was supposed to be a policy on school health (Shung-King, 2006), and its contents and language are for the most part identical to what ended up being the 2003 NSHP. This led to some people wondering why there was a need for a separate school health policy when school health services forms one of the main pillars of HPSI (Shung-King, 2006).

The answer lies in the fact that these two initiatives were driven by different people, within the DOH: HPSI was driven by the Health Promotion Directorate and the NSHP was driven by the Mother Child Health Welfare Directorate. The vision was that school health policy would articulate with the HPSI (DoH, 2003), however, that did not necessarily happen (Shung-King, 2006). In some provinces (e.g. the Western Cape), the two initiatives worked in an integrated manner while in some provinces they functioned differently, even competing for resources at times (Shung-King, 2006).

In provinces where these initiatives worked together in an integrated way, e.g. the Western Cape, schools that were already health promoting schools (i.e. implemented HPSI) were allowed to do so, and supported as needed because health promoting schools is the intended end goal of the NSHP. It appears therefore that since educators from the historically disadvantaged school were already 'buying-in' to the HPS philosophy, and were already engaged in several HPS activities in their school, it was not crucial to re-

introduce the NSHP to educators in schools that were already health promoting schools. This may help explain why educators in this school, despite having functional school health services, were not too familiar with the NSHP but very familiar with HPSI.

For the historically disadvantaged school, it is difficult to make an association between the school health activities that were taking place (especially activities that were carried out by the educators) and the implementation of NSHP by nurses in this school. This is especially true when considering that some of the educators in this school, who played critical roles in the organization of school health activities in this school, were not even aware of the NSHP. Most of the school health activities that were taking place in this school could therefore be attributed to the introduction of the HPSI and possibly school health activities that already in place in the school district prior to the introduction of NSHP. As stated earlier school health services in this school dates back to over two decades ago, and even when school health services were going through a slow death in the entire country, this school district kept their school health services alive. The participation of this school in the early phase of HPSI may have also further reinforced the school health services in this school.

At the same time, the value of introducing the NSHP as a national policy that guides the provision of school health services in the entire country cannot be discounted. This is because the policy provides a blueprint of achieving health promoting schools. Nurses assist in making schools health promoting by using the implementation guidelines specified in the NSHP. Certainly, there was evidence of health promoting school best practices and there are many lessons to be learnt from efforts at this school. This bodes well for similar schools to follow the example of this school, which despite its disadvantages, has managed to implement the objectives of a health promoting school.

At the time of this study, the NSHP was not yet implemented in the suburban school, possibly because the suburban school was not considered a priority for the implementation of this policy, mainly because of its socioeconomic standing (refer to Table 2). However, prioritizing the historically disadvantaged school over the suburban school, while consistent with the policy implementation guidelines (DOH, 2003), had an unintended consequence of further deepening inequalities in the quality of these services between the two schools. The differences in the nature and scope of the school health services provided between the two schools were staggering. For instance, instead of relying on nurses from DOH for their school health services, the suburban school works with private practitioners such as psychologists, occupational therapists, speech therapists etc to provide these services at a reduced rate in exchange for 'room and board.'

Learners from this school currently benefit from the services of private practitioners who work closely with educators on a daily basis. This type of inequity in the nature and quality of school health services available to different public schools was one of the problems that were meant to be rectified through the implementation of this policy (DOH, 2003). However, the findings of this study seem to suggest that this is not necessarily happening, as it was the case in the two schools that participated in the study.

A possible explanation for the stark disparities in the nature and scope of school health services between the two schools is the amount of resources that each school possessed when the NHSP was introduced. For instance, the historically advantaged school was already endowed with more resources e.g. safe and equipped playgrounds and 'extra' rooms in the school while the historically disadvantaged school has none of those facilities. The nature and scope of services that can be offered through the implementation of the NSHP, will be largely determined by the availability of resources (or facility) at each school. Schools without 'extra' rooms that can be rented by private

providers at a lower fee, will find it difficult to attract private practitioners to offers services to them. Likewise, in the schools with no safe playgrounds for the learners such as the historically disadvantaged school, learners are less likely to be motivated to take part in voluntary and meaningful healthy physical activities during recess times. Therefore, as long as there are these glaring disparities in availability of resources between different schools, it will take a long time for the NSHP to bring about equitable school health services.

Educators and school health nurses generally had good working relationships around the provision of school health services. This may be due to the fact that educators are becoming increasingly aware of the interconnectedness between learning and good health (Lynargh et. al. 1997; DOH, 2003), and they may have also seen positive outcomes from the work done by nurses in the assessments for the learners. Reported collaboration between nurses and educators in health education was also an indicator of the healthy relationship between these policy actors. Educators and private practitioners were also reported to enjoy a good working relationship in the suburban school.

Implementation guidelines for this policy recognize active involvement and participation by parents and community as a one of the critical success factors for implementing this policy (DOH, 2003). However, the findings of this study showed that parental involvement in school health matters varied according to the context. Context under which the policy is being implemented is known to influence the manner of implementation as well as the outcome of policy implementation (Walt & Gilson, 1994). Relevance of context in this case is important especially when considering the differences in socioeconomic profiles of the two communities within which the two participating schools in this study were based.

There appear to be some contradictory reports regarding the level of parental involvement in the provision of school health services in the historically disadvantaged school. Educators from this school reported low levels of parental involvement in schools health matters. There were reports by some of the educators from this school that it is not uncommon for parents in their school to send a sick child to school with the hope that educators will do something about it. Some of the reasons given by educators in this school for this low parental involvement included high levels of poverty i.e. parents not having resources to follow-up on child's health as recommended by the educators and the fact that some parents' employers may not allow them to take time-off to attend to school health matters.

School health nurses however, reported adequate parental involvement in school health matters. Good parental participation reported by the nurse could possibly be attributed to two things. Firstly, nurses do dispense some common medications (e.g. de-worming creams) to the learners where applicable, therefore parents may be too willing to work with the nurse because they know that if they do not take advantage of the nurses' visit at the school, they may have to go to the local clinic (where they may have to wait in a long line) for the same service. The second reason may be the fact that nurses have the means to drive up to the learner's home (as part of their job) for follow-up visits where indicated. i.e. school health teams are provided with state vehicles to drive around to different schools. This is something that teachers are simply not able to do due to competing curriculum issues. Furthermore, teachers tend to view curriculum matters, rather than health issues, as their primary focus.

Low levels of parental involvement in school health matters may hamper effective implementation of this policy. Parents are the ultimate custodians of their children's health and successful management of their children's health related issues largely

depends on their active involvement. If parents are not aware of the input that their children get from school regarding health information, they are less likely to reinforce healthy habits that children learn at school in the home environment (Lynagh et al, 1997). Therefore there will be limited carryover of health information from school to home and vice versa. Involvement of parents, care-givers and the broad community is therefore essential for the effectiveness and sustainability of school health services (Perry et. al, 1988).

Reports from the implementing staff indicated that there is no formal forum that brings educators, school health nurses and parents together on one platform to discuss learners' health matters. Current working relationship is between nurses and educators, nurses and parents and parents and educators, but no direct working relationship among these three stakeholders at the same time. This may help explain the variable patterns of working relationships between these stakeholders. Likelihood of successful implementation of this policy is also dependent close working relationship between all these stakeholders (Perry et. al, 1988; Lynagh et al, 1997). There is a need to bring these stakeholders together on one platform for school health purposes. Existing formal structures in each school such as the School Governing Body (SGB) and the Educator Support Team (EST), if used effectively can be instrumental in bringing these different stakeholders together to address school health matters collectively.

Key services specified to be provided at phase 1 level of service provision are health assessments of Grades R and 1 and health promotion activities for grade 1 (DOH, 2003). However, a comprehensive range of services, including all services specified in phase 1 as well as health education, social services and at times responding to special requests such as the Vitamin A campaign, is currently being provided. The information emerging from this study seemed to suggest that health assessments have now taken precedence

over most of the services currently being provided. This is said to be mainly due to a recent push from the DOH requiring as many learners as possible to be assessed. Nurses reported that they now have less time for other important components of school health services e.g. health promotion activities that they should provide. Over-emphasizing health assessments at the expense of other school health services can undermine the holistic model of school health services advocated by this policy. This can lead to these services reverting back to traditional models of school health services, which were essentially mobile health assessments in a school setting (Resnicow & Allensworth, 1996).

Sufficient financial resources are an important requirement for effective implementation of a policy or programme (Mazmanian & Sabatier, 1989; Hildebrand & Grindle, 1994). Specific to the implementation of this policy, both educators and school health nurses reported that there is no budget dedicated to school health services from neither DOE nor DOH that. Schools are expected to cover school health- related expenses from their central budget. This could create a problem for schools because their primary focus is to put curriculum matters first. Health matters should not be perceived to be competing for limited financial resources with curriculum matters in a school setting, especially when considering that provision of school health is not the responsibility of DOE. Schools should not be expected to cover expenses for school health services from their own budget. All school health related expenses should be covered by the DOH.

It is understandable that there is no separate budget for school health services from the DOH since these services are part of PHC package of service (DOH 2000). However, there is a need for a dedicated budget for school health services to facilitate better planning and monitoring of these services. Budget allocation should be done according to the guidelines specified in the policy implementation guidelines (DOH, 2003).

4.2.1 Challenges and Constraints Reported by Implementers

Implementing staff reported numerous challenges they face with implementing the NSHP. Some of the challenges reported were broader systemic problems that called for intervention at higher levels of government. These included:

- Long waiting times at health facilities
- Poverty and other social problems amongst school community members
- Large class sizes and
- Reported shortage of nursing personnel

Some challenges however, e.g. lack of parental involvement in school health matters called for new approaches on the part of the educators for engaging parents. One approach will be to work closely with nurses when following up on learners identified with health problems. Nurses appeared to be the most influential stakeholders in the implementation of the NSHP. For instance, nurses reported better success in working with parents than educators, therefore educators could take advantage of nurses' good working relationship with parents. Other approaches may involve effective use of existing structures such as the SGB to promote parents' participation in school health matters.

School health nurses reported lack of support for school health services from some senior DOH managers. They indicated that there are some individuals in senior management position who are opposed to the fact that these services are provided by the DOH, and even worse, that these services focus on "healthy children" and not sick people. There are also some reported differences of opinions between some senior DOH managers regarding where school health services belong (i.e. DOH or DOE).

According to Winter (1990), it is not unusual to have implementers of a public policy who are not completely committed (and in some cases who are opposed) to its implementation as it appears to be the case with this policy. This is because, public servants are sometimes required to assist in the formulation and or implementation of policy or programme without first demonstrating their commitment to such programme (Winter, 1990). This could be one of the reasons why some people are still resistant about giving the implementation of this policy the support that it deserves. As stated in earlier sections of this report, school health services is part of PHC package (DoH, 2000), managers in the DOH are expected to deliver this service regardless of whether they support it or not. However, managers who are opposed to these services are less likely to devote any or additional resources to them.

Another challenge reported by school health nurses during this study was the shortage of personnel to implement this policy. Nurses reported that they were severely short-staffed to an extent that some school health teams were made up of only one member. It was not possible to confirm this reported shortage of personnel during this study, but a review of the 2007/8 Western Cape Provincial Department of Health (WCPDOH) annual report showed the department was understaffed (e.g. a vacancy rate of 24.51% at District Health Services) which to some extent corroborated the nurses' claims. Because of this shortage of implementing personnel, there were schools within the district that were reportedly still not covered by these services. This forced some school health teams to take on more schools than they were supposed to, leading to nurses feeling overworked. Staff shortages coupled with demand from the DOH to meet set targets with regard to health assessments of learners put pressure on nurses to perform.

Availability of adequate personnel is a critical requirement for effective implementation of a policy (Mazmanian & Sabatier, 1989). When a policy is faced with shortage of

implementing officials, there is always a danger of implementers modifying it in order to cope with their work demand. According to Winter (1990), "street-level bureaucrats" (front-line implementing staff) have the capacity to systematically distort the implementation of a programme or policy as it was the case during the implementation of a similar programme, the Primary Schools Nutrition Programme. Because of lack of competent staff (and shortage of personnel in general), the programme was distorted to a point that several of its components were totally lost during its implementation (Labadarios, et al 2005). With reports from implementing staff indicating that some services (e.g. health promotion) are often left out to give more time for health assessments, there is a danger that implementing staff may modify the implementation of this policy to provide only those services that available personnel feel they can reasonably cope with.

4.3 Was the Policy Implemented According to the Guidelines?

It is not possible to state whether educators implemented this policy according to the guidelines as the NSHP guidelines are not explicit on how educators were expected to implement this policy (Shung-King, 2006). However, nurses implemented most aspects of this policy according to specified policy implementation guidelines, including phased implementation with focus on health assessments, prioritization of disadvantaged areas and consideration for different staffing options to compensate for shortage of nursing personnel.

There were some aspects such as; providing phase 1 services in all school districts by 2007, and progression from phase 1 level services to higher phase services that did not go according to the stated guidelines. With respect to phased implementation, this study found that the DOH was committed to ensuring that all school districts get phase 1 level

services, before higher levels of service could be offered. For instance, nurses in school districts that were already providing services at phases 2 and 3, were ordered to scale down their services to phase 1 level to ensure that at least all the learners get basic services.

With regards to the provision of at least phase 1 service in all school districts by 2007, nurses reported that there are still some schools in this district that were not covered by school health services. This was confirmed by the WCDOH 2007/8 annual report which indicated that despite the school health services being implemented in all the education districts within the WCED, 76% of Grades 1 and R learners had health assessments during the 2007/8 school year. Shortage of personnel was indicated as the main reason for not achieving 100% coverage. However, it might also be because of lack of prioritisation by senior management and lack of a dedicated budget.

4.4 Are the Minimum Requirements for Policy Implementation Met?

The study found that minimum requirements for the implementation of school health services, specifically with reference to phase 1 level of services were met. All health assessments outlined in the policy are currently being done, requirements for health promotion are met, nurses refer to higher level facilities, recommended staff mix are currently being used, and the number of school visits per annum and required follow-up are executed as specified in the guidelines (DOH, 2003).

However, there were concerns about health promotion activities. Due to reported shortage of staff and pressure from the DOH to perform health assessment of all Grades R and 1 learners, health promotion services were for the most part left out to give more attention to health assessments. It was found that despite appropriate school health

composition and health team to learner ratio, nurses generally reported being overworked, possibly suggesting a need to revise the school health team-to-learner ratios specified in the guidelines to make the work more manageable. Overall, all the minimum requirements for the Phase 1 implementation of the NSHP appeared to have been met in the one school where this policy was implemented.

5 Chapter 5: Conclusion and Recommendations

This study sought to evaluate the implementation process of the 2003 NSHP, and no attempt was made to evaluate the impact of policy implementation, therefore conclusion from this study is limited only to the evaluation of the implementation process.

From the perspective of school health nurses, this policy has for the most part been implemented according to the policy implementation guidelines and the minimum requirements with respect to the implementation of phase 1 level of services were met. There were some aspects of the policy that did not go according to the implementation plan, e.g. delay in the implementation schedule to cover all schools reported by nurses and failure by schools that already had phase 1 level of services to move to the next levels of service provision.

Broader systemic problems hampered policy implementation, and requires intervention at a national level. However, some aspects could be addressed at a lower level. These include the fact that educators and school health nurses did not have the same level of knowledge and understanding of this policy; low levels of parental involvement in school health in some context; reported shortage of implementing personnel, and lack of dedicated budget for the provision of these services that threatened to undermine the implementation of this policy. Despite these challenges, implementing staff were generally happy about the implementation of this policy and recognized its potential positive impact on learner's health and ultimately on the learning process.

5.1 Recommendations

The recommendations are drawn from the findings of this study and take into account suggestions made by the study participants on improving school health services. Suggestions for future research topics are also listed below.

5.1.1 Improve educators' level of awareness and understanding of the 2003 NSHP

The results of this study showed that educators and nurses do not have the same level of awareness and common understanding of the 2003 NSHP. It is important that educators be familiarised with this policy since they are key to its implementation. Educators should also be aided to understand how this policy is related to the HPSI. The current guidelines should be updated in consultation with the DOE and include the role of the DOE broadly and of educators specifically.

5.1.2 Use of existing structures such as the SGB to promote school health

There is a need to have key stakeholders, such as educators, parents and nurse meet regularly to discuss school health matters. Open communication is necessary among these various stakeholders to address and educate each other about the relevance of this policy to them, as well as a discussion and explanation of the respective roles of each party. At present there is no formal forum that brings all these key stakeholders together. SGB can provide an excellent forum for that purpose if used effectively.

5.1.3 Review and revise NSHP guidelines

Both educators and nurses expressed a wish to have a frequent contact with each other to address school health matters effectively. Current school population to team ratios may need to be reviewed to allow nurses to spend more time at their designated schools and to focus on health promotion activities, including building some or all of these activities into the existing school curriculum. Alternatively, the recommended number of visits should be revised. The role of parents should also be included in the revised guidelines.

5.1.4 Dedicated budget from DOH for school health services

At the moment schools have to pay for school health related expenses out of their schools central budgets, making it difficult for disadvantaged schools to do so. This may have the unintended consequence of exacerbating inequity among schools in different geographical areas with different socio-economic profiles. The DOH should dedicate a certain amount of funds from the District Health budget towards school health services. The size of this dedicated budget should be consistent with the estimates determined during the costing exercise done when this policy was developed. This will facilitate better planning, organization and monitoring of these services.

5.1.5 Continually lobby and educate senior DOH managers about the value of school health services

One of the challenges faced by school health nurses was the lack of buy-in and at times reported opposition from some senior DOH managers who felt that money spent on school health services is not money well spent, as it is spent on healthy children and not sick people. There are also reports of managers who feel that school health should be the responsibility of the DOE and not that of the DOH. These managers should be orientated towards a broader public health approach, which includes the value of prevention and health promotion, and towards recognizing the value of these services. Nurses should also use their statistical records to illustrate that school health services are an important package of district level services.

5.2 Suggestions for Further Research

There is a dire shortage of evaluation studies on school health services in South Africa. More research needs to be done in this area to generate a body of evidence that can be

used to improve these services on an ongoing basis and to justify their existence. Possibilities for future research studies are listed below:

- Cost-effectiveness studies on school health services in South Africa;
- A representative survey across all the nine provinces to document progress or lack of progress with regards to the implementation of the NSHP;
- A study evaluating the outcomes or impact of the school health policy on learners' health;
- A study to determine how the current school health activities could be aligned with or mainstreamed into the educational curriculum;
- Perceptions of parents regarding school health services;
- Survey of knowledge, attitudes and perceptions of those in senior management positions with regards to the importance of the NSHP;
- A teachers' survey on their perceptions of the NSHP and their role to be with regards school health services.
- Development of indicators to measure equity in the provision of school health services across the country, between urban and rural areas, and between public and private schools.

The findings of this study will be presented to both school health nurses and educators in the two schools, and to the WC DOH and WCED, it is hoped that it will be used to further improve school health services.

REFERENCES

Ahmed, N., Flisher, A.J., Mathews, C., Jansen, S., Mukoma, W., & Schaalma. (2006). Process evaluation of the teacher training for an AIDS prevention programme. *Health Education Research: Theory & Practice, 21(5)*, 621-632.

Al-Amari, H. (2007). An evaluation of the role of elementary school teachers in Kuwait in promoting health. *International Journal of Health Promotion & Education, 45(4)*, 121-124.

Bundy, D.A.P., & Guyatt, H.L. (1996). Schools for Health: Focus on Health, Education and the School-age child. *Parasitology Today, 12(8)*, 1-14.

Bundy, D.A.P., Shaeffer, S., Jukes, M., Beegle, K., Gillespie, A., Drake, L., Lee, S. F., Hoffman, A., Jones, J., Mitchell, A., Barcelona, D., Camara, B., Golmar, C., Savioli, L., Sembene, M., Takeuchi, T., & Write, C. (2006). School-Based Health and Nutrition Programs. In D.T. Jamison, J.G. Breman, A.R. Measham, G. Alleyne, M. Claeson, D.B. Evans, P. Jha, A. Mills & P. Musgrove (Eds.) Disease Control Priorities in Developing Countries (2nd Edition), (pp1091-1109). New York, USA: Oxford University Press.

Centres for Disease Control and Prevention. (1996). Guidelines for School Health Programmes to Promote life-long healthy eating. Morbidity and Mortality Weekly Report Recommendations and Reports.(45): pp 1-41.

Child Health Unit. (1998). Workshop on an Integrated policy for school health. *MCH News No. 8.* March 1998.

City of Cape Town. (2009). Presidential Urban Renewal Programme. Retrieved 23 May, 2009, from http://www.capetown.gov.za/en/urbanrenewal/Pages/default.aspx.

Cloete, F. (2006). Policy Evaluation or Assessment. In F. Cloete & H. Wissink, H (Eds). Improving Public Policy.Van Schaik. Pretoria. Republic of South Africa.

Creese A. (1991). User Fee Charges For Health Care: A Review of Recent Experience. *Health Policy and Planning, 6*: 309-319.

Creswell, J.W. (1998). Qualitative inquiry and research design: Choosing among five traditions. Thousand Oaks, California, USA: Sage Publishing.

Department of Education. (1999). National Policy on HIV/AIDS, for Learners and Educators in Public Schools, and students and educators in further Education and Training Institutions. *Government Gazzette Vol. 410, No. 20372, 10th August 1999.*

Department of Education. (2002). Education Statistics in South Africa at a Glance in 2002. unpublished.

Department of Health. (2000). The Primary Health Care Package for South Africa -a set of norms and standards. Pretoria South Africa.

Department of Health. (2001). The Youth and Adolescent Health Policy Guidelines. Pretoria. Government Printer.

Department of Health. (2003). School Health Policy and Implementation Guidelines. Pretoria. Government Printer. Pretoria

Department of Welfare. (1997). White Paper for social Welfare: Principles, guidelines and recommendations. Proposed policies and programs for the development social welfare in South Africa. Department of Welfare. Pretoria

Durlak, J. A., & Wells, A. M. (1997). Primary prevention mental health programs for children and adolescents: A meta-analytic review. *American Journal of Community Psychology, 25,* 115-152.

Fay, M., Leipziger, D., Wodon, Q., & Yepes, T. (2005). Achieving Child-Health-Related Millennium Development Goals: The Role of Infrastructure. *World Development, 33(8),* 1267-1284.

Government of the Republic of South Africa. (1996). Constitution of the Republic of South Africa, Act 108 of 1996. Section 28. Pretoria.

Government of the Republic of South Africa. (2000). Regulations for the Preferential Procurement Policy Framework Act (Act 5 of 2000). Pretoria.

Government of the Republic of South Africa. (2004). South African Health Act. Act no.61 of 2003. Pretoria

Government of the Republic of South Africa. (2004). South African Social Security Services Act. Act no.9 of 2004.

Guthrie, T., Shung-King, M., Steyn, K., & Mathambo, V. (2000). Children and Tobacco in South Africa. A literature review of health effects, youth smoking patterns and tobacco control measures. Child Policy Institute/Medical Research Council. Cape Town.

Hamilton, K., & Saunders, L. (1997). The Health Promoting School: A Summary of the ENHPS Evaluation Project in England. HEA, London.

Henry J. Kaiser Family Foundation. (2001). Henry J. Kaiser Family Foundation (2001): *Portrait of young South Africa*. Johannesburg: Love Life.

Hildebrand, M. E., & Grindle, M. S. (1994). Building Sustainable capacity: challenges for the public sector. Harvard University: Harvard Institute for International Development.

James, S., Reddy, P., Ruiter, A.C., McCauley, A., & van den Borne, B. (2006). The Impact of an HIV and AIDS Life Skills Program on Secondary School Students in KwaZulu-Natal, South Africa. *AIDS Education and Prevention, 18(4)*, 281-294.

Kingsman, J., Harrison, S., Kengeya-Kayondo, J., Kanyesigye, E., Musonke, S., & Whitworth, J. (1999). Implementation of Comprehensive AIDS education program for schools in Masaka District, Uganda. *AIDS CARE, 11(5)*, 591-601.

Kingsman, J., Nakinyingi, J., Kamali, A., Carpenter, L., Quigley, M., Pool, R., & Whitworth, J. (2001). Evaluation of a Comprehensive school-based AIDS education program in rural Masaka, Uganda. *Health Education Research: Theory & Practice, 16(1)*, 85-100.

Kuhn, L., Steinberg, M., & Mathews, C. (1994). Participation of the school community in AIDS education: an evaluation of a high school programme in South Africa. *AIDS CARE, 6*,161-71.

Labadarios, D., Steyn, N.P., Mgijima, C., & Dladla, N. (2005). Review of the South African nutrition policy 1994-2002 and targets for 2007: Achievements and Challenges. *Nutrition, 21*,100-108.

Leedy, P. D., & Ormrod, J.E (2005). Practical Research: Planning and Design. New Jersey, USA: Prentice Hall.

Leger, L. (1998). Australian teachers' understanding of the health promoting school concept and the implications for the development of school health. *Health Promotion International, 13(3),* 223-235.

Lynagh, M., Schoefield, M.J., & Sanson-Fisher, R.W. (1997). School Health Promotion Programs over the past decade: a review of the smoking, alcohol and solar protection literature. *Health Promotion International, 12*, 43-60.

Magnani, R., MacIntyre, K., Mehyrar, K., Lisanne, B., & Hutchinson, P. (2005). The Impact of life skills education on adolescent sexual risk behaviours in KwaZulu-Natal, South Africa. *Journal of Adolescent Health, 36*,289-304.

Manios, Y., Kafatos, A., & Mamalakis, G. (1998) The effects of a health education intervention initiated at first grade over a 3 year period: physical activity and fitness indices. *Health Education Research*, 13, 593–606.

Mantu, R. (2005). "Social security grants increased." *Bua News.* Retrieved August 26, 2008, from www.southafrica.info/doing_business/economy/fiscal_policie/budget2005

Mazmanian, D.A., & Sabatier, P. (1989). Implementation and Public Policy. New York. USA: University Press of America.

Mbananga, N. (2004). Cultural clashes in reproductive health information in schools. *Health Education, 104(30),*152-162.

Mukoma, W., & Flisher, A. (2004). Evaluations of health promoting schools: a review of nine studies. *Health Promotion International, 19(30),* 357-368.

Onya, H. (2007). Health Promotion in South Africa. *Promotion and Education, 14(4),* 233-237.

Owen, J.M., & Rogers, P.J. (1999). Program Evaluation: Forms and Approaches. London. UK: SAGE Publications.

Perry, C.L., Luepker, R. V., Murray, D.M., Kurth, C., Mullis, R., Crockett, S., Jacobs Jr, D.R. (1988). Parent Involvement with Children's Health Promotion: The Minnesota Home Team. *American Journal of Public Health, 78(9)*, 1156-1160.

Program for Health and Development in South Africa. (2004). HIV and Sexual behaviour among young South Africans: A national survey of 15-24 year olds. Retrieved January 20, 2009, from http://www.kff.org/southafrica/7066.cfm.

Purdon, S., Lessof, C., Woodfield, K., & Bryson, C. (2001). Research Methods for Policy Evaluation. Department for Work and Pensions Research Working Paper No 2. Retrieved March 10, 2008, from http://www.dwp.gov.uk/asd/asd5/WP2.pdf.

Resnicow, K., & Allen, D. (1996). Conducting a Comprehensive School Health Program. *Journal of School Health, 66(2)*,59-63

Schagen, S., Blenkinsop, S., Schagen, I., Scott, E., Eggers, M., Warwick, I., Chase, E., & Aggleton, P. (2005). Evaluating the impact of the National Healthy School Standard: Using National Datasets. *Health Education Research, 20(6)*, 688-696

Scheirer, M. A. (1994). Designing and using process evaluation. In J. S. Wholey, H. Hatry and K. Newcomer (Eds.), Handbook of Practical Program Evaluation (pp. 40-68). San Francisco : Josey Bass.

Skinner, D., & van der Walt, H. (1997). Qualitative methodology: An introduction. In J.M. Katzenellenbogen, G. Joubert, & S.S. Abdool Karim (Eds). Epidemiology: A manual for South Africa. Johannesburg. RSA
Oxford University Press.

Shung-King, M. (2006). The Ebb and Flow of Child Health Policy Development in South Africa. Children's Institute. Cape Town.

Statistics South Africa. (2002). *Census 2001. A population Profile of Mitchell's Plain.* Pretoria: Statistics South Africa, 2002. Retrieved May 22, 2009 from http://www.capetown.gov.za/en/stats/CityReports/Documents/Population%20Profiles

Turok, I. (1991). Policy Evaluation as a Science: a critical assessment. *Applied Economics, 23,* 1543-1550

UNICEF (2008). Millennium Development Goals; about the goals. Retrieved December 19, 2008, from http://www.unicef.org/mdg/28184_28230.htm

United Nations. (1989). Convention of the Rights of the Child. Geneva; Switzerland.

United Nations General Assembly. (2000). United Nations Millennium Declaration, G.A. Res. 55/2, U.N. GAOR, 55th Session. Retrieved December 19, 2008, from http://www1.umn.edu/humanrts/instree/millennium.html.

Venter, J. (1997). School Health Services in the North West Province.. In E. Abrahams & A. Wigton (2008). Proceedings of a workshop on an integrated Policy for school health; 4-5 December 1997.

Veugelers, P.J., & Fitzgeral, A.L. (2005). Effectiveness of School Health Programs in Preventing Childhood Obesity: A Multilevel Comparison. *American Journal of Public Health, 95(3),* 432 -435

Walt, G., & Gilson, L. (1994). Reforming the health sector in developing countries: the central role of policy analysis. *Health Policy and Planning, 9 (4).* 353-370.

Wang, L. Y., Gutin, B., Barbeau, P., Moore, J. B., Hanes, Jr, J., Johnson, M.H., Cavnar, M., Thornburg, J., & Yin, Z. (2008). Cost-Effectiveness of a School-Based Obesity prevention Program. *The Journal of school health, 78(12)*, 619-624.

Warwick, I., Aggleton, P., Chase, E., Schagen, S., Blenkinskop, S., Schagen, I., Scott, E., & Eggers, M. (2005). Evaluating healthy schools: Perceptions of impact among school-based respondents. *Health Education Research: Theory & Practice, 20(6),* 697-708.

Western Cape Department of Health (2008). Annual Report 2007/8. Retrieved December 3, 2008, from http://www.capegateway.gov.za/Text/2009/2/wc_dept_health_annual_report.

Western Cape Education Department. (2008a). Search for WECD Schools. Retrieved September 3, 2008 from http://wced.wcape.gov.za/home/home.html.

Western Cape Education Department. (2008b). Schools Annual Survey 2008. Unpublished Report. Cape Town.

Wiley, D.C., James, G., Jonas, J., & Crosman, D.E. (1991). Comprehensive School Health Programs in Texas Public Schools. *Journal of School Health. 61(10),* 421-425

Wilson, P., O'Meara, S & Summerbell, C (2003). Effective Health Care Review Team. The Prevention and treatment of childhood obesity. *Quality and Safety in Health Care ,(12),* 65-74.

Winter, S (1990). Intergrating Implementation research. In D. Palumbo and D. Calista (eds). Implementation and the policy process: Opening the black box. New York, USA: Greenwood Press.

WHO/AFRO. (2002). A Special Health Promotion Project: The Health Promoting Schools Initiative. Retrieved January 7, 2009, from http://www.afro.who.int/healthpromotion/project.html.

WHO. (2009). School and Youth Health: Global School Health Initiative. Retrieved January 7, 2009, from http://www.who.int/school_youth_health/gshi/en/

World Bank.(1993) In: World Development Report: Investing in Health. New York, USA: Oxford University Press

GLOSSARY OF TERMS

Children's Institute- a University of Cape Town based child health research institution

Health promoting school initiative-a program of coordinated services that has been jointly developed by various sectors to address comprehensively the health and development needs of school communities. The initiative is designed to improve the health of students, school personnel, families and other members of the community through schools. School health is a component of this initiative.

Health promoting school-a school that constantly strengthens its capacity its capacity as a healthy setting for living, learning and working.

Maternal, Child and Women Health (MCWH)-a section in the DoH that is responsible for the programmes relating to health of women and children

Millennium Development Goals – A set of eight broad goals formulated by the United Nations general assembly in 2000 as an attempt to address the world's key developmental challenges

Policy evaluation - an assessment of a policy performance or impact against its objectives to determine whether to continue with the implementation of a policy or programme, or curtail, terminate or expand it

Process evaluation - a measure of the degree or the extent of the implementation of the policy

Primary Health Care Package-An outline of health care services to be delivered at the primary level of care

Primary school nutrition program-a feeding program implemented in primary schools to address the nutritional needs of these children

School-going child-a child of school-going age, usually between 6-18 years of age

APPENDICES

Appendix A: Interview Schedule for Key Informants

Name of School	
Position/Designation	
Date of interview	

a. Could you please tell me about your involvement in the implementation of the school health policy in your school (probe: roles and responsibilities; how long they have been involved?)

b. Could you tell me whether there is a budget for the implementation of the school healthy policy?

c. Do you have a person responsible for managing the school health services in this school?

d. Do you have a coordinating forum for school health services in this school?

e. How are the services in this school organized (probes:, relationship between school staff and school health nurses, how often are Grade R/I assessments done, referrals and follow-up)

f. What specific services outlined under this policy are currently being provided? (PROBE: who provide which services; how are the services in this school being provided?)

g. Do you record the number of all learners who had Grade R assessments? (if the answer is yes), May I please have a look at the records (Note: The researcher is not interested in the identifying information of the learners).

h. Could you comment on the involvement of the school governing body/parents in the implementation of the policy?

i. What do you see as some of the success(es) in terms of the implementation of this policy in your school?]

j. What do you think account for those success(es)?

k. What do you see as constraints/obstacles or challenges (if any) in the implementation of this policy in your school?

l. What were the reasons for these?

m. How have you addressed these challenges that you have cited so far

n. If you were to change or do anything differently in how this policy has been implemented, what will it be?

o. Any other information/comments that you would like to add to what you have said so far?

Additional Information:

The following information will be noted from the statistical records of the learners assessed:

i. % of learners who had Grade R/I assessments
ii. % of referrals of learners with health problems
iii. % of learners with identified problems successfully treated
iv. % of learners with health problems who have been followed-up at least once.

[check the contents of the first aid box]

Thank you very much for agreeing to talk to me.

Appendix B: Self-Administered Questionnaire

Table 2: Minimum Requirements for the Implementation of School Health Policy

A. Grade R/I Assessments				
	Yes	No	Not Sure	Additional comments
Are the following assessments done: a. Hearing b. Vision c. Gross-motor d. Anthropometric	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	
B. Referral Facilities Required	Ye s	No	Not Sure	
Access to: a. an Audiologist b. an Optometrist c. a Physiotherapist d. an Occupational therapist e. Nutritionist	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	
C. Health Promotion	Yes	No	Not Sure	
Is the following available in the school: a. At least 1 staff member trained in first aid b. Fully equipped first aid box	☐ ☐	☐ ☐	☐ ☐	
D. Staff Mix	Yes	No	Not Sure	
The services are provided by the following team members: a. School health nurse b. Nursing assistant/health promotion worker c. Other	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	
E. School Health team Work load	N/A	N/A	N/A	
a. Team to learner ratio for grade R/1 assessments b. Team to target population ratio c. Number school visits per annum	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	
F. Follow-up	N/A	N/A	N/A	
Average length of follow-up for a. Re-screening b. After referral to a professional	☐ ☐	☐ ☐	☐ ☐	

Appendix C: Information sheet

Good day

My name is Lebogang Ramma. I am a Master of Public Health student from the University of the Witwatersrand. I am currently conducting a study to find out how the School Health Policy is being implemented for the learners in your school.

I would like to invite you to participate in the study. If you decide to take part in this study, I would like to interview you about your experience with how health services are being provided in your school. The interview will take about 45-60 minutes of your time. The interview will be tape recorded so that I can listen carefully to what you are saying without having to take a lot of notes. Should you choose to take part in this study, I would like to inform you of rights with respect to the following:

- Your participation in this study is entirely voluntary.
- You may stop taking part in this study at any time without fear of any negative consequences coming unto you.
- You may choose not to have the interview tape recorded, which means I will only have to take notes
- Please remember that neither your name nor the name of your school will be used in the study. This is to ensure that what you say remains confidential and private at all times.
- The audio tape records of your responses during the interview will be destroyed as soon as the research report is completed.

Your participation in this study will help me to get a better understanding about the progress that has been made in providing health services to school going children since the introduction of the national School Health Policy, as well as uncovering challenges that still exist in trying to provide health services to this population.

If you would like to be part of this study, please complete the consent form attached to this page. If you wish to be informed of the results of this study, please feel free to request for these and they will be provided to you once the study report is finalized. I can be reached at any of the details below:

Thank you.

Sincerely,

Lebogang Ramma
(011) 021-406-6954 (office)
073 153 3803 (cell)
Email: lebogang.ramma@uct.ac.za

Appendix D: Interview consent form

The study has been clearly explained to me by the researcher, Lebogang Ramma, and I have had a chance to ask questions and have them answered to my satisfaction. I have freely chosen to take part in this study. I am aware that I can change my mind about participating in this study at anytime and stop the interview without any penalty. I have been informed that agreeing to take part in this study will not be of any personal benefit to me. I have also been informed that my answers to questions will remain confidential and that this consent form will not be linked to the answers I give. I have been given contact numbers that I may call if I have any questions or concerns about the research.

_____

Participant's Full Name

_____

Participant's signature

Appendix E: Consent for audio taping the interview

I have been asked for my permission to allow the interview to be tape-recorded so that the researcher has a record of the information that I provide during the interview. I have had the procedures involved in the tape recording explained to me, including how the confidentiality of the information that I provide will be protected, and I am satisfied with the explanation. I have been told I can ask for parts of the tape to be edited or ask for the recording to be stopped at any time if I feel uncomfortable about what I say being recorded. I therefore agree to give the researcher permission to tape record what I will be saying during the interview session.

_____
Participant's Full Name

_____
Participant's signature

Appendix F: Ethics Clearance Certificate encl.

Appendix G: Permission Letter from the WCED encl.

Appendix H: Approval of title letter encl.