

**IMPLEMENTATION AND OUTCOMES OF THE SCHOOL HEALTH
PROGRAMME IN DITSOBOTLA**

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Witwatersrand, in 50% fulfilment of the requirements for the degree of Master of
Management (in the field of Public and Development Management).

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Declaration

I declare that this report is my own, unaided work, it is submitted in partial fulfilment of the requirement of the degree of master of management (in the field of public development and management) in the University of Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination in any other university.

Signature

Kelebogile Joyce Keothaile

Dedication

I dedicate this research report to my family members. I give special thanks to my children, Tumelo, Thato and Neo Keothaile and my husband who have always stood by me during the rough times of sleepless nights trying to put the report together. Above all, I dedicate this report to the one above; everything has been possible because of the greatness of my Lord Jesus Christ.

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GLOSSARY OF TERMS

Learners : All school going children from grade R to grade 12.

School community : Parents, learners, teachers and administrative support staff and parents

Health promoting school concept : It is an initiative that serve as an international policy framework for school health program implementation.

LIST OF ABRREVIATIONS

AA	: ADMIN ASSISTANT
APP	: ANNUAL PERFORMACE PLAN
CSTL	: CARE AND SUPPORT FOR TEACCHING AND LEARBING
DAC	: DEVELOPMENT ASSISTANCE FRAMEWORK
DHIS	: DISTRICT HEALTH INFORMATION SYSTEM
DOE	: DEPARTMENT OF EDUCATION
DOH	: DEPARTMENT OF HEALTH
GWM&E	: GOVERNMENT WIDE MONITORING AND EVALUATION
HPS	: HEALTH PROMOTING SCHOOL
ISHP	: INTEGRATED SCHOOL HEALTH PROGRAM
NGO	: NON GOVERNMENTAL ORGANISATIONS
QLTC	: QUALITY LEARNING AND TEACHING CAMPAIN
SAPS	: SOUTH AFRICAN POLICE SERVICE
SCT	: SOCIAL COGNITIVE THEORY
SGB	: SCHOOL GOVERNING BODY
SRH	: SEXUAL REPRODUCTIVE HEALTH
WHO	: WORLD HEALTH ORGANISATION

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Abstract

The objective of the South African Integrated School Health Programme is to improve health status of learners at schools. Health programmes have been implemented through the integrated school health programme at schools in South Africa since 2012. Targets were set to monitor the implementation of the programme in provinces. The North West Province did not reach its targets for the health programme between 2014 and 2015. A qualitative study was conducted to investigate barriers to implementation of the programme in Ditsobotla sub district. A sample of twenty five participants was selected from a group of teachers, principals and school governing body at ten schools, nurses, education managers, and NGO. In-depth interviews and focus group discussions were conducted. The main findings were that learners were not able to utilize the integrated school health programme service because parents did not give consent. The programme did not have enough dedicated school health programme service providers. Consequently the study recommends that more advocacy sessions should be conducted with the key stakeholders. This study can form a basis for further research seeking to improve the integrated school health programme in the North West Province.

CHAPTER ONE: INTRODUCTION

In South Africa, Integrated School Health Programme (ISHP) refers to a comprehensive program of health services conducted at schools. The programme seeks to improve the health status of learners at schools so that their learning capabilities can be improved. The ISHP targets learners from grade R to grade 12 at school premises. The South African Schools Act number 84 of 1996 defines grade as ‘that part of an educational programme which a learner may complete in one school year’. The educational programme starts from grade R, followed by grade one to grade 12. Grade one refers to first education programme the learner has to complete. Grade 12 refers to the last educational programme.

This report serves to present the results of the qualitative study conducted on implementation and outcomes of school health programme in Ditsobotla conducted from February to March 2016. The study aimed at establishing challenges that serve as barriers to the implementation of school health services in Ditsobotla sub district. The report is divided into five chapters which cover the introduction and background, literature review, methodology, presentation and analysis of data and recommendations.

The programme is implemented by the National Department of Health through provincial government in collaboration with the Department of Education (Integrated School Health Policy, 2012). Targets are set by National Department of Health and the Province also has theirs. National and Provincial targets will be discussed under the background.

Geographical location of Ditsobotla sub district

Ditsobotla sub district is situated at Ngaka Modiri Molema district in the North West Province. The North West province is one of the nine Provinces of South Africa which implement the ISHP. This Province is divided into four Districts which are; Ngaka Modiri Molema, Dr Kenneth Kaunda, Bojanala and Dr Ruth Segomotsi Mompati. The districts are further divided into sub districts where

implementation takes place. Each district has a maximum of four to five sub districts. Table 1 below indicates the sub- division of each district of the North West Province.

Table 1 : Geographic overview of the North West Province

Name of Districts	Ngaka Modiri Molema	Dr Kenneth Kaunda	Dr Ruth Segomotsi Mompati	Bojanala
Name of Sub districts	<ul style="list-style-type: none"> • Ditsobotla • Ratlou • Ramotshere Moilwa • Tswaing • Mahikeng 	<ul style="list-style-type: none"> • Ventersdorp • Tlokwe • Matlosana • Maquasi Hills 	<ul style="list-style-type: none"> • Naledi • Greater Taung • Mamusa • Lekwa Teemane • Kagisano Molopo 	<ul style="list-style-type: none"> • Rustenburg • Kgetleng • Madibeng • Moses Kotane • Moretele

Table 1 above provides a summary of the North West province which is divided into districts and sub- districts. Each district has five sub- districts except for Dr Kenneth Kaunda which has four. Dr Kenneth Kaunda district previously had five sub districts before the year 2012. The fifth sub district was Carletonville which has been placed under Johannesburg. Ditsobotla falls under Ngaka Modiri Molema district. The research focused on the community of Ditsobotla sub district.

1.1. Background

In the year 2012 the President of South Africa launched the ISHP which is currently guiding implementation in South Africa (Integrated School Health Policy, 2012). According to the Integrated School Health Policy (2012), the school health programme has the following specific objectives:

- To offer preventive and promotive health services to learners and young people regarding their current and future health
- To identify and address health barriers to learning

- To provide accessible health care services to the learners
- To assist and support schools in creating a safe school environment for effective learning and teaching.

In the North West Province, school health teams are used to provide school health programs at schools which comprise of school health nurses, assistant nurses and health promoters. School health nurses are registered professional nurses who work as team leaders. The national school health programme policy for 2012 outlines ISHP service package as follows;

- Health Education and Promotion: ISHP views health education as a critical component. The policy emphasises that health education can impact positively in lives of learners. The activities of health education and promotion are embedded in education curriculum provided through life orientation learning areas. However, activities should be supported by co-curricular programs which are school based.
- Learner assessment and screening: Individual learner health assessment conducted by a professional nurse. Learners should be screened for health barriers on vision, hearing, oral, fine and gross loco motor, mental health, chronic illness and nutrition.
- Provision of onsite services: The services provided at school should cover immunisations, parasite control and treatment of minor diseases. Other services include environmental assessment by environmental officers. Sexual reproductive health (SRH) services and HIV counselling and testing also forms part of onsite services.
- Follow up and referral: Learners screened and found to be requiring referral should be referred to different health facilities. Referral should be done only in cases where treatment cannot be offered on site. Further from referral, follow ups should be done at school in case referral is not done. An example of follow up can be learners who were screened and need to be immunised, nurses can come to school only for immunisation as follow up.

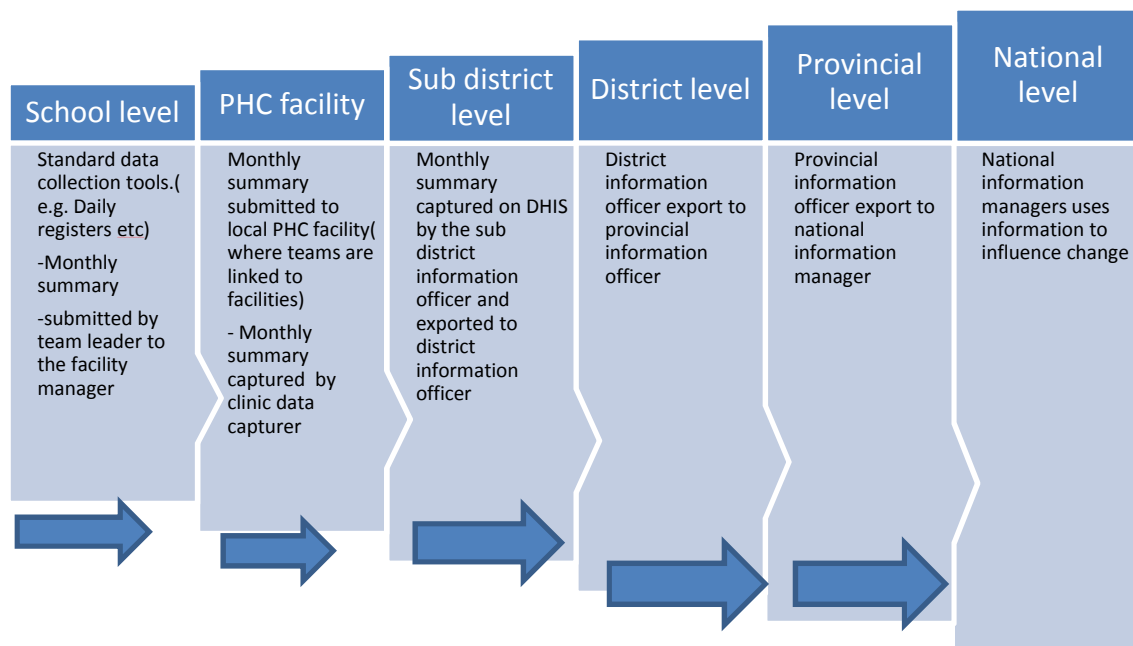
1.1.1. School health data management

The school health teams schedule visits to schools to provide school health service package to learners. There are standard data collection tools which are used for recording school health activities. These tools include the daily school health register, learner assessment forms, three referral forms and weekly summary sheet.

The school health team leader uses learner assessment form, referral forms and daily school health register at school level for data collection. Referral letters were given to learners who were assessed at schools and discovered that there was a condition which needed further health management at health facilities. At the end of every month, data for school health is consolidated and entered into the District Health Information System (DHIS) at sub district level. Every sub district has an information officer who is responsible for data capturing on DHIS monthly.

Information managers are located at district and provincial level and they are responsible for data capturing on DHIS. Sub district information officer captures data and exports to district information manager. The district information manager also exports a consolidated sub district data to the provincial manager. The data on DHIS can therefore be accessed by managers for program reviews. The provincial information officer exports data collected to national office. Figure 1 below summarises the school health program data flow process from school level to national office.

Figure 1 : ISHP data flow process



1.1.2. School health program performance

The Department of Health at national, provincial and district level is using the Annual Performance Plan (APP) and strategic plan to guide and monitor performance of programmes. The APP has program objectives, goals, indicators and targets which are monitored quarterly through review meetings. The set targets are aligned to the policy screening package and also guided by the national APP which also monitors and guides ISHP. Due to the large number of learners at schools the Department of Health has been setting targets annually for the roll out of school health program. A five year implementation plan was developed nationally for provinces to implement.

When the ISHP programme started in 2012 the main focus of implementation was only at quintile one and two schools. Integrated School Health Policy (2012: p.5) defines quintile classification as “a system of ranking and funding schools which takes into account the socio-economic circumstances of learners. The intended objective is to ensure that public funding is skewed in favour of the poorest learners”.

The education department uses numbers of one to five to do quintile classification. Quintile one and two are the most disadvantaged whereas quintile three are better than one and two. Quintile four to five are the previous model C schools. ISHP has previously been directed to most disadvantaged schools. Table 2 further outline the targets for 2014 and 2015 that were appearing on the provincial APP of the North West Province.

Table 2: North West Province APP targets for 2014/15 financial year

Strategic Objective	Indicators	2014/15 targets
To develop a strong service delivery platform that responds to the health and access needs of the population	School ISHP coverage	80%
	School Grade one screening coverage	70%
	School Grade four screening coverage	70%
	School Grade eight screening coverage	50%
	Human papilloma virus(HPV) first dose coverage	80%

Source: North West Province Department of Health APP, 2014/15

During the 2014 to 2015 financial year, only learners from three grades were targeted for ISHP package of service. The targets were used to guide and monitor implementation of school health programme for a period of 12 months starting from first April 2014 to 31 March 2015.

The Province has been implementing the school health programme across all four districts. Provincial performance of school health programme for 2014/15 financial year is displayed on table three. The performance was aligned to the APP targets for 2014/15 financial year. Table 3 below indicates the performance achieved by districts in the year 2014 to 2015.

Table 3: Provincial School health program performance for 2014 to 2015 financial year

Indicator	Annual Target	Ngaka Modiri Molema	DR Kenneth Kaunda	Bojanala	Dr Ruth Segomotsi Mompati	Province
School grade one screening coverage	70%	32.6%	46.7%	38.7%	36.5%	38.2%
School grade four screening coverage	70%	19.1%	18.4%	28.7%	26.4%	23.7%
School grade eight screening coverage	50%	9.5%	16.7%	18.8%	17.0%	15.5%
School ISHP coverage	80%	44.5%	202.2%	54.8%	186.0%	97.4%

Source: District Health information System (DHIS), May 2015

Table 3 indicates programs that were implemented in the North West Province even though targets were not met in 2014 to 2015 financial year. The ISHP coverage refers to the percentage of schools visited for provision of ISHP service. The percentages in table 3 further shows all districts performed below the set

target for grade one, four and eight screening coverage. The lowest percentages were at Ngaka Modiri Molema. The school ISHP coverage for Dr Kenneth Kaunda (202.2%) and Dr Ruth Segomotsi Mompati (186.0%) were however more than 100%. The study will be focused in Ngaka Modiri Molema district due to lower performance on set targets for 2014 and 2015 compared to other three districts. Further programme performance data for Ngaka Modiri Molema is highlighted on table 4 below.

Table 4: Ngaka Modiri Molema District school health performance

Indicator	Annual Target	Ditsobotla	Tswaing	Ratlou	Ramotshere Moilwa	Mahikeng
School grade one screening coverage	70%	16.9%	6.1%	37%	43%	48%
School grade four screening coverage	70%	10.8%	32.7%	22.5%	40%	4.4%
School grade eight screening coverage	50%	0%	12.7%	3.6%	37.8%	0.3%
School ISHP coverage	80%	28.2%	44%	75%	36.9%	42.9%

Source: DHIS, May 2015

Table 4 indicates the ISHP performance for 2014 to 2015 in Ngaka Modiri Molema district, the performance is displayed according to APP targets for 2014 to 2015. All sub-districts of Ngaka Modiri Molema did not achieve desired percentage on targeted screening coverage for grade one, four and eight. Ditsobotla sub district has lower percentages as compared to other sub districts of Ngaka Modiri Molema.

1.2. Problem statement

School health programme is one of the programmes which have been considered as a cost effective strategy that can reduce disease burden amongst children (Fuller et al., 2015). Health services have been rendered at schools nationally in South Africa. However, there was still poor performance in school health programme indicators for 2014 to 2015 financial year in the North West Province. Furthermore, there is not much research conducted on school health program implementation in Sub Saharan countries. This means that there are less documented practices of the programme that could provide implementers with information on what others have been doing. School health programme data on DHIS in the province indicates that set targets for the program in 2014 to 2015 financial year were not achieved. Implementers of school health programmes indicated inadequate school health teams as the reason for not achieving targets. Since the program has been implemented in the province from 2012, the researcher could not find a study conducted on ISHP in the North West Province regarding implementation of the programme. A study on school health programme implementation would be important in understanding challenges, outcomes and learning the processes followed regarding implementation. It was therefore important to conduct a study that explores implementation and outcomes of the school health programme in the North West province.

1.3. Purpose

- To establish factors that serve as barriers of implementation of the integrated school health programme in Ditsobotla sub district.
- To understand the implementation and outcomes of ISHP in Ditsobotla

1.4. Research Questions

According to Wagner, Kawulich and Garner (2012), qualitative research questions should be phrased in a way that won't give you yes or no answers but in a way that allows discussions with your participants. Most questions are aimed at understanding what, how and why things happen. The research questions were based on Development Assistance Committee framework used for evaluations and they are described below:

1.4.1. Research Question One: What is the health service package provided at schools?

Sub questions

- Who are beneficiaries of the school health programme
- How are health programs offered in schools?
- What are the qualifications, knowledge and experience of school health program providers with respect to the programme?

1.4.2. Research Question two: To what extent are the stakeholders involved in planning and implementation of school health programme.

Sub questions

- Who are the school stakeholders?
- What are the roles and responsibilities of SGB?
- What is the composition of SGB?
- What training did the SGB receive?

1.4.3. Research question three: What has been the challenge in implementing the school health programme?

1.5. Summary of Chapter one

Chapter one discussed the North West Province fiscal requirements during the financial year 2014 to 2015. Brief information on recorded programme performance at Ditsobotla sub district has been presented as baseline information. Furthermore, the information on this chapter highlights that integrated school health programme in South Africa has been guided by the integrated school health policy for 2012. Chapter two will therefore provide a global overview of literature on what and how other countries are implementing the integrated school health programme.

CHAPTER TWO: LITERATURE REVIEW

The North West Province has been implementing the ISHP guided by the National School health policy of 2012. However, there was a need to understand what and how other countries are doing to render health programs in schools. The literature review of this study aimed to explore and discuss implementation approaches globally. The focus was also on factors that are considered as barriers to implementation and the enhancing factors. The topics that were covered by this literature review chapter were the origin and rationale of the programme, implementation approaches internationally and in Africa and school governance. Schools are organizational structures and therefore issues on school governance become important and needs to be discussed.

Definition of school health programme

Different authors outline definition of school health programme as the procedures that are performed at school aimed at understanding, maintaining and improving health care of the learners and school staff (Adegbenro, 2006). Buckley et al. (2012) defines school health services as different health programmes or services implemented at schools. Adegbenro (2006: p.29) further outlined that the school health programme has three major components and they ware as follows:

- Health services conducted at school premises.
- Health education
- Healthy school environments

In South Africa the Integrated School Health policy (2012) defines school health programme as the programme that is provided to improve the mental, physical and social well-being of school going learners. The policy further indicates that health services should be provided only to learners whose parents have signed consent forms. McIsaac, Storey, Veugelers, & Kirk (2014) indicates that comprehensive school health programme is s synonym for health promoting school. This health promoting school concept is defined below under the origin of school health programme.

2.1. Origin of school health programme

Jourdan et al. (2008) indicates that school health program originated in the early 80s supported by the World Health Organization (WHO) and the International Union for Health Promotion and Education. In the 1980s, the WHO Ottawa Charter for health promotion introduced a new initiative called Health Promoting School (HPS) (Martin, Deschessness, & Hill, 2003). The initiative served as an international policy framework for school health programme implementation. This initiative was well accepted by education department as a good and successful strategy to provide school health programs (Hung, Chiang, Dawson, & Lee, 2014). HPS is defined as a school that always strives to improve the health setting, learning and living conditions of its school community (Shasha, Taylor, Dlamini, & Aldous- Malcock, 2011). Furthermore, HPS has also been defined as an alternative phrase for Coordinated or Comprehensive School Health Programme (McIsaac, Storey, Veugelers, & Kirk, 2014). Therefore, this means the school health programme originated from WHO as a strategy of introducing health programmes in schools.

2.2. Rationale for school health programme

According to the Integrated School Health Policy (2012) children spent much time in classrooms learning which limits their visit to health facilities. It is for this reason schools have been considered as good settings for health programmes (Bindler et al., 2012; Hayes et al., 2013; Jourdan et al., 2008). The health and wellbeing of children internationally has been a great concern that led to new health developments such as implementation of health programmes at school (Buckley et al., 2012).

School health programme needs to be implemented so that positive health outcomes can be achieved such as reduction in all youth risky behaviours. The youth risk behaviours includes teenage pregnancy and smoking (Cornwell, Hawley, and St Romain, 2007). Sherwood-Puzello et al. (2007) indicated that if health programmes are conducted at schools, student health could be improved and therefore learner absenteeism from schools could also be improved. It has

also been indicated that implementation of health programmes at schools can lead to improved physical and mental alertness and ultimate reduction in the community health care burden (Sherwood-Puzello et al., 2007).

2.3. Components of school health program

McIsaac et al, (2014) identified a challenge regarding lack of standard protocol which guides implementation in different settings at schools despite HPS framework availability. The protocol that is required for health programmes implementation at school should rather address critical processes than key activities conducted by health providers. The lack of standard protocol has led to differences of implementation strategies at schools.

Limited researches on the program evaluation has been noted internationally due to differences in implementation (McIsaac et al., 2014; Hung et al., 2014; Shipley, Lohrmann, Barnes & O'Neill, 2012). However some studies have outlined eight components of HPS. The components of HPS outlined are the same as coordinated school health programme with minimal variation. According to Shipley et al. (2012); Klostermann, Perry, & Britto (2000); Barnes, Torrens, George and Brown (2007); Basch (2011); Jourdan et al. (2008), the eight components are as follows:

- Health education
- Healthy school environment
- Physical education
- Health promotion for staff
- Nutrition services
- Community involvement and participation
- Health services
- Individual skills in taking healthy decisions

These eight components of HPS form the basis of implementation of school health programme by different countries. With regard to what the literature has highlighted regarding components of HPS, some similarities in health care service package were noted between the HPS and ISHP 2012 policy. The ISHP has highlighted four packages of health services which are health promotion and education, referral and follow up, learner assessment and screening together with

on-site services. The on-site services refers to vaccinations and treatment for minor ailments.

2.4. Global approaches to implementation

The discussion on global approaches covered review from information about some few countries from the globe. A sample of countries discussed were those whose information was available for the researcher by the time of information searching. The discussion focused on some countries in other continents outside Africa and in Africa such as Europe, Asia, North America, Australia and Africa.

There are differences in implementation of school health programs. Klostermann et al. (2000) indicates that health programs at schools are rendered informally in other areas. Informal implementation in this regard refers to implementation by non-health professional such as secretaries and any school administration staff. The non-health staff distribute medication on school premises and also assist children who are injured by providing first aid. Other schools have nurses on site whereas schools attached to clinics and others have health centres that are based at schools.

2.4.1. Europe

Austria

According to Flaschberger, Nitsch & Waldherr (2012), implementation in Austria focused mainly on health education sessions conducted by educators in classrooms. The education sessions were guided by health promotion strategy developed by the two Ministries of Education, Arts and Culture Federal Ministry and Federal Ministry of Health. Austrian government had school wellness policies in place that were written and from a range of these policies there were dominating policies on nutrition and physical activity.

Greece model of implementation

Alexandropoulos, Sourtzi, & Kalokerinou (2010) indicated that school health services implementations in Greece have been guided by different laws. Greece started school health services from 1910 guided by national policies which promoted primary health care services provision to the whole population. Furthermore, schools had health inspectors and visiting school health teams on site as implementers until 1983. The school health teams were comprised of nurses, physicians and registered nurses with post graduate qualification in public health. These teams were visiting schools to assess the health status of learners. From 1983 the model of delivery changed and nurses were only placed at special schools to render the service by the same teams (Alexandropoulou, Sourtzi, & Kalokerinou, 2010).

According to Cholevas & Loucaides (2011) service delivery model for implementation at Greece is through utilisation of educators in classroom. Educators were rendering classroom health education voluntarily. However, selection /appointment of educators volunteering were based on their knowledge on health education topics and experience in teaching. The Education ministry in Greece appointed district coordinators to oversee health education topic at schools in their districts thus coordinating all health programs (Cholevas & Loucaides, 2011). Despite a long history of implementation in Greece, there is still limited research on the status of implementation in Greece that is conducted and published (Alexandropoulou et al., 2010).

Georgia

Burke, Meyer, Kay, Allensworth, & Gazmararian (2014) reported that an NGO called HealthMPowers was founded in 1999 by the three stakeholders to address childhood obesity in Georgia. The three stakeholders were Children's Health Care of Atlanta, Centre for Disease Control and Rollins school of Public Health at Emory University. The NGO formation came as an initiative of two parents who wanted to make sure that learners make healthier choices. The whole school

community was targeted to influence behaviour change. The approach for implementation was based on views of theoretical models. Activities conducted at schools included physical activity, nutrition education, healthy eating messages and improving school environment

Furthermore, Burke et al. (2014) indicate that involvement of teachers and families in activities meant for learners can positively impact on the behaviour of children and thereby bring change. It has been argued further that teachers and family members can serve as role models of students (Burke et al., 2014).

Summary of approaches in European countries

The literature review on school health program implementation approaches in European countries with special reference to Austria, Greece and Georgia, shows that all three countries are implementing school health program but in a different way. Table 5 indicates a summary of services implemented in Europe.

Table 5 : Summary of school health program package rendered in three European countries

Country	Services implemented	Providers of the service
Austria	<ul style="list-style-type: none"> • Health education in classrooms • Implementation of some school policies targeting certain conditions 	Teachers
Greece	Health screening of learners	Nurses
	Health education and promotion in classrooms	educators
Georgia	<ul style="list-style-type: none"> • Nutrition education • Physical activity • Healthy eating messages 	NGO

Even though the service is implemented by different stakeholders, the package of services rendered in these three countries was aligned to the HPS concept as the international framework for schools health.

2.4.2. North America

New Mexico

According to Sánchez et al. (2014) the focus of school health programs in New Mexico was on school environment as an important location for future intervention. Most districts adopted school wellness policies that deal with nutrition and physical activity. Activities conducted were on development of school meal programs and physical activity. Implementation was the responsibility of school management and stakeholders (Sánchez et al., 2014),

Canada

Gleddie and Hobin (2011) presented implementation of school health program in rural Alberta, Canada as aligned to HPS international framework. The school division had a health intervention called Battle Rive Project (BRP) mainly concerned with HPS implementation. The BRP activities conducted were focusing on strategies for healthy eating, physical activity and school environment (Gleddie & Hobin, 2011).

The other province of Canada, Nova Scotia, implements HPS concept. Nova Scotia has a provincial HPS strategy introduced in 2006. The move to introduce HPS strategy in Nova Scotia was influenced by childhood obesity (McIsaac et al., 2014). The whole of Canada has extramural activities for vaccinations of Human Papilloma Virus to girls aged 11 years to increase vaccine uptake (Hayes et al., 2013).

Summary of services provided in North American countries

A summary of school health programs rendered at two North American countries namely; Canada and New Mexico indicates different services rendered at schools but still in line with the HPS international framework. Similarities of HPS components on were noted; physical activity, and extramural activities for human

papilloma virus vaccination. Summary of services provided in Canada and New Mexico is presented in Table 6.

Table 6: Summary of school health program provided in North American two countries

Country	Services implemented	Providers of the service
New Mexico	<ul style="list-style-type: none"> • Physical activity • School meal program 	School management and stakeholders
Canada	Physical activity	Battle River Project
	Extramural activities on Huma Papilloma Virus vaccinations	Nurses

2.4.3. Asia

Philippines

Benzian et al. (2012) highlights implementation in Philippines as aligned to an international framework for school health. The approach used is called fit for action school action framework and it's aligned to the HPS concept. Benzian et al. (2012) indicates that in 2009 the country was internationally awarded for the best model implemented .The model looks at the prevailing diseases/infections which affect school children and teachers are used to conduct activities aimed at improving those infections. Examples of the activities conducted are leaners de-worming and hand washing techniques. As a result of the benefits of the model, three other Asian countries were considering adapting it (Benzian et al., 2012)

2.4.4. New Zealand

According to Buckley et al. (2012), New Zealand services are implemented by school health nurses who are appointed based on their qualification as registered nurses with post graduate studies on youth health services. Services provided are health assessments, vaccinations, prescriptions where necessary, health promotion and education. Implementation is guided by the Primary Health Care

strategy developed in 2001 by the Health Ministry targeting all population at different settings of which schools are part (Buckley et al., 2012).

Summary and comments on New Zealand approach and Philippines

New Zealand implements school health program through nurses. The package of service outlined was in line with the HPS components. In Philippines the service providers for school health program implementation in were teachers mainly focusing on deworming and hand washing technique. The services provided had some similarities with the HPS components.

2.4.5. Africa

Activities of health promotion targeting youth at their different setting have been much directed to the HIV/AIDS and not much has been documented and researched on the progress in Africa (Aarø et al., 2006; Mukoma et al., 2009). The discussion will cover implementation in Tanzania, South Africa and two West African countries namely Benin (Cotonou) and Burkina Faso (Ouagadougou).

Tanzania

Obasi et al. (2006) provides a narration on how Tanzania implemented their health programmes through projects. In Tanzania, school health programs were conducted through projects and two were noted with different implementers. The first project was mainly focusing on adolescent sexual reproductive health whereby learners were health educated by peer educators in classrooms (Mukoma et al., 2009). The classroom education was led by trained educators (Obasi et al., 2006). The second project was run for three years by Federation International de Football Association (FIFA) and it aimed at reducing obesity amongst learners. Activities included health education on non-communicable disease causes and the other parts covered physical activity through playing football guided by FIFA. The project was not only done in Tanzania but also conducted in other four African countries namely Zambia, Malawi, Namibia and Ghana (Fuller et al., 2015).

Benin (Cotonou) and Burkina Faso (Ouagadougou) - West Africa

Delisle, Receveur, Agueh & Nishida (2012) indicated that Benin and Burkina Faso implement Nutrition Friendly School Initiative which was in line with HPS concept. The initiative was launched by WHO in 1995 as part of the global school health initiative to reduce childhood obesity. Activities included annual nutritional assessments which covered weighing and height measurement, educating teachers on nutrition, integration nutrition education into the school curriculum, teaching food vendors on food groupings and handling and health professional training on nutrition assessments.

South Africa

Shasha et al. (2011) shared the South African implementation approach by school health teams encompassing nurses and other qualified health professionals. The implementation approach derived from the HPS concept however the country had national school health policy guidelines which were launched in 2003 to direct implementers (Shasha et al., 2011).

Shasha et al. (2011) further indicates that the policy came as an initiative by the country to reduce inequalities and to improve provision of school health program at schools. The other aim of the 2003 policy development was to complement the existing school nutrition program.

In 2012, the president of South Africa launched an Integrated School Health Policy. The Integrated school health policy has since been implemented from 2012 at all South African nine provinces (Integrated School Health Policy, 2012)

In addition to the ISHP policy that is implemented by health care workers, there are some health programs that are provided at schools by educators. According to Visser, Schoeman and Perold (2004) educators are also used to implement HIV/AIDS school based programs. Activities of the school based programs include HIV/AIDS and sexuality education, life skills development and positive attitude enhancement. Mukoma et al. (2009) indicated that South Africa implemented HIV/AIDS education in classrooms. The education was integrated into the life

orientation subject taught at schools by teachers. The discussion of South African model therefore indicated that implementation was guided by policies that were aligned to HPS concept.

Summary of African approach

Implementation of school health program has been summarised to give a clear picture of services provided. The summary was based on the following countries as discussed; Tanzania, Benin (Cotonou), Burkina Faso (Ouagadougou) and South Africa. Table 7 provides a summary of program activities rendered at the African countries discussed.

Table 7: Summary of school health program implementation of the African countries

Country	Services implemented	Providers of the service
Tanzania	<ul style="list-style-type: none"> • Health education 	Learner peers
South Africa	<ul style="list-style-type: none"> • Health education and promotion • Referral and follow up • Learner screening and assessment • On- site services 	Nurses
	School based HIV/AIDS program through <ul style="list-style-type: none"> • Sexuality education • Life skill development • Positive attitude enhancement 	Teachers
Benin (Cotonou) and Burkina Faso (Ouagadougou)	<ul style="list-style-type: none"> • Nutritional assessments which covers weighing and height measurement • Educating teachers on nutrition, integrating nutrition education into the school curriculum 	Not specified

	<ul style="list-style-type: none"> • Teaching food vendors on food groupings and handling and health professional training on nutrition assessments. 	
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The school health program implementation in the three African countries mentioned in table seven shows a lot of similarities with the HPS concept.

In general summary of global approaches discussed with reference to the specific countries, a conclusion can be drawn that school health programs rendered globally are guided by the Health Promoting School framework. There were similarities in implementation in terms of services provided. Different stakeholders were noted as providers of school health program and this includes nurses, teachers and Non- Governmental Organisations.

2.5. School governance structures

Schools may be regarded as settings of health but they still needs to be governed like any organization to avoid maladministration problems (Bush & Heystek, 2003). School governing bodies (SGB) are governance structures for schools. This section will cover England and South Africa’s governing structure. These countries were selected as a result of the information that was available during information searching by the time of proposal submission.

2.5.1. England

According to James et al. (2011) the main principle of school governance is to ensure that parents, community and business partners are included. The members of SGB in England are parents and staff, partners, community members, local authority and representatives from founders of the school.

2.5.2. South Africa

In South Africa the SGB consist of teachers, parents, community representative, and support staff from the school, principal and members co-opted by schools. Parents are considered as major stakeholders of the school (Bush & Heystek, 2003; Quann- Baffour & Arko-Achemfour, 2014).

2.6. Facilitating factors of the program

There are several factors considered as facilitating program implementation (Cholevas & Loucaides, 2011 ; Mukoma et al., 2009). Some factors discussed from different studies include theoretical models, planning, and funding and program coordination.

There are theoretical models that are said to be important in planning activities or strategies to be undertaken. Implementation of the school health program should follow a certain theoretical model which is informed by the situations at schools (Aarø et al., (2006); Flaschberger et al., 2012). More dominant theory advocated by most researchers is the Social Cognitive Theory. This theory mainly focuses on enriching individual's information through giving health education and skills building for the purpose of change in behaviour (Bindler et al., 2012).

Planning has been noted as very critical for implementation (Bindler et al., 2012; Hayes et al., 2013; Lott & Johnson, 2012; Williams et al., 2012). Careful planning has been regarded as very important in keeping the stakeholders (Deschessness et al., 2003). According to Bindler et al.(2012) joint planning among school personnel and service providers are essential and can facilitate processes of resource availability such as space for provision of services .

Funding and Program coordination through delegated officials also facilitates smooth implementation (Williams et al., 2012). Further from what has been discussed as facilitating factors, there are four key themes identified from different readings. The key facilitating factors are stakeholder collaboration, multifaceted approach, communication and knowledge of implementers. These factors are discussed as follows.

2.6.1. A Comprehensive approach.

Bindler et al. (2012) indicated that implementation of an interdisciplinary approach is crucial and beneficial for the success of the programme. Integrated or comprehensive school based activities are needed for implementation. Activities should address all school community rather than a child as an individual (Bindler et al., 2012; Flaschberger et al., 2012; Gleddie and Hobin, 2011).

2.6.2. Stakeholder collaboration.

School stakeholders are critical in the whole process of implementation starting from planning of activities. Early involvement is important for successful planning (Lott & Johnson, 2012; Sánchez et al., 2014; Cholevas & Louicades, 2011; Flaschberger et al., 2008; Gleddie & Hobn, 2011). According to (Deschessness et al. (2003) the success of the programme lies in the active collaboration of school, family and the community. Bindler et al. (2012) also indicated that participation of the family in activities that were aimed to improve youth health was regarded as critical to the success of the programme. Sánchez et al. (2014) further suggested that successful implementation of wellness policies was dependent on the support and involvement of the community. Visser et al. (2014) indicated that there was lack of participation in introducing the HIV/AIDS topics at school. This was due to the non-involvement of the community, teachers and learners in the program of HIV/AIDS topics as an intervention.

2.6.3. Knowledge of the implementers.

Cholevas & Louicades (2011) has indicated that lack of teachers training and skills to carry out health program activity at schools served as a barrier in implementation. Visser, Schoeman, & Perold (2004) has highlighted that in South Africa the National Education and Welfare Departments in collaboration with organisations came with a strategy to address the psychosocial pressures young people were faced with. The strategy introduced was called life skills subject which is conducted at schools. To introduce the strategy the teachers were trained to be able to provide health education regarding HIV/AIDS. Teachers who were trained were able to cascade information to learners in classrooms. Untrained teachers were not able to cascade information in classrooms. This shows that knowledge of implementers is critical to program implementation. It is therefore important for implementers to have extensive knowledge on the type of job they are hired to perform.

2.6.4. Communication.

There are multiple methods of communication to get buy in from parents and other targeted groups essential for implementation (Hayes et al., 2013). The methods

for communication with parents that were highlighted by Hayes et al. (2013:p.122) were as follows:

- Backpack mailings sent to parents about the programme going to be offered to children at schools
- Information about programme shared to parents during the school events such as learners registration
- Sending automated voicemails to parents regarding the health programmes offered at schools
- Circulating school newsletter which has information about health programmes
- Sending postcards to parents
- Send letters to parents through learners

Following what has been discussed as facilitating factors of program implementation it is therefore beneficial for implementing countries to take note of these factors during planning sessions.

2.7. Implementation Barriers

Facilitating factors have been discussed, however, looking at different literature there are challenges to implementation highlighted from different studies (Mukoma et al., 2009). The four general key challenges identified are unqualified providers, competing priorities, unclear roles of providers and lack of understanding of policies. The four key challenges are discussed as follows:

2.7.1. Inexperienced and unqualified providers of school health program.

Proper qualifications of program implementers are crucial for taking the program forward. Lack of skills and knowledge needed for the program lowers provision of the service (Cholevas & Loucaides, 2011). It has also been indicated by Mukoma et al. (2009) that teachers who did not get enough training on sexuality education where posing a challenge in implementation of the programme.

2.7.2. Competing Priorities.

Education Department prioritize other activities related to their Department rather than health activities due to the nature of the program and the settings where service happens (Bindler et al., 2012). In other instances, health workers providing this service take it as an addition to their work and not their key mandate, therefore prioritising other health activities than school health (Hung et al., (2014).

2.7.3. Lack of understanding of policies.

Implementers and stakeholders sometimes lack knowledge of existing policies in their fields, as a result they are unable to implement policies properly (Sánchez et al., 2014; Benzian et al., 2012). It has been indicated by Sánchez et al. (2014) that lack of understanding of the school health written policies by personnel from schools and other staff members has a negative impact on program implementation.

2.7.4. Unclear roles of providers.

Lack of proper roles and responsibility allocation for team members or providers contributes to poor implementation of the program (Klostermann et al., 2000; Alexandropoulou et al., 2010).

2.8. Monitoring and evaluation

In every organisation, monitoring and evaluation plays a very critical role. Policy framework for the government wide monitoring and evaluation system (2007: p.4) states that “ A monitoring and evaluation system is a set of organisational structures, management processes, standards, strategies, plans, indicators, information systems, reporting lines and accountability relationships which enables national and provincial departments, municipalities and other institutions to discharge their monitoring and evaluation functions effectively” . According to Serona, Yu, Aguinaldo and Florece (2014) monitoring and evaluation is strengthening tool that is intended at scrutinizing the developments and outcomes. A number of evaluation approaches were explored for use in the study. Three frameworks were discussed namely the Development Assistance Committee

framework, Logic framework and the Government wide monitoring and Evaluation framework.

2.8.1. Government wide Monitoring and Evaluation framework

In government departments of South Africa, there is a Policy Framework for Government wide Monitoring and Evaluation (GWM&E). The policy framework is used at all spheres of government which are national, provincial and sub district (Policy framework for the Government-wide Monitoring and Evaluation Systems, 2007). The key concepts of monitoring and evaluation in the framework are inputs, activities, outputs, outcomes and impacts. The policy highlights that effective monitoring and evaluation are built on good planning and budgeting.

2.8.2. Logic Model Framework

According to Hulton (2007) the logic model can be a resourceful framework for health professionals who are involved in development and planning of the program. Hulton (2007: p.105) further indicates the three key logic framework components as follows; inputs, outputs and outcomes. Figure 2 further summarises the logic framework components and the examples of those components.

Figure 2 : Summary of the Logic framework model



Source: Hulton (2007: p.105)

2.8.3. Development Assistance Committee framework

The Development Assistance Committee is an international forum where all countries come together to assist developing countries to achieve their Millennium Development Goals (MGD's) (Development Assistance Committee, nod). According to Austrian Development Cooperation (2009), the Development Assistance Committee framework consist of five characteristics namely relevance, effectiveness, efficiency, impact and sustainability. Relevance refers to the relevance of activities rendered at schools whereas effectiveness is measured against the planed objectives. Efficiency covers the general efficiency on utilisation of resources. Impact and sustainability are based on interventions put in place. The Development Assistance Committee framework was found to be the most appropriate for the study because it is more detailed and also allows comparison and alignment globally with the five characteristics mentioned.

2.8.4. Theories of implementation

Some studies have revealed few theoretical models applicable to program implementation. Literature has revealed that teachers also provide health promotion activities in classrooms over and above what nurses are doing. Conner and Norman (2005) outlined different social cognitive models which assist in understanding behaviour of individuals and the elements that leads to behaviour change. The most commonly used social cognitive models mentioned by Conner and Norman (2005) were the health belief, protection motivation theory, theory of planned behaviour and the social cognitive theory. The health belief theory argues that an individual's behaviour is influenced by two characteristics in responding to threat caused by illness. This means that if the individual is threatened by a certain disease, the behaviour of an individual will be determined by the perception he or she holds regarding the illness (Conner & Norman, 2005). Protection motivation theory seeks to understand the fear and how an individual reacts or respond when fear is experienced. Planned theory is the theory that looks at understanding different types of behaviours . This theory further reveal reasons that leads to individual behaviuors (Conner & Norman, 2005).

According to Bindler et al. (2012), the social cognitive theory suggests that the whole environment should be targeted to change or influence an individual's behaviour. The relevant model for this study was the social cognitive theory because it deals with individual behaviour as influenced by action taken and motivation received through health programs. This study focused on the social cognitive theory meaning that in order for the school health program to impact positively on beneficiaries, the school environment must be conducive for learning. Individuals should have information that will make them take action that leads to positive health outcomes. Bindler et al. (2012) further indicates that Social Cognitive Theory proposes that in order for an individual to change behaviour there is a need for capacity building to improve skills and capabilities. According to Conner and Norman (2005), the Social Cognitive Theory is dependent on three expectancies namely; situation outcome, action outcome and perceived self-efficacy expectancies. The three expectancies of this theory as tabled by Conner and Norman (2005) are further explained as follows;

- Situation outcome expectancies. This refers to an individual belief that the outcomes of the prevailing situation will not change despite the action taken by an individual. An example of the situation outcome was cited as any health threat
- Action outcome expectancies was said to be the belief of an individual that behaviour will cause certain health outcome
- Perceived self-efficacy referred to a belief of an individual that he or she is not capable of performing certain actions or behaviours

Figure 3 summarises the three expectancies of the Social cognitive model as indicated by Conner and Norman (2005: p.10).

Figure 3 : Summary of the Social Cognitive Theory model



Source: Conner and Norman (2005: p.10)

WHO (1999) cited in Fuller et al. (2015) has indicated that school based education programmes which are aimed at increasing the knowledge of learners and impact on their change of behaviour regarding health issues , can be efficient and cost effective strategies. Furthermore Hung et al. (2014) argues that educators assume that the cognitive skills of learners enable change of their behaviour and attitude due to what they have learned.

The Social Cognitive Theory model links well with the integrated school health program components such as health promotion and education. For an individual to adapt to positive behaviour health lifestyle there is a need for health empowerment through education. The individual's empowerment or motivation influences the action taken for behavioural change. In conclusion, the theoretical framework for this study was emanating from the social cognitive theory model.

2.9. Summary of chapter two

The literature review indicated that there are different approaches of program implementation in schools. There is lack of consistency regarding implementation

approaches. However all approaches discussed in the literature review have an element of HPS components. Literature has indicated that in South Africa ISHP has been guided by the Integrated School Health Policy of 2012. School health nurses were highlighted as implementers of the program in South Africa whereas in other countries teachers were also assisting. It came to the attention of the researcher that in South Africa teachers were more involved in HIV/AIDS education in classrooms. The conclusion can therefore be reached that all reviewed approaches were guided by HPS strategy. Most researchers have raised a concern on limited information of research conducted on implementation.

The concern of limited research on school health was raised even at countries that started implementation many years ago. Some general factors that facilitate implementation and barriers also have been learned. These factors may be of great assistance in program evaluation of this study. Literature review has therefore assisted in gaining more knowledge on implementation of integrated school health program internationally. Minimal literature was found on implementation in the African context.

In terms of the package of service that has to be provided at schools, the theoretical framework of the study linked well with the social cognitive theory due to its influence on positive behavioural change. The monitoring and evaluation of the study will be based on the Development Assistance Committee framework. The latter committee framework provides criteria for evaluation internally and internationally.

CHAPTER THREE: METHODOLOGY

The aim of this chapter is to present the research methodology chosen for this study. The discussion of topics under this chapter will address the research strategy and design followed. Population, sample and sampling methods and area where the study was conducted will be discussed in this chapter. The other discussions will be on processes of data collection, validation, entry, processing and analysis. Ethical procedures employed throughout the study and challenges related to the processes of research will also be discussed. Furthermore, data limitations and significance of the study will be outlined.

3.1. Research strategy

Bryman (2012: p.35) states that “by a research strategy I simply mean a general orientation to the conduct of social research” when defining a research strategy. Furthermore, Bryman (2012) outlines three types of research strategies as follows; qualitative, quantitative and mixed method. A qualitative research methodology or strategy involves words in collection and analysis of data whereas quantitative research methodology employs quantification or measurement (Wagner et al., 2012). It has also been indicated by Newman (2014) that quantitative research strategy follows a linear path and qualitative research strategy follows a non-linear path. The linear path refers to systematic process of doing things and non-linear refers to a non-systemic method of doing things (Newman, 2014). A mixed method research strategy refers to the combination of both quantitative and qualitative strategies (Bryman, 2012; Wagner et al., 2012).

In this study data was collected from participants through interacting with them face to face during an interview. Qualitative approach was therefore adapted as basic method for gathering data in this study. The approach or strategy was chosen because the researcher wanted to understand views of participants regarding how the programme was implemented. According to Newman (2014) a researcher in a qualitative study depend on what the participants personally beliefs in. A non-linear path was taken throughout the whole process of data collection. Participants were interviewed and more probing was done to get more information where necessary.

3.2. Research design

Wagner et al. (2012) has indicated four types of research designs that can be followed under qualitative research strategy. The four research designs were ethnography, action research, grounded theory and phenomenology and they are explained on the next paragraph below.

Ethnography study design focus on studying cultural behaviour of certain members of the community. Action research design is used if the researcher wants to improve the situation. In this instance, the researcher might plan, act and observe the changes after implementation and document. If there are no changes the cycle might be repeated until there are noticeable desired outcomes. In grounded theory the researcher collects data by asking questions in a systematic manner. The researcher who employs phenomenology focuses on describing the experience of the participant and not explanation of the experience (Wagner et al., 2012).

It has been indicated by Newman (2014) that in grounded theory the theory can be built in data collected and this theory can be built through comparisons. Apart from the four designs indicated there were other two research designs reported by Babbie (2014) and they were cross sectional and longitudinal study designs. Cross sectional study design was defined as a design in which the researcher observes a sample from a population at one point in time. A longitudinal study design referred to a design that involves data collected at different points in time (Babbie, 2014).

Bryman (2012) defines cross sectional research design as a study where data is collected from multiple cases at a single point in time. The research design employed in this study was therefore cross sectional because the researcher collected data from different participants at a single point in time. Data was collected from participants at a single point in time and the study was not repeated.

3.3. Population and sample

3.3.1. Population

A study population has been defined as the large group of cases or units from which the sample of the study is drawn (Newman, 2014). A number of target groups were envisaged at three levels of implementation which were provincial, sub district and school levels. From the levels of implementation, school health team members as providers of the program, principals or educators, education managers and school governing body were interviewed. The principals and SGB group members of schools at Ditsobotla sub district, provincial and district managers at Education Department in the North West Province and the school health personnel also formed part of the population.

Table 8 summarises the population from provincial, district and school levels of implementation.

Table 8: Summary of study population at different levels

Province	District	Sub district	Schools (eighty four)
Education manager responsible for health services at schools (One)	Education manager (one)	School health team members (one)	<ul style="list-style-type: none"> • Principals or teachers responsible for health services (eighty four) • School governing body structures(eighty four)

Table 8 indicates that the population for the study was emanating from four levels of implementation which were provincial, district, and sub district and school levels. In summary, the population of this study was as follows; one provincial and one district education managers responsible for school health program, ten principals of all schools in Ditsobotla and one school health team in Ditsobotla sub district. The population of this study was relevant because it was chosen from the

area under study (Ditsobotla) and participants from schools, health offices and education offices and NGO were responsible for study focus.

3.3.2. Sample and sampling methods

Sample

According to Newman (2014) a sample refers to a small number of units or cases extracted from the bigger population of study. The sample was selected from the population at different levels as indicated on table eight in Ditsobotla sub district. The sample contained principals, teachers and SGB members at selected schools. The other category of sample was the education managers and the school health personnel. Other provider identified by one respondent was the local NGO. In order to get the sample, schools were the main entry point, therefore schools were selected first. Data was collected from ten educators, ten SGB groups, two health professionals, two education managers and one NGO representative. The educators and SGB groups emanated from ten schools.

3.3.3. Sampling methods

Wagner et al., (2012) indicates that non-probability sampling is not based on random selection but on the availability and willingness of the participants. Non-probability sampling was used for this research. Unlike probability sampling, non-probability sampling is more cost effective (Wagner et al., 2012). Due to the time allocated for this research and lack of budget and other resources, non-probability sampling was used. Snowball sampling methods was used to identify other participants who were providers of the program not known by the programme manager. One NGO was mentioned by the principal during interview. Sampling methods and data collection methods differed at different levels of implementation. The differences in sampling methods are discussed below.

Sampling at provincial and district level

At provincial and district level the method of sampling that was used to select participants was purposive. According to Bryman (2012), the goal of non-probability purposive sampling is to choose the sample that is strategically relevant to the research questions. Two managers were selected and interviewed

from education Department. The managers were from provincial and district offices. The selected managers were those who were responsible for school health services at their levels. The plan was to interview more than one manager at provincial office but only one was interviewed. The reason for interviewing one manager was because she was the one responsible for health services at schools by the time of study.

Sub district level

Bryman (2012) indicates that some people who are sampled initially tend to mention other relevant people for the study. The sampling of the other mentioned people suggested by the initial sample is called snowball sampling. Only one method was used which was purposive. Two school health team members were interviewed at sub district level. Snowball sampling could not be employed at sub district level because no full time implementers were mentioned by the group interviewed. However some primary health care nurses were mentioned by the school health team members interviewed but they could not be interviewed due to time constraints. Integrated school health program at Ditsobotla has been provided by school health teams. Purposive sampling was used to identify the respondents for this category of school health team.

School level

There are different categories of schools in South Africa for example primary, secondary and intermediate schools. Wagner et al. (2012) suggests that if the population has sub groups, all sub groups should be adequately represented in a sample. The method of non- probability sampling that allows adequate representation of groups is called quota. Ditsobotla sub district had seventy eight schools on DHIS categorised into four groups namely primary, special, combined and intermediate schools. The seventy eight schools were categorised as follows; one special school, fifty one primaries, eleven combined and one intermediate.

The area project officer from education department was approached after permission was granted to request list of schools. A total of eighty four schools were received from the education area project officer. The data collector took a

decision to utilize the list of schools provided by Department of Education area office because it was a true reflection of schools in existence at the time of study. The list had names of schools grouped according to four clusters of Ditsobotla, namely, Lichtenburg, Coligny, Itsoseng and Bodibe. Schools were selected from all four clusters of Ditsobotla; therefore quota sampling method was employed. The respondents of the study at schools were principals and SGB of the selected schools.

Sample size

Wagner et al., (2012) also indicates that sample size in qualitative research depends on the technique and the methods of data collection that will be used, for example, if you intend using individual interviews more time will be required than when using other methods such as focus group interviews. In this research, sample size was selected by the data collector considering the limited time allocated for this study. The study was supposed to be completed and report to be submitted by end February 2016. The calendar for schools ended in early November 2015 and December most of the health professionals were on leave. This meant that the data collector only had February 2016 to collect data from participants.

The total sample size comprised of twenty five participants. Ten schools were selected and therefore ten principals were interviewed and ten school governing bodies at those selected schools were interviewed. In case principals were not available or not knowledgeable with health activities conducted at schools, teachers responsible for health services at schools were interviewed. One principal at one of the schools visited mentioned one NGO health facilitator who assists sometimes at school and the snowball sampling method was applied. The NGO official was present during the day of interview and the opportunity was utilised to interview the official. The other sample came from education district and provincial offices, two managers were interviewed. The last numbers of respondents were two health personnel responsible for ISHP at Ditsobotla. Table 9 summarises the sample size at different levels of data collection.

Table 9: Summary of sample size at different levels of data collection

Level of data collection	Sample	Sample size
Provincial	Education managers	One
District	Education manager	One
Sub district	Health personnel rendering health activities at schools	Two
School	School governing body	Ten
	Principal or teacher responsible for health services	Ten
	NGO	One

The plan was to interview two schools in one day but due to some challenges experienced at schools, the plan was changed. The challenges included permission to conduct interview from both Departments (Health and Education) which was granted in separate month. Education gave permission on the second week of December 2015 and schools were already closed. The Department of Health gave permission to conduct research on the 28th January 2016 and all these delayed the data collection process. The distance travelled between schools was between sixty and forty km daily. The distance affected the number of schools visited in one day due to the early knock off time for schools. Most of the appointments with schools were around twelve o` clock midday. The minimum period of stay at school was between two and half hour and therefore travelling to the other school was not easy.

The other challenge included difficulties in getting a one-on-one with the head of school due to competing priorities within education department. The data collector could only be able to visit one or two schools in a day.

3.4. Data collection

Wagner et al. (2012) proposes three basic methods for collecting data in qualitative research. The three methods of data collection are interviews, observation and

records analysis and they are commonly used as a combination. Furthermore Wagner et al. (2007) indicated three types of interviews that can be used for data collection. The first is semi-structured interviews which refer to an interview held using list of basic questions to be asked. The second is structured. In structured interview questions are pre-determined and asked in the same order. Lastly unstructured interviews refers to the interviews conducted formally using a scheduled time.

According to Babbie 2014 a qualitative interview refers to the interaction between the researcher as the interviewer and the interviewee as the participant. The researcher has a set of questions to be asked and the questions are normally not systematic. Observation method is employed when the researcher observes what the participant does and documentation of what the researcher thinks the participant has done (Babbie, 2014). Document or record analysis has been defined as an analysis of the contents of documents (Wagner et al., 2012).

There are three types of documents that can be analysed to get data in a qualitative study outlined by Wagner et al., (2012:p.141) and they are discussed as follows:

- Primary, secondary and tertiary documents: The primary documents are the documents that are written by people who were there when the events take place and they are regarded reliable. An example of primary document may be newspaper articles. However primary documents are also subject to biasness and to address subjectivity the researcher may use triangulation or secondary sources. Triangulation refers to the usage of multiple data collection methods. Documents that are written by an author who was not available when the events unfold are called secondary sources. Tertiary documents allow the researcher to locate more information on certain things. Internet and libraries are hubs for these tertiary documents. An abstract can be taken as an example of these documents.
- Public and private documents: There are four categories of public documents. The first category is called the closed documents which are regarded as secret documents like files kept by police. Secondly, restricted document like medical

files and the third is called open-archival. The last public document is open-published. Open – archival documents are reports that may be extracted from certain sources like census reports. Government acts, regulation and policies can be used as examples of open published documents. Private documents are private cannot be made available for the public.

- Solicited and unsolicited documents: Solicited documents are documents that have been created for the purpose of research whereas unsolicited are documents that are created for personal usage.

More than one data collection method helps to increase trustworthiness of data and this is called data triangulation (Wagner et al., 2012). This study employed the two methods of data collection which were; interviews and document analysis. There are some basic principles in terms of the numbers of the focus group members. Bryman (2012) suggests the number of members in a focus group should be from six to ten. Babbie (2014) has indicated five to fifteen and Wagner et al.(2012) mentioned five to twelve. However Bryman (2012) has further indicated that there are variances in the number of group members . In his book (Bryman, 2012; p.506) he cited different studies conducted listing differences in numbers of group members. There was an example of four studies conducted whereby authors had focus group members ranging from three to ten.

Interviews and document analysis were used in this study. One on one interview was conducted with ten participants from a group of teachers and principals, nurses, NGO representative. Focus group interviews were held with ten SGBs. Seven SGB had four members each and three SGB had five members. It was difficult to get full members of SGB available at school during interview because most of them were at work during the day. The methods of data collection were used because the researcher aimed to understand implementation of the school health programme from views of participants. It has also been indicated by Babbie (2014) that in a qualitative interview, there is an interaction between the researcher and participant. The interviews and documented events kept by participants were the methods that could give more information to the researcher regarding the topic under study.

Research instruments

Wagner et al. (2012) outlined three types of interviews as already discussed under data collection. The three types interviews were semi structure, unstructured and structured. In a semi structured interview the researcher uses an interview guide which contain basic question that can be asked to address the research purpose. Structured interviews are conducted using predetermined questions that have to be followed in an orderly manner. The questions normally are in a multiple choice format but open ended. Unstructured interviews employs data collection without list of questions but the researcher has a clear goal in mind of what to ask (Wagner et al., 2012).

In this study, semi- structured questionnaires were used to conduct face to face interviews and focus group interviews. A list of basic questions that were aimed at addressing the research questions was used. The interviews were conducted at schools for principals, education managers, nurses and NGO representative. Focus group interviews were held with SGB members. The questionnaire was used at all levels of data collection. The interviews lasted for approximately one hour per session. Questionnaires were developed in line with the five development assistance committee framework characteristics. Alignment of questionnaire with DAC framework was done to get more information on the whole process of implementation.

Participants were grouped into four categories and therefore four types of semi structured questionnaires were used to collect information during interviews. The four categories of participants were principals and teachers, education managers, school health nurses and school governing body members. Questions asked on the questionnaires were developed in line with the five key themes of the DAC framework that is relevance of the program, effectiveness, efficiency, impact and sustainability. Data collection started on the first week of February 2016. Schools were visited from 16 February until 11 March 2016. There were some challenges affecting data collection such as delays in getting permission to interview the school principal and or teachers. SGB members were not always available at schools during the day. The available SGB members were interviewed.

Primary data collection

Ten schools were selected for participation and the aim was to interview principals of those schools. Where the principal was not available a teacher responsible for health services was delegated by the principal to represent the school. At one of the schools the delegated teacher was a maths teacher who did not have enough information on health services rendered at schools. The teacher indicated she was only informed in the morning when the researcher was at school to be interviewed and therefore complained that the study was interfering with the classes. However, the interview was done with the teacher irrespective of the challenge.

Fifteen face to face interviews were conducted (ten at schools, two from education managers, two from health personnel and one from NGO official). Most schools have teachers delegated as focal person for health activities in schools. It was difficult to get principals at schools and the permission to come to school for interview was delayed because of the unavailability of principals. Four principals out of ten schools were interviewed. Furthermore, five teachers interviewed were life skill, life orientation teachers and one teacher was interviewed for maths.

Two school appointments were cancelled due to unavailability of principals attending principals meetings outside school premises. Education area office of Ditsobotla provided a list of schools with names and contact numbers of the principal. Some of the names of principals and contact numbers were not updated. Three school principals were no longer at those schools and one teacher was already on pension. The process of securing permission was delayed because the data collector had to do verification of principals list with education area office.

There was an issue of data discrepancy on the number of schools on DHIS and number of schools reported by Ditsobotla education area office. The number of schools on DHIS was seventy eight and education provided a list of eighty four schools. The researcher took a decision to use the second list provided by the education officials to get more buy in and full ownership of the information provided from the education department. One of the farm schools visited was around hundred kilometres single trip in the rural farm. The road to the farm

school was bad gravel and the data collector got lost first before the destination was reached. The farm school was one of the quintile one schools visited which are the most rural schools.

Secondary data

Secondary documents have been discussed under data collection. From the interviews conducted, there were few copies of documents which were collected as proof of activities taking place at schools. The documents were requested as proof after being mentioned by the respondents during interviews and the researcher thought it might be valuable to analyse them to check relevance. The copies of documents collected at schools were as follows;

- Learner screening consent form for integrated school health programme
- South African schools act 84 of 1996
- Proof of visits from other stakeholders including health officials and services rendered
- School governing body meeting programme
- Lafarge excellence awards forms distributed at schools
- Pregnancy and HIV/AIDS material (novel for leaners)
- Annual schedule of parents and SGB meetings

The documents were given to the data collector as proof of ongoing activities at different schools. All documents were analysed to check alignment to what the respondents indicated during interview. The results are discussed in chapter five of this report.

3.5. Data Entry

Semi structured questionnaires were used to gather data. During face to face interview sessions, data collected was recorded on the data collection instruments used and on the research journal of the data collector. A voice recorder was used at four schools. Data was collected from 2nd week of February until 11 March 2016. Data collection instruments were given alphabetical labels to identify schools where interviews were conducted, for example, school one visited was labelled

School B and the rest of other nine schools followed as school C, D, E, F, G, H, I, J, and K to avoid calling schools by their names.

Face to face interview and focus group interview

Fifteen respondents for face to face interviews were given labels to maintain privacy of participants. The ten respondents at selected schools were labelled according to the alphabets allocated to their schools, for example, respondent one at school B, C, D, E, F, G, H, I, J and K. The remaining five respondents who were not interviewed at school were labelled respondents one, two, three, four and five. Focus group interviews were held with school governing bodies of selected schools. The school governing bodies were given labels according to school labels, for example, SGB B meaning school governing body for school B.

The data collected from interviews was recorded on data collection instruments and on the voice recorder. After the first interview, data was transcribed into the computer in a form of spreadsheet. Data entry into the computer started on the second week of March 2016 and completed on the fourth week March 2016. Different themes were used to code data entered according to questions asked. Respondents were not asked the same questions.

3.6. Data validation

Wagner et al. (2012) indicates that using more than one method of data collection and different researchers to measure same thing ensures data reliability and validity. In this study, data was conducted through interviews (face to face and focus group interview) and document analysis. Three field workers were supposed to assist with data collection but due to the time constraints this could not happen. The field workers were supposed to assist in November and December 2015 whilst still on leave. Late permission granted by Departments also delayed the process of data collection. Data was therefore collected by one data collector using questionnaires and some recording was done in some sessions to allow validation. Questionnaires were piloted on colleagues to check understanding and interpretation of the questions. Wagner et al. (2012) further indicates that trustworthiness of data is improved by making sure that the participants are

interviewed in a very safe environment and less disturbed by the interviewer. In this study the participants were interviewed at their place of work which were assumed to be safe. Confidentiality and privacy was maintained through signing of consent forms. No participant was coerced to participate.

3.7. Data analysis

Bryman (2012) has indicated that coding is the basic principle of qualitative data analysis. Babbie (2014) has defined coding as a method of categorizing or classifying data collected from participants. Wagner et al. (2012) outlines four basic and commonly used methods to analyse qualitative data as follows; narrative, thematic, discourse and phenomenological. Narrative analysis refers to analysis of data collected from narrated stories that participants told the researcher. This is mostly used in story analyses like fairy tales. Thematic analyses involve analyses of data through identifying common themes or data patterns. The researcher will look at what was said mostly or less common by participants. Discourse refers to analyses that takes into consideration what the participants say and relating to the language used. It is believed that in discourse analyses the language influences the behaviour of an individual and therefore careful consideration are made when analysing data. Phenomenological analyses involve analysis of single case and comparing it with others. The aim is to get information on what others experience looking at similarities shared by cases (Wagner et al., 2012).

The method chosen for this study was thematic analysis. This method focused on analysing qualitative data through identifying and grouping common themes from respondents. More focus was directed in identifying common data patterns or themes that address the research questions. One of the aims of this research was to explore challenges in the school health programme implementation. Thematic analysis was chosen with the aim of identifying common responses from participants which might be useful to the study.

A spreadsheet was developed to enter or transcribe the responses from the notes made during the day after collecting data. Volumes of data were collected from the twenty five respondents. Wagner et al. (2012) further indicates that analysis

of data should aim at making sense out of data collected through processes called data reduction, display and thereafter make conclusions. In this study, data collected was transcribed into the spreadsheet according to identified themes from respondents. Different colours were used to identify common data themes on the notes and thereafter entered into the computer. The process of entering coded data was done according to the research questions

3.8. Limitations of the study

The study was conducted at Department of Health and Department of Education. Learners were excluded from the study. This may have limited the data in terms of perceived value of education. The number of schools selected was limited and this might have not represented the views of all principals in Ditsobotla. Seven out of ten focus group interviews conducted had four members in each group. Three out of ten SGB group interviews had at least five members in each group. The numbers of group members of the SGB groups were limited and this might have limited the information collected from SGB members during group interviews. The information gathered through literature review was according to what was available for the researcher by the time of information searching. The views of respondents from the study do not represent the views of all population of Ditsobotla and can therefore not be generalized to the entire population.

3.9. Significance of the study

The study has revealed some implementation and outcomes of school health at selected schools of Ditsobotla and therefore some lessons were learnt. The learners as beneficiaries of the study targeted by the policy could benefit from the study. If the school health programme performance improves that means there will be more health services provided to the targeted group than before. Therefore lessons learnt at all levels of implementation could be relevant to other sub districts in the province as well.

3.10. Ethical considerations

Permission to conduct research was requested from both departments of health and education in the first week of December 2015. On the 9th December 2015, the provincial department of education granted permission to conduct research at

schools. The provincial health department delayed to give permission due to processes the department undergoes for approval. Permission was granted by the department of health on the 18th January 2016. Schools were closed from second week of December and opened on the second week of January 2016. Data collection started from the first week of February with managers of education and at schools data started from second week of February to 11 March 2016.

Wagner et al. (2012) indicates the four key issues that need to be highly considered in ensuring that the research is ethically correct. The four issues include accuracy, privacy and confidentiality, deception and lastly informed consent. Even though purposive sampling was used to get respondents, participants were not forced to participate in the study. Privacy and confidentiality was maintained to those who agreed to participate in the study. Views of the respondents were not discussed or shared with their colleagues and supervisors.

Particulars of participants were not made public and this referred to their names and addresses. All participants were required to sign an informed consent form. Information in the consent form was not changed in the process of the research to avoid deception. The consent form had the following contents; purpose, procedure, potential benefits and risks, duration of the study, information on how privacy and confidentiality will be maintained. Other key contents of the consent included records handling, contacts of the researcher and indication that participation was voluntary.

The consent forms were sent to the education area office manager with an attachment of a permission letter to conduct research on the first week of February 2016. The aim was for the respondents to read and understand before visits were conducted at schools for interview. Two out of ten schools had seen the consent forms before the interview and eight did not see the consent forms. The data collection process was delayed by explaining to the teachers and SGB why the research was conducted and why they were chosen to participate in a study. Explaining to the participants is one critical step not to be missed in a research but participants should receive information prior the interview. Two schools did not arrange with the SGB for interview and therefore the data collector had to

wait for the principal to call SGB first. The two SGB groups were interviewed later after school hours and the other one interviewed during weekend.

3.11. Summary of chapter three

The study employed a qualitative method of investigation. Study sample was selected from a group of school governing body, teachers and principals at schools in Ditsobotla, education managers at district and provincial office, nurses and NGO. The discussion under this chapter has highlighted the challenges encountered during data collection which are worth noting. The challenges include limited number of SGB members at some schools which might have limited information or data collected from focus group interviews. A total of twenty five participants were selected to represent the population. The views of the respondents have been discussed under chapter four.

CHAPTER FOUR: PRESENTATION DISCUSSION AND ANALYSIS OF RESEARCH RESULTS

This chapter serves to present, discuss and analyse research findings. Discussions were based on the research results and themes which came up from the literature review were used such as social cognitive theory and the DAC. The study had two aims. Firstly, to establish and explore factors that serves as barriers of implementation of school health programs in Ditsobotla. Secondly, the researcher aimed to understand implementation and outcomes of school health program in Ditsobotla. To address this, twenty five participants were interviewed using semi-structured questionnaires. Participants of the study were principals, teachers, and school governing bodies, education managers, school health nurses and NGO.

The methods of data collection used for the interviews were one on one face and focus group interviews. Document analysis was also done on documents that were provided to the researcher during interviews. Four types of questionnaires were used to collect information from a group of principals and teachers, education managers, school health nurses and the school governing body. Each questionnaire was administered to different groups. Voice recorder was also used to capture participants' views at some schools.

Literature review revealed that the DAC framework is an international tool used to review and monitor program implementation. For this study, the DAC framework was therefore selected as the monitoring and evaluation tool. The questionnaires for all groups of participants had two sections of questions which were similar, namely demographics and the five key themes of DAC framework. School health nurses questionnaire had an added third section of qualifications whereas the teachers and principal questionnaire had a section on quintile classification of the school added. The additions on the questionnaires were influenced by what came up from the literature review regarding provider's qualification and the school quintile classification.

The literature review highlighted that qualified providers are able to provide better services than unqualified officials. It has been noted again from chapter one that quintile one and two schools were prioritized during implementation of the

school health program. The results of the study have been presented below and it's a full representation of the respondents' views.

4.1. Description of Respondents

There were fifteen one on one face interviews conducted and ten focus group interviews. The one on one interview participants were school principals, teachers, education managers, school health nurses and NGO official. Focus group interviews were held with school governing body of each school selected. Seven SGB had four members each and the remaining three had five members in each group interviewed. The total number of focus group members interviewed was forty three. There were eight quintile one schools, one quintile three school and one quintile four school visited to interview participants.

4.2. Research questions

The study had three research questions under which there were seven sub questions. The respondents were asked questions to address the research questions. Additional information was also noted from respondents in addressing the questions. In addressing the research questions, the questionnaire was aligned to the five key characteristics or themes of DAC framework which were as follows; relevance, efficiency, effectiveness, impact and sustainability. The responses of the respondents are discussed in line with the five DAC framework characteristics as follows;

4.3. Presentation of research question one: What package of service is implemented at schools?

Relevance

In line with the DAC framework in assessing the relevance of the integrated school health program, all respondents were asked to indicate the package of health service rendered at their schools. The general view of most respondents regarding package of health services was health assessment, immunisation and health education. One participant at school D was noted saying "*Nurses are coming to schools to do screening for eye problems, immunisations, yesterday the nurses were doing deworming .They come to school per request or invitation, and they also gave*

health education to grade six and grade seven learners". However, other package of services noted differently from few other respondents was referral of learners after assessment and follow up. Participant at school J indicated that "*nurses check teeth and eyes of the learners and refer where necessary. Last week they came for deworming and HPV vaccination to prevent cervical cancer in girls*". The other participant four added by saying "*package of service include learner assessment and screening, health education and promotion, on site services which include immunisation, referral and follow up*". Further from the mentioned package of service, other participants indicated sanitary pads distribution as a health service provided at schools.

One member of SGB C when responding to the question said "*Distribution of sanitary pads for certain grades in the school from grade five to seven when there's a need and immunisation of girls. Care givers gave support to learners who have health and other problems and refer to clinics. Always company came for distribution of sanitary pads and health education last year*". One member of SGB D when asked to elaborate more on the package of service said "*hand sanitary pads were given to learners and immunisation. In case a child is sick a letter is written to the clinic (referral). Arrangement has been made with local clinic to assist the child without following the que*".

Three different groups of teachers, nurses and education managers gave additional information about the relevance of the school health program when they responded to the questions below (on the package of services).

- What guides implementation of the school health program?
- What analysis has been done to identify the health priority of learners at schools?
- Are educators providing any health activity and if yes what are those?

Responses on what guides the implementation of school health program

The views of respondents from the group of nurses and education managers indicated that ISHP policy was used as a guide to implement the school health

program. One participant was noted saying *“ISHP 2012 policy is used as a guide for implementation. Teachers are provided with guidelines on implementation during their trainings. The district CSTL (Care and Support for Teaching and Learning) coordinator and life skill HIV coordinators are the ones who are conducting trainings”* said Participant one. Other participants indicated that CSTL framework also guide implementation of the school health program. Participant two said *“ISHP policy direct implementation. CSTL policy within the Department of Education introduced in 2012 also serves as a guide. The CSTL policy advocates for nutritional support, health promotion, curriculum, infrastructure and others”*.

Responses on what analysis has been done to identify the health priority of learners at schools

Three groups of participants from principals and teachers, nurses and education managers where asked to indicate if there was any analysis conducted to determine any priority in health. The general view from respondents was that nothing was done to determine the health priority. Most participants indicated that even though nothing was done there were some records of illnesses learners suffered at school. Participant at school E when asked about any analysis conducted at school said *“Nothing formal, but records are kept for illnesses that learners are suffering from. Learners are referred to local clinics and hospitals if there is a problem”*. The other participant said *“A formal analysis has not necessarily been done but the cluster care coordinators identify children with health problems and refer to clinics. Nothing formal was done and no study was conducted but information is there at schools”*.

Other participants indicated that services were just implemented as the policy required. Participant at school B said *“none, the programme was just implemented and learners were taken in the class for screening. Health officials were not informed of any situation by teachers”* Participant at school H said *“ None. The health needs of learners are only revealed by nurses after screening”*.

The responses on health activities given by educators at their schools.

A group of educators were asked to indicate if educators were providing any health activity at school and to specify that activity. The general response from the respondents was that educators were providing health education topics in classrooms. Names of topics were also highlighted by the respondents. Most of the respondents also indicated that teachers have been providing first aid to learners injured at schools.

The participant at school E when asked if educators have been providing any health activity said “*Yes, educators are used to rendering health activities such as health education topics integrated into the curriculum*”. Participant at school I further said “*Yes, through life orientation subjects, topics they touch are nutrition, physical education on healthy lifestyle diseases and importance of exercises, sexual reproductive health topics, for example sexual reproduction*”. Other participants further highlighted that educators provide first aid to learners injured on school grounds. Participant at school F said “*Yes, life orientation subject offered by teachers. First aiders also provide first aid, one trained teacher provide basic emergency care and no medication is kept inside*”. The participant at school C said “*First aid teachers are doing first aid level one. There are life skill teachers but they are not offering health services*”.

The group of teachers were then asked a follow up question to indicate if they were orientated on health topics they have been giving at schools. Most of the respondents indicated that health education topics were part of the curriculum and there were no special workshops for that. Others said they attended general education workshops organised by education department to address all issues of the curriculum. The participant at school G when asked what topics they have been giving in classrooms and if they were orientated on said “*Other health topics on life skills include exercises, healthy food, changes in the body of young children like puberty. Teachers are not orientated on health topics, they just use guides on curriculum on textbooks. We also do research and google topics on internet before teaching*”. Participant at school B when responding to a question regarding orientation of teachers on health topics said “*we are sometimes invited for*

workshops, not orientated much on health issues like workshop for first aid. Teachers are selected randomly for life skill teaching”.

Furthermore more information was given by educators in their response when elaborating on health topics given by teachers at schools. Teachers and principals were asked to mention topics that were provided at schools by them. Most of the participants from this group of teachers and principals mentioned sexual reproductive health. Fewer had mentioned healthy eating and exercising as a physical activity. Participant at school G when responding to the question what topics are given by teachers at schools said *“Other health topics on life skills given by teachers include exercises, healthy food, changes in the body of young children for example puberty. Teachers are not orientated on health topics, they just use guides on curriculum on textbooks. We also do research and google topics on internet before teaching”.*

The respondent from school F said *“Teachers handle topics such as sexual reproduction, teenage pregnancy, child headed families. Teachers are guided by the syllabus. Discussion or orientations are held during educators’ forum”.* The participant at school C was noted saying *“Teachers give education on good exercising, good food and safety”.* The other respondent at school E said *“Life orientation Teachers only focus on DOE curriculum topics such as exercising, good diet and hygiene. The school have balls for physical activity but orientation is guided by education curriculum”.*

4.3.1. Who are the beneficiaries of the school health program?

Most of the participants when asked if they know who the school health program beneficiaries were, they indicated that learners at school were the beneficiaries. One participant when asked if they know who the beneficiaries of the school health program were said *“Yes. Last year an annual general meeting was held and health officials came to explain and give information on the health program and what they will be coming to do for learners”* participant at school B. The other participant at school H said *“Yes because the nurses who come indicate the targeted group and*

the principal thereafter conveys the message. Meetings are conducted by individual stakeholders to address the current problem". However, other participants at school E, F and I said they were not aware of the beneficiaries. Participant at school E when responding to the question said *"No, the school is not aware of the programme"*.

Effectiveness and impact

In determining the effectiveness and impact of the programme, the participants were asked to indicate how the health service package has affected the beneficiaries. The responses from participants were that there has been a positive improvement in the learners' general health and school attendance. One member of SGB B when asked to respond to the question said *"the problems and illnesses of learners have decreased, the clinic is too far so the programme is doing something better. The learners who are on chronic medication when they have forgotten tablets, they are assisted"*. Participant SGB K member said *"nurses provided toothpastes/tooth brushes and menstruation cups to hold menses. This assisted learners"*. Participant two when asked to explain how the beneficiaries are affected by the service provided said *"Yes there is a positive change. There are network for health services .Relationships with local companies within Ditsobotla area has been strengthened .There has been health assessment of learners spectacles were issued to those who were in need. Provision of school uniform has been done to needy learners. Some private doctors from around assisted the needy learners who were sick without payment"*.

Participant at school D said *"positively, girls absenteeism was high on days of menstruation before service was provided at school , department of health provided pads, the last delivery was in December 2015, plus minus 20 grade six and seven girl learners received pads last year"*. At school J, the participant was noted saying *"positively the benefits are there, especially those who had eye problems first, the school used to have learners with tearful watery eyes and now the cases have reduced"*.

However, other participants had different views on how the service affected beneficiaries. Participant one said *“not all children are receiving the services”*. The SGB K when asked to respond indicated that *“Nothing has been observed because parents never mentioned anything to us”*.

4.3.2. How are health programme offered in schools?

To further determine effectiveness in the way the program was provided, participants were asked to indicate how the health services were rendered at schools. Most of the respondents said that health programs were rendered at school premises during school working hours. The participants also indicated that nurses came to school to screen learners, give health education and provide immunisation. Participant one when asked how services have been provided at schools gave a broad overview and said *“school health nurses came to schools to assess learners and refer to local clinics or hospital. In Ramotshere Moilwa district, Bakwena N1N4 organisation came and assessed learners for vision, hearing and provided relevant treatment. In Some parts of Bojanala district, Dr Ruth Segomotsi Mompati and Ngaka Modiri Molema districts, Transnet Company provided sexual reproductive health services through health education at schools. The focus was on grade six, seven, eight, nine and ten. At Ditsobotla, Lafarge company health officials are supporting all schools with sexual reproductive services through health education”*. The other participant at school G said *“appointment was made with the school; nurses came to school and render services in classrooms”*.

4.3.3. What are the qualifications, knowledge and experience of school health program providers with respect to the program?

Efficiency

To address the above research question, all participants were asked to indicate who provides the health programs at schools. In addition to this question, the implementers of the program (nurses) were asked to indicate their qualification.

The implementers were also asked to indicate if there were some health officials who were providing health programs at schools.

Responses on who provides integrated school health program

Most participants said the integrated school health program have been provided by nurses and other health officials. Participant at School D when asked who have been providing health programs at school said “*nurses and other health officials, yesterday the team that came had plus minus six members*”. One member of the participant SGB H responded by saying “*nurses from re-engineering*”. The participant member of SGB H was asked to explain what the nurses from reengineering meant. The explanation was given that it meant nurses who are visiting households at ward level. However other participant mentioned other people who provided services besides the nurses. Participant one responded by saying “*At Ditsobotla, Lafarge company health officials is supporting all schools with sexual reproductive services through health education*”. The information received from the participant one was that Lafarge Company was the private cement company around Ditsobotla.

The implementers’ responses

The implementers’ responses indicated that other primary health care nurses were sometimes providing the health program at school. Participant three when asked if there were any health officials assisting in rendering school health program said “*partly yes, the PHC reengineering staff, most of the activities they help with are HPV and Td. HPV is done during campaigns. Td is done as own initiative at their wards. Learners identified to get Td were referred to PHC reengineering nurses but if they were unable to assist the school nurses were doing it. Five PHC re-engineering nurses are sometimes assisting and not always. They are not regarded as doing school health on daily bases*”. Participant four when asked if there were any other providers of the program said “*PHC re-engineering, they help us working effectively and efficiently as we are short staffed*”. The participants explained PHC abbreviation as primary health care and Td as tetanus toxoid

Qualifications, knowledge and experience of the providers

The implementers were asked additional four questions in determining their knowledge and experience on the programme they were providing. Firstly, they were asked to indicate if they were full time or part time providers of the program. Secondly, they were requested to state their qualifications. The third question was on trainings they have attended with regard to the school health program. Lastly, the resources needed for provision of services.

In responding to the question of whether they were full time or part time, general response was that they were providing services full time. However one participant (number five) had a different response. Participant five when asked to respond said *“No, I’m volunteering”*.

The responses on the question regarding qualification of the providers indicated that providers had qualifications of the job they were currently occupying by the time of interview. Participant three when asked what qualification she was holding said *“Diploma in general nursing, psychiatry, community and midwifery. Post graduate diploma in Management and Education, Diploma in clinical health assessment, treatment and care and certificate in integrated management of childhood illnesses”* Participant four responded by saying *“Enrolled nursing certificate”*.

The participants were further asked to indicate what training they attended regarding school health programme and to indicate when the training was conducted. Participants were also requested to mention if the training was relevant or not. The responses were that they have attended ISHP training course and they also felt that the training was relevant to what they were doing. Participant three when responding to the question said *“I attended ISHP training in 2012 June, vision screening training in 2013 and audiometry training in 2013. Yes it was relevant, because the screening of eyes requires information or training to be able to diagnose, it also provides you with a skill to screen efficiently”*.

Participant four when responding to the asked question said *“I attended ISHP training in 2014; primary eye care 2015 and all trainings were relevant”*. However

one participant had a different answer. Participant five was noted saying “Facilitation of health topics, discussions, building skills of facilitation, Furthermore I use own knowledge and yes, it was relevant, it keeps our mind busy, not to forget what you learned”.

On the question regarding what resources were needed for provision of service, the response was human resource, material and equipment. Participant three was noted saying *“Human resource. According to the policy it is supposed to be professional nurses, enrolled nurses and health promoters. Material resources such as scales, stadiometer, examination set, audiometer, stethoscope and E- chart. The sub district has three local areas and four clusters, according to the policy each cluster should be having nurses but now it’s only one team of professional nurse and enrolled nurse for the whole sub district”.* Respondent number four when responding to the question on resources needed said *“Equipment, personnel and stationery, for example individual assessment forms and referral forms”.*

4.3.4. Discussion and analyses of research question one

Package of service provided at Ditsobotla schools

According to the literature review, the Integrated School Health Policy (2012) outlines the four package of service as follows; health promotion and education, referral and follow up, on site services and learner assessments. Literature review further indicates eight components of HPS as health education, health promotion for staff, healthy school environment, nutrition services, physical education, community involvement, health services and individual skills in taking the healthy decisions. School health programme components are defined as health education, healthy environment and health education from the literature review chapter. The findings from this study revealed six themes on package of service provided at schools. The themes were health screening or assessment, immunisation, health education, referral, follow up and sanitary pads distribution. There are similarities on the service health service package provided at schools in Ditsobotla sub district on components of health education and health

services conducted at schools. This was supported by most of the responses from participants.

What has guided implementation of school health implementation at schools?

The study has revealed two themes regarding what guided implementation of the school health programme at schools. The first guiding document was the ISHP policy of 2012. Secondly, the CSTL framework of 2012 was mentioned. Literature review has indicated that the HPS strategy as an international guideline for school health implementation. The package of the ISHP policy of 2012 and the HPS international strategy components had some similarities.

What analysis has been done to identify the health priority of learners at schools?

Only one theme was identified under this question. All respondents overwhelmingly said there was nothing done to determine the health priority at schools. The responses from participants indicated that the service was just implemented without assessing the health problems that were prevailing at schools. According to the literature review, the implementation of the school health program should derive from a certain theory. In this study, from the participants view, the program was just implemented as there was no analysis done.

Health activities conducted by teachers at schools

There were two themes identified on what health activities were conducted by teachers at schools. The first theme was health education. Most of the respondents mentioned health education in classrooms conducted by teachers. The second theme was first aid provision to injured learners at schools. Most teachers however mentioned that they did not attend any special workshop regarding health topics they were offering. The teachers mentioned that they attended general education workshops that were addressing all education issues. The literature review has indicated that the providers of the school health program should be knowledgeable

in the service they are providing. In this instance, teachers were providing health education and first aid. However, most of the teachers said they were not specifically trained or orientated to offer health education topics in classrooms.

Health topics given in classrooms by teachers

Three themes were identified from the responses. The first theme was related to sexual reproductive health. Secondly, healthy eating and exercises was the third theme. This shows that sexual reproductive health was mostly echoed by participants and therefore there is a need for integration and more workshops to empower teachers on this subject. In the literature review it was also indicated that social cognitive theory advocates for behavioural change through health education and other health programs offered in classrooms at schools.

Who are the beneficiaries of the school health programme?

Two themes were identified regarding who the beneficiaries of the school health program were. First theme was learners and the second one was not known. The responses from participants showed that the learners were the beneficiaries and others said they were not aware of the beneficiaries. Effectiveness of the program should be measured by what the program aimed at against what was done or achieved. The study wanted to check if the beneficiary was known and if they received the service. Literature has shown that the targeted group for the school health program was the learners. Most respondents were aware of the beneficiaries and few were not aware of the beneficiaries. The findings therefore show a need for advocacy sessions at other schools on the integrated school health program.

How were the health programme offered in schools?

In line with the DAC framework characteristics of effectiveness, the participants were asked a question on how the health programs were conducted at schools. There were two themes which emanated from the views of participants regarding how the services were rendered at schools. The first theme indicated that services were provided at schools during school hours. The second theme was that health

officials came to school to offer services. The research findings showed that school health program was implemented by health officials at school premises during school hours. One participant indicated that campaigns were held to provide services at schools and gave an example of human papilloma virus campaign. The other participant further presented a provincial picture of other service providers of school health in the province. This was supported by participant one who was noted saying *“in Ramotshere Moilwa, Bakwena N1N4 organisation came to school and assess learners for vision, hearing and provided relevant treatment. In Some parts of Bojanala, Dr Ruth Segomotsi Mompati and Ngaka Modiri Molema districts, Transnet provides services through health education at schools. The focus is on grade six, seven, eight and nine. At Ditsobotla, Lafarge is supporting all schools with SRH services through health education”*. This quote gave a provincial overview of health service providers at schools.

There were some companies and NGOs mentioned to have supported the schools but not visiting schools on daily basis. This showed that not only nurses were providing health services at school and therefore stakeholder collaboration is needed to avoid duplication of health services at schools.

Qualifications, knowledge and experience of the providers

Previous results of other studies have indicated unqualified and inexperienced program providers as a challenge in school health program implementation. The results of this study have indicated that the nurses were qualified and knowledgeable. The nurses interviewed had the necessary qualification needed for the posts they occupied. On training and knowledge of the implementers, the interviewed providers had indicated recent training they attended on integrated school health program. However, one participant only had grade twelve as a qualification and further workshop on facilitation skills. This might be a challenge in implementing health promotion activities at school due to insufficient knowledge on health issues.

4.3.5. Summary of research question one

The participants at all schools visited had mentioned that health programs were conducted by teachers at schools in classrooms through health education. This platform conforms well to the principles of social cognitive theory. Even though the Integrated School Health policy was launched in 2012, the literature review has reveals that school health programs were rendered before the year 2012. The new Integrated School Health Policy (2012) has outlined one of the aims of the new school health program as a “a commitment to close collaboration between all role-players, with the Departments of Health (DOH), Basic Education (DBE) and Social Development (DSD) taking joint responsibility for ensuring that the ISHP reaches all learners in all schools” (P.7), and this shows that provision of integrated school health program is a joint strategy.

The findings of this study had similarities with what was highlighted from the school health policy as package of health services and implementation. The other key finding was that all school teachers and principals interviewed mentioned that health education activity were conducted in classrooms through life skill and orientation subjects. The conclusion can be drawn that says that integrated school health programmes were integrated into the curriculum.

In summary of research question one, the questions that were asked to the participants also aimed to assess the relevance and consistency of the school health program. The program was found to be relevant as it addresses what the policy requires. However, from the participants’ responses regarding analysis done prior implementation at schools, the program seemed not targeting the health priorities at schools. This has been supported by an overwhelming response from participants which indicated that no analysis was done at schools to identify the health priority. On the question regarding the names of health education topics more responses indicated that sexual reproductive health was the leading topic in classrooms. This requires that teachers must be more empowered to deal with the topic in classrooms.

4.4. Data presentation of research question two: To what extent are the stakeholders involved in planning and implementation of school health program?

Sustainability

All respondents were asked a question on who were their school stakeholders. The question was asked to determine if the schools had stakeholders and if the stakeholders were known.

Face to face interviews

Most of the respondents said that SGB, other government departments, business sectors and NGO were their stakeholders. Participant one when asked to indicate who the school stakeholders were said *“SGB members, parents, social development to assist in signing of consent form where there are no parents. There are NGOs which are dealing with health issues, other departments and other business sectors which can bring funds into the school”*.

Focus group interview

Most of the responses from focus group interview indicated that SGB, other government departments and business sectors were the school stakeholders. One member of SGB D when responding to the question said *“In this school we are working with learners, parents, community, teachers and SGB. Business sectors like OK foods, Supersave, SPAR, LBM Company for computers and metropolitan are also supporting us. There are also pastors and a social worker attached to school”*. The other member from SGB B when asked to mention the stakeholders for their school said *“SGB, teachers, learners, Love life ,Lottery, South African police services, department of health, south African social security agency and German project Konkodia”*. However, three focus groups indicated educators or teachers as part of stakeholders for the school.

To what extent are the stakeholders involved in planning and implementation of school health program?

Sustainability

In line with the DAC framework, participants were asked some few questions to respond to get information on how stakeholders were involved.

All participants were asked a question on how would they assess the overall cooperation or coordination with the various stakeholders internally and externally. Other groups however gave additional information regarding stakeholder involvement in program management when responding on how the other stakeholders have been informed. The additional information was given when responding to the following questions regarding the involvement of stakeholders in program implementation:

- Are the stakeholders adequately involved in school health program management?
- How is the school management informed about the school health program?
- Were the roles of stakeholders in school health program implementation clarified?

Responses

The participants were asked to indicate how they would assess the involvement, collaboration and cooperation of stakeholders. Most of the participants from face to face interview felt that there was an average involvement and cooperation of stakeholders. The average involvement and coordination was regarding all school activities which include school health program. Participant one stated that *“Collaboration is about 70%. Education and Health Departments are already working together. Some parents are still refusing to sign consent forms. Advocacy sessions are still needed for parents. At school level in most cases the principal and CSTL coordinators are in support of the program and in some schools other staff members are not supporting the program. Others think that it is not in their job description”*.

Participant two was noted saying *“Cooperation or coordination is minimal amongst stakeholders. There are competing priorities which affect the service, for example, school health nurses who act as managers whilst needed at schools. With Internal stakeholders there’s shortage of staff, example CCC of Bodibe is responsible for 8 schools, and other clusters do not have CCC. Itsoseng CCCs resigned in 2013”*. Participant two was asked what CCC meant and indicated that it meant child care coordinators. The school C participant responded by saying *“Implementation of the program is not always 100%, health workers have their own program and cannot assist always”*. However focus groups had different views.

Most of the participant from focus group indicated that cooperation of the school stakeholders was good. Participant SGB F when asked a question on how would they assess the overall cooperation and involvement of stakeholders at their school said *“99%. The Department is supporting the school on daily basis. Learners are not having problems but drug abuse was identified in the school, learners were smoking dagga. SAPS responded well. There is adopted a cop service, a list is available for all stakeholders”*. The abbreviation for SAPS in this statement was referring to South African Police Service. The SGB C participant responded by saying *“Internally there is full participation of SGB. There is community participation locally, nurses are coming to school, care givers are also assisting, and educators are participating. Externally the nurses are coming for health services and business people are also participating fully”*.

Additional information was given by other participants when responding to questions on stakeholder involvement in school health implementation. The responses are presented below.

Responses: Are the stakeholders adequately involved in school health program implementation?

Most of the participants from face to face interview indicated that the stakeholders were not adequately involved in the program implementation. Participant two

when explaining further said ‘said “Nurses go to schools and discuss screening dates with school management team before screening. There is no platform for nurses to plan for implementation. Planning is done with district officials. Nurses just go to school to discuss and agree on which date to come and render the service. Planning with schools only happens during campaigns and awareness events”. Participant one was noted saying “The involvement is not up to standard. Meetings are sometimes held in the absence of most stakeholders like school management and others. They are only called when needed. No plans were developed together with schools. Health is sometimes called when there are some health issues”.

The majority of focus groups indicated that they were involved in program implementation. The Participants of the SGB B when asked how they have been informed about the school health program implementation they said “Principal write a letter to SGB and parents. We have been also been informed through SGB meetings and phone calls. SGB meetings are held on quarterly bases”. The participants of SGB H group when asked if they have been informed and how they said “We were informed by principal through letters”.

Responses: How is the school management informed about the school health program?

The majority of respondents indicated that the school management was informed by the nurses about the school health program implementation. However two participants mentioned that letters were written to schools by the education offices and the advocacy workshops were held with school management.

In the category of participants who indicated that nurses visited schools to inform school management, participant at school H was noted saying “Nurses make appointment personally and educators will be informed by the principal”. Participant three when responding to the question on how the school management have been informed about the program said “school health team visits school physically to make appointment. Distribution of consent forms to the principal. This is only done to schools not used to the ISHP. Those used to the ISHP are called telephonically”. Most of the focus groups participants indicated that the principal

informed them after being informed by the nurses. Participants from SGB c group said *“Through the principal, the principal is informed by health service providers”*.

The two participants however indicated that the schools were informed by the Department of Education officials about the school health program. Participant one when responding to the question on how school management were informed about the school health program said *“circulars were written to all schools. Advocacy session for principals, teachers and SGB were held. Training of principals, CSTL coordinators and SGB members were held. Trained officials go back and give feedback”*. Participant two said *“Through advocacy sessions, through circulars that are written to schools informing teachers about the campaigns and routine screening. Getting slots during principals meetings to advocate and convey messages”*.

Responses: Were the roles of stakeholders in school health program implementation clarified?

Majority of the participants felt that they knew their roles in school health implementation. However three participants felt that the role of stakeholders in school health implementation was not known.

One of the participants when asked to indicate and explain if in terms of human resources clear roles and responsibilities were defined for education officials regarding school health implementation said *“Yes. At provincial level, the managers provide circular to inform the schools about the program, ensure readiness of the school. Distribution of consent forms to ensure that districts are informed about the plans. Empower district officials and ensure that plan is implemented. Monitor implementation. At school level roles were also defined. Schools make sure that they provide and prepare space for nurses. Monitor the return of consent forms and report the challenges related to parents not signing consent forms. School management write letters to parents and monitor if children got services”*. The participants from SGB G when asked what support does they give health officials during screening they said *“We assist with controlling of lines*

and observation of children given medication to check if the learners do not vomit tablets given”

4.4.1. What are the roles of SGB in school health implementation?

Sustainability

The question that was asked under sustainability as one of the characteristics of DAC framework was relating to role of SGB in school health program implementation.

The participants were asked to indicate the roles of school governing body in school health implementation. Majority of the face to face interviewed participants indicated that SGB role in school health program was to make sure that parent supports the health programs. The other role mentioned was the participation of SGB in school safety committees. Participant at school G when asked to indicate what the role of SGB was regarding school health said *“The SGB takes those learners who left school back to school and they inform and encourage parents to participate in health programs at school”*. Participant at school D when responding to the question said *“most committees are run by SGB members, for example, scholar patrol and school health safety committees are run by the SGB”*.

The participants from focus group interview mentioned that the SGB were responsible for informing parents about the health programs provided at schools. However, three groups said they were not aware of their role in the school health program implementation. The SGB D when responding to the question regarding their role in school health implementation said *“The SGB has been issuing letters to the parents regarding the date and implementation of services”*. SGB H responded by saying *“we give information to parents regarding health visits and services to be conducted by nurses”*. One focus group (SGB B) had a different view from others. The SGB B was noted as follows; *“Only teachers work closely with nurses because they come during the day at school when we are not in, First aiders are available to assist and we wait for principal to make a request”*. The SGB B

was asked to explain what first aiders were and they said it referred to the teachers offering first aid to injured learners at schools.

4.4.2. What is the composition of the SGB?

The participants were asked to mention the composition of the school governing body structure and most of them mentioned the same members expected to sit in a governance structure. The members who were mentioned were parents, teachers, principal and non-teaching staff from the school. Most of the focus groups outlined the parents, principals, teachers and admin assistant (AA). However, few participants mentioned learners at secondary or high schools. Furthermore, additional information was received from focus group interviews on SGB roles. The participants were asked to indicate what support the SGB has given to the school health teams during school visits for program implementation. Different responses were noted regarding the support given to health officials during visits. Some participants indicated that they offered the health officials to space for health assessments. Others said they assisted with administration duties. Some participants mentioned nothing. The SGB C was noted saying *“accommodation for health screening was granted to health officials”*. The SGB D said *“We created space for them and also provided water. In this area from 8am to 5pm there is no water. There is no water tank in the school yard, no borehole; all are still in the pipeline”*. However one focus group could not mention the support they gave to health officials because school activities are conducted on their absence during the day. SGB H was noted saying *“normally the nurse visit when SGB members are not around in schools during the day but we assist by writing letters to parents informing them about the service”*.

4.4.3. What training did the SGB receive?

The focus group participants were asked to indicate whether they had attended any training and to further specify those trainings. Most of the participants mentioned that they attended the training on SGB general roles. SGB G when responding to the question said *“We attended SGB workshop in August 2015 on*

roles of SGB. This SGB was only appointed last year September 2015". The other participant SGB C said "the new SGB members were trained on how the SGB members must assist the school and the roles of SGB members. The workshop was attended on the first week of February 2016. Other trainings were done last year 2015 on the third term".

Other participants indicated that they attended training on school funds management. SGB B was noted saying *"We attended workshop in January in Lichtenburg for three days, the contents of the training covered how to use school funds".* The SGB H when responding to the question of what they were taught during the training said *"we were taught how and when to sign cheques in the school".*

4.4.4. Discussion and analyses of research question two.

Who are the school stakeholders?

Most of the participants have indicated the four stakeholders which were; SGB, business sectors, other governmental departments and NGOs. Few participants had mentioned teachers as part of the stakeholders. The consulted literature indicates parents as major stakeholders of the school. Most participants have identified government departments like health, social development and police as school stakeholders. There was a similarity from results presented with what was on literature review. Parents form part of the school governing body. The study shows that more participants were regarding other departmental governments as stakeholders. Majority of participants knew the stakeholders at their schools. This could be used as a foundation of the involvement of stakeholders in school health program implementation. Sustainability of the programme depends on stakeholder involvement.

To what extent are the stakeholders involved

Few questions were asked to understand the extent in which the stakeholders were involved in school health implementation. Few themes were therefore identified.

Stakeholder involvement

Two themes that emanated from the responses regarding the question on what extent were stakeholders involved. Firstly, majority responses from face to face interview showed that the stakeholders were not completely and fully involved. This was supported by majority responses from participants. The other participant further indicated that nurses only go to schools to communicate dates for screening and not to plan for screening. Secondly, most of the focus groups felt that the stakeholders have been engaged.

Furthermore, the findings show that school management was informed about the school health program by nurses. Other responses revealed that the education offices had sent circulars to schools to inform the school management about the health programs.

The literature review consulted previously highlighted planning and stakeholder collaboration as critical factors of program implementation and success. The results of the face to face interview indicated that participants felt that stakeholders were not adequately involved in planning. Focus group participants felt that they were informed about the service. Therefore involvement of stakeholders was seen to be at infancy level. All Stakeholders should be involved in planning and implementation.

Roles of SGB in school health implementation

Previous literature has highlighted school governing body as the governance structure of the school. The role of SGB in school health implementation is therefore necessary for sustainability of the program. There were four themes identified in roles of SGB in school health implementation from participants.

Firstly, the face to face interviews indicated that SGB role was to make sure that parents support the health program. The second theme was the SGB participation in school safety programs. The third theme which emanated from focus group interview was that SGB was responsible for informing parents about planned health programs. The last theme from focus groups was that participants were not aware of the role of SGB in school health implementation.

Composition of SGB

Previous research results from other studies indicated that in South Africa the composition of SGB is characterized by parents, teachers, learners, representatives from the community, administration support staff and principals, community representative, principal and members co-opted by schools (Bush & Heystek, 2003; Quann- Baffour & Arko-Achemfour, 2014). Research results indicated one common theme on the composition from participants interviewed as follows; parents, teachers, non-teaching staff and the principal as the head of the school. Other participants mentioned learners at secondary and high schools. There were similarities in terms of what was presented on the literature review and what the study has revealed.

Training of SGB

The literature review showed that school governing body was the governance structure of every school. The governance structure of every organisation needs to be trained to enable proper decision making and participation. The SGB was requested to indicate the trainings they attended to identify further if they were given any information on school health. Two themes were identified on the training they attended. The first theme was general SGB role workshop. The second theme was training on school funds management. There was not enough evidence from responses of participants that indicates any training or workshop regarding school health. The SGB therefore needs to be orientated on school health to get more buy in of the program and sustain the program further. In conclusion the school governance structures had a chance of being trained on general roles of SGB. The training platforms could be used to cascade ISHP key information.

4.4.5. Summary of research question two

Most of the participants felt that schools were not involved in planning of the implementation of school health programmes at school level but rather involved at district level. Nurses were coming to schools to communicate dates of screening and not to discuss the plan on how the program will be implemented at schools. However, the focus group discussions indicated that there was involvement of programme implementation at schools because the SGB was informed about the screening by the principal prior nurses visit. The school management should therefore be involved in planning of the school health programme implementation for support and sustainability of the programme in future.

4.5. Research question three: What has been the challenge in implementing school health program?

All participants were asked to indicate the challenges they have been experiencing regarding implementation of the school health program. Few mentioned that they did not have challenges because they were informed about the health programs in time. Participant at school J responded by saying *“provision of health services is good but social workers are not assisting in other cases, there’s no challenges of services in this school, nurses come only when they have something to offer”*. At school H, the respondent when asked what the challenges in the school regarding health programs were said *“none so far”*. The other mentioned unsigned and unreturned consent forms. Out of the few that mentioned unsigned consent forms, the participants indicated that the consent forms were not returned because the parents could not read and write. Participant at School C when asked what the challenges in school health programs were said *“Consent forms, most parents can’t read and write the consent forms therefore signing is a challenge. Most of the time they request kids to sign”*.

The other few participants mentioned lack of staff (nurses and education coordinators) responsible for school health program. Participant three said *“there*

is shortage of staff, currently there are three health areas served by two health officials". Participant one when responding to the question on what has been the challenge in implementing the school health program was noted saying *"Lack of support from other educators and parents who did not sign consent forms. No space for screening. There is lack of school health nurses to provide the service. Lack of education coordinators at all levels. Lack of human resource for school health has also been observed".* The other few participants mentioned that health programs were not offered at their schools except health education. Participant at school I said *"nurses in the past 2013 and 2014 came per request to the school to offer health services. Currently only blood bank officials come to school. They address learners first before they donate on the precautions. In 2015 they never came but health education was given to learners by teachers".*

Fewer participants had mentioned lack of space for screening at school and no early communication with the school regarding visits for health programs. When responding to the question regarding challenges, the participant at school D said *"Department of health do not give program schedule in advance, only come when there are campaigns".*

Furthermore, all participants were asked to indicate if there were any plans in place to sustain the health programs at schools. All participants overwhelmingly said there were no plans in place to sustain the program. However, most respondents also indicated that there was first aid boxes kept at school used only during emergencies. The participants also indicated that parents are called to take their children during an emergency. Participant two when asked if there were any plans in place to sustain the school health programme despite the challenges said *"no plans , but there are teachers who are trained on first aid and sexual reproductive health .The first aiders do not keep medication but only keep bandages and other stuff for emergencies".* The participant at school H said *"none so far. First aid box has been bought by the school. Parents are phoned in case of emergency and children are taken to local clinics".* Participant at school H was noted saying *"none, but, children are taken to the clinic during emergencies and*

parents are called, utilises own transport and public transport to take learners to the clinic”.

4.5.1. Discussion and analyses of research question three

The literature review has outlined some factors that serve as barriers of implementation as follows: inexperienced and unqualified providers of school health program, competing priorities, unclear roles of providers and lack of understanding of policies. The interviews conducted revealed some challenges of implementation. There were five themes identified regarding challenges related to school health implementation. The first theme on challenges indicated was unsigned and unreturned consent forms. One of the reasons provided from this challenge by participants was that some parents were not able to read and read. Secondly, lack of dedicated staff for school health provision was mentioned. This referred to health officials and education coordinators responsible for school health program. This was supported by the view from participant one as indicated on findings. The third theme identified was lack of space for screening at schools. Fourth theme mentioned was no health programs and the last was that there were no challenges.

The findings from the results of respondents do not have any of the mentioned challenges from the literature review. There are no similarities from the previous challenges mentioned from literature consulted previously.

The responses from participants regarding plans put in place for the sustainability of the program has shown that all levels of implementation lack sustainability program. It is therefore important to put some strategies in place for the program to be sustained at schools. The participants have however mentioned that there are teachers providing first aid to learners during emergency. It has also emerged from the responses that parents are called during an emergency to fetch their children

4.5.2. Support of the school health programme

In conclusion of the interviews, all participants were asked to indicate if the school health programme was well supported at all levels (school level to provincial office level).

Findings on the support of the school health programme

Most of the participants felt that the programme was well supported. However few indicated that the programme was not supported. When responding to the question of whether the programme was well supported or not, Participant at school B said *“Yes. It’s well supported and accepted. The area is a farm. Nurses are discovering things that parents are not aware of. With referrals parents are taking learners to the clinics and other referral centres”*. SGB C indicated that *“in our school yes, because we give them attention and permission to conduct services. At other levels it’s not supported because they do not come to school”*.

Other few participants who said the programme was not well supported, one of the of the focus groups was noted saying *“No, few parents returned consent forms, lack of signing consent forms but reasons not known”*. The participant number one was recorded saying *“No. At school level the programme is supported by the school principals and CSTL coordinator at district level. At Provincial level there is a coordinator. At area project office level there are no coordinators. Parents are sometimes included in trainings together with SGB”*.

4.6. Summary of chapter five

This chapter presented the views of participants as they were responding to the questions asked .The discussions were based on the research results versus what came up from the literature review with special focus to SCT and the DAC framework. Majority of the participants knew the school stakeholders. This could serve as a good foundation of strengthening collaboration between stakeholders. There were four categories of participants which were interviewed to address the research questions. The reason for interviewing different categories of

participants was to get information on the elements of DAC framework which were; relevance, sustainability, efficiency, effectiveness and impact of the program.

At one of the schools visited, one principal gave the data collector a copy of South African Schools Act for further reference regarding school governing body membership. Chapter three of the South African schools act highlights SGB composition, roles, membership and others. Out of ten schools selected for participation, there were eight quintile one schools, one quintile three and one quintile four schools. This means that schools which were visited were mostly disadvantaged schools. The following further discussion and analysis was made in line with the study.

From the schools visited, a copy of stakeholder book for visits was requested to check if nurses were visiting the school. The document received from school showed that nurses were visiting the school, human papilloma virus vaccination and deworming was given. The nurse contact details and number of learners who received vaccination for that day was recorded at school.

Apart from health services recorded, there was an evidence of some stakeholders who visited the school for service delivery. The stakeholders who visited the school were social workers doing school social work program. Other stakeholders were the child care coordinators (CCC) who came for assessment of HIV/AIDS programs. This clearly showed that even though the stakeholders were not adequately involved in school health program, some activities were happening at school level which was not known to other stakeholders.

The school records were also showing that social workers were invited to the parents meeting. A copy of school governing body meeting program received from one school only indicated general discussions of the school matters not related to school health program implementation

Theory of implementation

Social cognitive theory has been identified as one model of theory that was relevant to this study. The theoretical model has been discussed under literature

review and it was said to be focusing on the behaviour of an individual which is influenced by the society, information acquired, motivation and the actions taken by an individual. The SCT also argues that to influence an individual's behaviour there is a need for empowerment of the individual through information giving. The integrated school health program mainly focus on influencing positive health behaviours of learners and the society around them through provision of health services and health education. Teachers are also providing school health programme by giving learners health education in classrooms. Literature review further indicates that the in the SCT theory the behavioural change of individual is based on the knowledge and perception of individual. The findings of this study has indicates that more information was given to learners on sexual reproductive health. The knowledge learners have acquired from health education messages given could determine their behavioural change towards risky behaviours such as teenage pregnancy and other youth risk behaviours.

The study has revealed a range of health service package at schools which also includes health promotion activities rendered by educators. The conclusion can be drawn that the departments of health and education are doing something to ensure that learner's behaviours are positively influenced through health education sessions. Furthermore, literature review has indicated that the social cognitive theory argues that for the individual to positively change the health behaviour there is need for positive motivation and action by an individual. Sustainability of the program can be achieved if all stakeholders are working together. The SGB role as governance structure of the school is critical in taking the program forward.

CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS

This chapter presents the conclusion and recommendation of the study based on what has been discussed throughout the report. There were two aims for this study. The first aim was to establish factors that serve as barriers of integrated school health programme implementation in Ditsobotla sub district. Secondly, to understand the implementation and outcomes of school health programme in Ditsobotla sub district. The study sort to answer three research questions which were as follows:

- What is the health service package provided at schools
- To what extent are the stakeholders involved in planning and implementation of the school health programme
- What has been the challenge in implementing the school health programme

The recommendations based on the findings of the study are discussed below.

5.1. Package of services conducted at schools

In answering the first research question on what the health service package was, this study has shown similarities on package of health services at schools mainly on health education and health services provided at schools. Health education has been mentioned more than other health service package with more emphasis on sexual reproductive health topic provided by life skill teachers in classrooms. However, most of the teachers said they did not have any formal training that was done to improve their skills in handling health education topics.

The study has also indicated different providers of the school health programmes besides the nurses. There were NGOs that were mentioned who came to schools for health service provision. The responses from the respondents did not show that health services provided at schools were informed by an analysis of the prevailing health conditions.

It is therefore recommended that strategies should be put in place to sustain the health programs at schools. Teachers and other officials who have been giving

health education at schools should continue with education sessions. Department of education should empower life skill educators who are rendering health promotion activities in classrooms with skills and knowledge to disseminated health messages. The school management and the health program providers are supposed to know the health priority at different schools to improve on the impact and relevance of services provided.

5.2. Stakeholder involvement

The purpose of the second research question was to understand the extent in which the stakeholders were involved in planning and implementation of the school health programme. In the endeavour to answer the research question, the first key question asked was who the stakeholders of the schools were. The findings of the study have revealed that SGB, business sectors and other government departments such as Health, Police and Social Development were taken as stakeholders. Findings of this study revealed that SGB was comprised of parents, non-teaching staff and the principal. This shows that most schools knew their stakeholders and this could be used as a step towards identifying and engaging stakeholders on planning of the school health programme implementation.

The findings of this study have also revealed that stakeholders were not adequately engaged in planning of the school health programme at school level. If school management are not involved in planning sustainability of the program could be jeopardised. Therefore it is recommended that advocacy sessions for ISHP should be conducted to the whole school community. This refers to all SGB members, teachers, principals, learners and parents of all schools where the ISHP is provided to discuss plans for the programme. The collaboration of stakeholders needs to be strengthened and improved across all Departments, business sectors and NGOs visiting schools for implementation of the health programmes. The schools should be involved in planning and implementation of school health program at school level. Informing schools about planned dates of visits for health service does not mean the schools are involved in planning.

5.3. Challenges for school health programme implementation

The Integrated School Health Policy (2012) indicates that learners below the age of eighteen should have signed consent forms by parents' prior screening or provision of any health service. The consent forms must be returned back to schools after parents have signed. In the third research question on identifying challenges of school health programme implementation four challenges were mentioned. The first and main finding of this study was unsigned and unreturned consent forms by parents. This poses a challenge in implementation because learners who do not have consent forms are not supposed to be provided with health service. The reason mentioned by respondents for not signing and returning consent form was that other parents could not read and write.

The second challenge mentioned was lack of dedicated officials for school health programme in the department of health and education. This refers to nurses and coordinators of health programmes at schools. Lack of space for screening was mentioned as the third challenge. The study findings have revealed that health programmes were conducted in classrooms. This might have served as a barrier as most of the schools did not have sick bays. Non provision of health services at schools was mentioned as the fourth challenge. This might be due to limited school health officials or nurses in the area where the study was conducted. However there were responses that indicated that there were no challenges related to implementation of the school health programme. It is therefore recommended that strategies should be put in place to assist parents who cannot read and write in signing the consent forms. More advocacy session should also be conducted at schools to cascade information on the school health programme.

The advocacy sessions should target parents, learners and SGB. Officials dedicated for school health program at department of health and education should be increased to improve on service delivery. The department of health to employ nurses for school health implementation to cover all schools in Ditsobotla sub district. Enough space should be created for screening at schools to improve screening by health officials. Provision of health programs at schools should not

be stopped where they have been started to continue reaching learners where possible.

5.4. Conclusion

In conclusion, the literature review in this document indicates that there are different implementation approaches globally. The HPS is regarded as the standard international framework of the ISHP at schools. The literature further outlines eight components of health programmes conducted at schools for HPS as follows; health education , healthy school environment, physical education, health promotion for staff, nutrition services, community involvement and participation , health services and individual skills in taking healthy decisions. In comparison ISHP components were outlined as follows; health services conducted at school premises, health education and healthy school environments. The findings of this study has revealed two similarities on HPS and ISHP components implemented at schools. The similarities were health services and health education.

In South Africa and at the area where the study was conducted, the implementation of the programme has been guided by the integrated school health policy of 2012. This policy conforms well to the HPS concept. The school health programme policy requires that the parents sign consent forms before health programmes can be provided to learners at schools. The main findings of this study was the challenge posed by the parents who did not give consent for children to be provided with services. This challenge makes it difficult for the health learners to access ISHP services at schools. The study therefore recommends that more advocacy sessions for ISHP should be conducted at schools with key stakeholders especially parents.

The social cognitive theory argues that human behaviour is influenced by the knowledge of an individual. However this was not supported by the study findings. For instance, different respondents were unable to relate information imparted through ISHP health education component to behaviour yet service

delivery appeared to influence behaviour. Absenteeism of learners reduced at schools where service delivery in the form of sanitary pads was distributed to learners. Consequently the school health programme can be used as a vehicle to transform behaviour of learners through health education sessions and other health service delivery. This process can be facilitated by empowering the teachers and other providers of the school health programme.

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