

**THE IMPLEMENTATION OF THE INTEGRATED SCHOOL HEALTH POLICY IN PRIMARY
SCHOOLS OF REGION C IN THE GAUTENG PROVINCE**

by

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DECLARATION

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I declare that **THE IMPLEMENTATION OF THE INTEGRATED SCHOOL HEALTH POLICY IN PRIMARY SCHOOLS OF REGION C IN THE GAUTENG PROVINCE** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

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ABSTRACT

The primary aim of this study is to describe and explain the extent of which school managers and primary healthcare facility managers possess knowledge and awareness of their roles in the implementation of the Integrated School Health Policy in Region C in the Gauteng Provincial Department of Basic Education. The study used a qualitative research method by which semi-structured interviews were conducted using a descriptive and explanative design. A sample of ten respondents was elected using a purposive sampling strategy and conventional or content analysis was utilised in the interpretation and analysis of data. The main findings of the study revealed that managers know their role in the implementation of the policy. Although managers are aware of their important roles; they are unable to fulfil them due to a lack of skills. Therefore, the study recommends that the Department of Health and the Department of Basic Education should ensure that managers are skilled and more knowledgeable in implementing the policy objectives.

ACRONYMS

CDC	Centre for Disease Control
CSHP	Comprehensive School Health Program
CSTL	Care Support Teaching and Learning
DOH	Department of Health
DBE	Department of Basic Education
EFA	Education for All
FMOH	Federal Ministry of Health
FRESH	Focusing Resources on Effective School Health
ISHP	Integrated School Health Policy
NRHM	National Rural Health Mission
PHC	Primary healthcare
RAAP	Rapid Assessment and Action Planning Process
SIAS	Strategy on Screening, Identification, Assessment and Support
UNICEF	United Nations Children's Fund
UNESCO	United Nations Educational, Scientific and Cultural Organisation

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CHAPTER 1

GENERAL INTRODUCTION

1.1 INTRODUCTION

The research focuses on the implementation of Integrated School Health Policy in the primary schools of Region C in the Gauteng Province. It is important to understand that integrated school health is vested in the district level, where the schools and learners are reached. This means that the implementation of the Integrated School Health Policy is at the primary level where the school managers and the primary healthcare facility managers are based, to ensure that all learners are reached (Department of Health, 2012:17).

The integrated school health programme is a combination of services ensuring the physical, mental and social well-being of learners so as to maximise their learning capabilities (Department of Health, 2011: 65). It aims to help learners to enter school at the right age by dealing with health barriers to school entry; to help learners to stay in school until they have completed their education; to reduce absenteeism due to health reasons, and to contribute to educational performance by minimising health barriers to learning (Shung-King, Orgill & Slemming, 2014:60).

The integrated school health service is located within the administrative and functional structures for comprehensive Primary Health Care Services (PHC) using resources shared between its various components (Department of Health, 2012:3). From all these definitions, it is clear that there is a potential contribution of integrated school health services to keep learners in school because it targets all children attending learning sites.

It is important to indicate the demarcation of the area which is targeted for research. The City of Johannesburg, Region C is the old region 5; ward 70 in Region 4 and wards 44, 49 and 50 in old region. Region C is located on the northern side of Greater Soweto (Region D) and bordering, Mogale City Local Municipality on the west. In the north and east it shares boundaries with Diepsloot/Midrand (Region A) and to the east with largely

prosperous residential areas of Northcliff/Randburg and Sandton/Alexandra in Regions B and E respectively).

The Department of Basic Education has named this district D12, whereas the Department of Health still uses Region C as it is called by the City of Johannesburg. The District has a hundred and two (102) primary schools and twelve (12) primary health care centres. Two schools from this district are health promoting schools, namely Roodepoort Primary School and Durban Deep Primary School. Not all the schools are implementing the Integrated School Health Policy.

In this chapter the background and rationale for the research are presented, followed by the problem statement, secondary research questions, research objectives, and conceptualisation. Also, the delineations and limitations of this study are presented. The chapter concludes with a sequence of chapters and a summary.

1.2 BACKGROUND AND RATIONALE

Learners have unique health challenges that deserve the focused attention from policy-makers, commonly done through the provision of integrated school health programmes. Therefore, the implementation of the Integrated School Health Policy in schools requires not only the policy-makers, but also the school managers and primary healthcare facility managers to provide the appropriate support. In South Africa, the Integrated School Health Policy is a new policy hence, the importance of the presence of health and education officials at school and primary healthcare level in its structures are not yet fully functional (Shung-King *et al.*, 2014:66). Thus, the school managers and primary healthcare facility managers as the key actors find it difficult to support it.

At National level, there is an inter–sectoral task team which is responsible for the overall planning and development of the Integrated School Health Policy. The team also provides implementation support to provinces and districts with coordinators in each department, but are not exclusively allocated to school health (Department of Health, 2012:17). The implementation of the policy at primary level becomes difficult to support because of the use of top-down approach in policy implementation (Shung-King *et al.*, 2014:66). This will

mean that the policy decision-makers in the implementation process function at the top of the organisation and have the authority to manage and make decisions that affect the policy outcomes. Their actions and decisions tend to have the biggest effect on the policy outcomes (Kapti, 2009:4).

In order for the school managers and primary healthcare facility managers to meet the demands of the policy, the policy needs to have clearly designated roles for the school manager and the primary healthcare facility manager within the district of the Department of Health and the Department of Basic Education. This can only happen when the policy decision-makers in policy implementation consult with the school managers and primary healthcare facility managers and make sure that they understand not only the policy, but also their respective roles in the implementation of the policy (Mazibuko, 2007:2). The role of the school managers and primary healthcare facility managers is central to an understanding of the processes of policy implementation.

The proper implementation of the Integrated School Health Policy could have the potential to improve the quality of life of the learners. It could particularly look at the experiences encountered by the school managers and primary healthcare facility managers when implementing the Integrated School Health Policy. Again it could further investigate the nature of assistance rendered by the Department of Health and Department of Basic Education to school managers and primary healthcare facility managers during the implementation of the Integrated School Health Policy at school level.

The researcher is motivated to describe and explain the extent of the knowledge and awareness of school managers and primary healthcare facility managers of their roles in the implementation of the Integrated School Health Policy in Region C in the Gauteng Provincial Department of Basic Education. The researcher chose the research problem as a primary healthcare worker and interested in the way integrated school health is conceptualised in the Care and Support for Teaching and Learning programme (CSTL). Within the Care and Support for Teaching and Learning programme, integrated school health aims to realise the educational rights of all the learners, including those who are most vulnerable, through schools becoming the inclusive centres of learning, care and support. The Care and Support for Teaching and Learning programme also provides a

framework for dealing with all dimensions, including the health of all school learners which would enable them to enrol at, stay in, and complete their school careers successfully.

The researcher is motivated by the Draft National Strategy on Screening, Identification, Assessment and Support (SIAS), which provides guidelines on the assessment of the level and extent of support needed from the relevant stakeholders, for example the school managers and primary healthcare facility managers, to maximise the learners participation in the learning process (Department of Basic Education, 2014:34). Furthermore, the Draft Guidelines on Inclusive Learning Programmes, also provides guidance to educators, administrators and other personnel like the primary healthcare workers on how to deal with diversity in the classrooms and schools of our country.

These two policies mentioned in the previous paragraph are closely aligned to the Integrated School Health Policy to establish a seamless system of early identification and effective intervention to minimise learning breakdown and potential dropout. These policies also outline the role and functions of school structures responsible for the planning and provision of support to learners with barriers to learning (Department of Basic Education, 2001:17).

The researcher notes that many of the health problems that affect learners have their origin in social determinants of health and will not be solved through health-specific interventions alone. Integrated school health is deemed appropriate as it provides various levels and kinds of support to all learners because all the support services are integrated into current mainstream structures (Mahlo, 2011: 2). It responds to the learner challenges and focuses on overcoming barriers in the system that prevent it from meeting the full range of learning needs.

As pointed out earlier, the research is concerned about the implementation of the Integrated School Health Policy by the school managers and primary healthcare facility managers at primary schools of Region C in the Gauteng Province. The research intends to empower school managers in their leadership role in managing integrated school health services in their schools. To this end, recommendations on how to handle challenges related to integrated school health services will be provided.

1.3 PROBLEM STATEMENT AND RESEARCH QUESTIONS

The problem statement and research questions play an important role in guiding the research process. In the ensuing sections, the problem statement and secondary research questions are concisely outlined.

1.3.1 Problem statement

School health has received unprecedented attention in South Africa over the past few years. The health programmes in South African schools have struggled in the past due to factors such as poor management, inequitable resource distribution and an historical lack of collaboration between the Department of Health and the Department of Basic Education. Thus the school managers viewed the programme as services that belong to the Department of Health. On the other hand, the primary healthcare facility managers did not view it as a priority as it was not implemented at the primary healthcare facilities but seen as something that should be implemented at the schools (Mohlabi, Van Aswegen & Mokoena, 2010:253).

It is common practice that the School Health Support Team should liaise with a School-Based Support Team and coordinate all matters in schools including health matters that concern learners (Shung-King *et al.*, 2014:66). In fact, the leaders of both teams (the school managers and primary healthcare facility managers) do not liaise with each other regarding matters concerning the delivery of school health services. This is evidenced by lack of awareness and clear understanding of the policy by the school managers and primary healthcare facility managers (Ramma, 2010: 48; Shung-King *et al.*, 2014:66).

As a matter of fact, Region C in the Gauteng Provincial Department of Education is not an exception regarding these challenges. As a result of the absence of awareness and understanding of the Integrated School Health Policy, it is not yet known whether the school managers and primary healthcare facility managers are knowledgeable and aware of their roles in the implementation of the policy. Therefore, the main research question guiding this study is: ***To what extent do the school managers and primary healthcare facility managers possess knowledge and awareness of their roles in the***

implementation of the Integrated School Health Policy in Region C in the Gauteng Provincial Department of Basic Education?

1.3.2 Secondary research questions

Based on the main research question, the secondary research questions can be stated as follows:

- (a) To what extent do school managers and primary healthcare facility managers possess knowledge about the implementation of the Integrated School Health Policy?
- (b) What systems can the Department of Health and Basic Education put in place to assist in the implementation of the Integrated School Health Policy?
- (c) What are the roles of school managers and primary healthcare facility managers in relation to the delivery of integrated school health services?

1.4 RESEARCH AIM AND OBJECTIVES

The aim of this research is to describe and explain the extent to which school managers and primary healthcare facility managers possess knowledge and awareness of their roles in the implementation of the Integrated School Health Policy in Region C in the Gauteng Provincial Department of Basic Education.

The sub-objectives are as follows:

- (a) To describe the extent to which school managers and primary health care facility managers possess knowledge about the implementation of the Integrated School Health Policy.
- (b) To explain the systems that can be introduced to assist the school managers and primary healthcare facility managers in the implementation of the Integrated School Health Policy.
- (c) To describe and explain the roles played by the school managers and primary healthcare facility managers in relation to the delivery of integrated school health services.

1.5 CONCEPTUALISATION

The following section clarifies the terms of the main concepts so that they could be understood in the context of this study.

1.5.1 Integrated school health

Integrated school health means the combining or coordinating of separate elements so as to provide an harmonious, interrelated whole (World Health Organisation, 1996:6). It is an organised or structured policy so that constituent units function cooperatively. This service is located within the administrative and functional structures for comprehensive primary healthcare services using resources shared between its various components (Department of Health, 2012:3). The school health programme is a combination of services ensuring the physical, mental and social well-being of learners so as to maximise their learning capabilities (Department of Health, 2012:06). The school health policy primarily targets all children attending learning sites.

1.5.2 Learner

A learner is a person who attends an Early Child Development Centre, school or Adult Basic Education Training Centre (Department of Basic Education, 2011:46). The definition includes any person, whether a child or an adult, who receives education or must receive education in terms of the South African Schools Act.

1.5.3 Policy

A policy is a statement of intent or a course of action adopted and pursued by government, ruler, political party, etcetera (Cloete & Wissink, 2005:03). Dye (2011:1) describes policy as whatever the government chooses to do or not to do and why they do it. Policy can be explained as a principle of behaviour or a conduct thought to be desirable or necessary especially as formally expressed by a government or other authoritative body.

1.5.4 Policy implementation

Policy implementation is defined as the actions taken by the public organisations to ensure that policy decisions are put into effect (Lindquist, 2006:246). It is the art of turning

words into action that is turning policy decisions on paper into actual goods and services for the citizen (Dye, 2011:1). Policy implementation is the fourth phase of the policy cycle in which adopted policies are put into effect. It is the process of moving an idea from concept to reality. In other words, implementation refers to a building process rather than a design process (Stofile, 2008:36).

1.5.5 Primary healthcare facility manager

According to the South African Nursing Council (SANC), a nurse is a person registered under section 31(a) of the Nursing Act 33 of 2005. However, a professional nurse is a person who is qualified and competent to practise comprehensive nursing and who is capable of being responsible and accountable for her or his omissions or actions. It is a health worker who has been trained with the necessary skills to provide school health services. The term “primary healthcare facility manager” refers to a person who is a leader at the primary health care facility, engaged in the promotion and improvement of the health of the population he or she is serving.

1.5.6 School manager

A school manager is an educator employed and appointed as a manager of a school responsible for providing school leadership and management (Department of Basic Education, 2010:61). A school manager ensures that teaching in the school takes place as it should, according to the national curriculum, but who also understands his or her role as a leader whose responsibility it is to promote harmony, creativity and a sound work ethic within the school community.

According to the South African Schools Act 84 of 1996, the school manager is the head, educator or the principal who is placed in a position of authority in relation to the school community and has the mandated power to execute leadership (South Africa, 1996:2). The school manager is accountable to the staff, the school governing body and to the education department. The researcher uses the term “school manager” to refer to the person in the position of overall leadership within a school, as it is a familiar term used within the South African educational context.

1.6 DELINEATIONS AND LIMITATIONS

The research is confined to schools in Region C in the Gauteng Province which, according to Department of Basic Education, are called D12 schools and only those primary healthcare centres offering integrated school health within their catchment area. In essence, it is essential to gain a broadened understanding of whether those who are tasked with the implementation of the policy have an unambiguous knowledge and understanding of their roles, particularly the school managers and the primary healthcare facility managers.

This is based on the fact that if the implementers do not possess knowledge about the policy, its implementation and their roles in the implementation process, the policy is bound to fail. This study does not include the perception or views of the parents and learners regarding the efficacy of the policy under consideration. Despite the importance of these key stakeholders in the implementation of the policy, they could not be incorporated in the study because the primary aim of the study is to describe and explain the knowledge and roles of the policy implementers with a view of suggesting new ways of improving the policy implementation processes.

In addition, not all the respondents selected agreed to participate in the study. In fact, the study set out to include ten (10) participants, but only seven (7) participants agreed to be interviewed for the purposes of this research. This might have contributed to limiting the depth of the data that was collected.

1.7 DEMARCATION OF THE STUDY TERRAIN

As indicated above, the research focuses on the implementation of the Integrated School Health Policy in primary schools of Region C in the Gauteng Province. In fact, the research covers the different government departments which are jointly responsible for implementing the aforementioned policy. The departments concerned are the Department of Health and the Department of Basic Education. In this regard, the Gauteng Provincial Department of Health and the Gauteng Provincial Department of Basic Education were consulted pertaining to this research. The two provincial departments

mentioned above are the focal point of this study, because the school health services are a provincial responsibility of the departments in question.

Moreover, the school managers employed by the Gauteng Provincial Department of Basic Education to head the primary schools of Region C, were identified as participants since they are responsible for creating an environment within which the Integrated School Health Policy could be implemented successfully. On the other hand, the primary healthcare facility managers, who serve under the auspices of the Gauteng Provincial Department of Health, were identified as credible sources of information regarding the implementation of the policy concerned since they are responsible for the provision of healthcare services to the learners. Of importance is the fact that, this research covered a period of four years, thus from 2013 to 2016. This was done to ensure that the research process was manageable and less cumbersome.

1.8 SEQUENCE OF CHAPTERS

This research is outlined as follows:

Chapter 1: Introduction

This introductory chapter presents the background and rationale, the problem statement, secondary research questions and objectives of the study. In addition, the main concepts are defined and clarified in the context of the study. Delineations and limitations of the study are explained appropriately, followed by the short outline of the sequence of chapters.

Chapter 2: Literature review: school health policy

Chapter 2 presents the historical background of the implementation of integrated school health services from an international perspective. Lessons that can be drawn from the global arena are also stated and explained. Furthermore, the chapter describes the context in which school health services are being rendered in South Africa. In addition, the discussion revolves around the various factors that account for failures in the policy implementation process.

Chapter 3: Research methodology

Chapter 3 describes the methodology adopted for the study, as well as the research methods used in collecting and analysing data. In this chapter, the target population is clearly identified and sampled according to the chosen methodology. Moreover, the issues relating to ethical compliance and trustworthiness of the data are also dealt with in this chapter.

Chapter 4: Findings and discussion

Chapter 4 presents the general findings and discussion relating to the extent to which the school managers and primary healthcare facility managers possess knowledge and awareness of their roles in the implementation of the Integrated School Health Policy in Region C in the Gauteng Provincial Department of Education. This chapter presents an elaborate discussion of the findings which are complemented by verbatim quotes from the participants.

Chapter 5: Findings, conclusion and recommendations

Finally, chapter 5 presents the summary of findings followed by recommendations and conclusions. This chapter also suggests recommendations for further implementation based on the results obtained from the study.

1.9 SUMMARY

This chapter has presented the background and rationale, problem statement and research questions. In addition, it has provided conceptualisation, delineations and limitations, and also outlined the sequence of chapters. The following chapter presents a literature review on the implementation of school health services internationally and locally.

CHAPTER 2

LITERATURE REVIEW: INTEGRATED SCHOOL HEALTH POLICY

2.1 INTRODUCTION

This chapter presents a broad perspective on the context of the study. The chapter outlines comprehensive school health as it was called when it was first introduced globally in the 1980s. This chapter also presents a theoretical outline of the fundamental elements in comprehensive school health system internationally and reviews literature pertinent to the implementation of a comprehensive school health policy. The overview of integrated school health in South Africa is provided in order to base the rationale for the implementation of the Integrated School Health Policy. The approaches that served to guide the implementation process are also outlined. The beneficiaries of integrated school health are identified. The successes and failures in respect of the implementation of the Integrated School Health Policy are analysed. Monitoring and evaluation as critical aspects in the implementation of the Integrated School Health Policy concludes this chapter.

2.2 INTERNATIONAL PERSPECTIVES ON THE INTEGRATED SCHOOL HEALTH POLICY

This chapter focuses mainly on when the comprehensive school health was introduced in each country stated in this research; how it is conceptualised and the implementation approaches used in these countries. The section analyses the comprehensive school health practices in seven countries. These include the developing and developed countries, namely the United States of America, India, Nigeria, Brazil, Tanzania and China. The reasons for selecting these countries is to understand factors that impinge on the comprehensive implementation of the Integrated School Health Policy in other countries that are characterised by underdevelopment, as well as the countries that are economically well off.

2.2.1 The United States of America

The concept of a Comprehensive School Health Programme (CSHP) was proposed in the 1980s by the Centre for Disease Control (CDC) intending to take advantage of the pivotal position of schools in reaching learners and families (Bundy, 2011:1). The concept relied mainly on a “school-based” approach, meaning that it is in the school environment that a whole range of selected activities come together to form an integrated whole. There is linking of health and education with the school planning process so that it becomes a built-in priority for the school managers rather than being perceived as an add-on programme.

Bundy (2011:6) states that health and education are interdependent, therefore healthy students are better learners and better-educated learners are healthier. Bundy (2011:15) argues that in the absence of a school health nurse the school health services are often supervised by education-based administrators who have no clinical preparation in the delivery of health services. Thus, it is important to develop closer links between the school health nurse and the educator to encourage greater involvement of both professionals in the planning and implementation of basic school health services because school health nurses are the backbone of the programme.

The link between the learners health and nutrition status on the one hand and educational outcomes on the other was clear and presented at the first World Conference on Education for All. The information presented at the first World Conference demonstrated that poor health and malnutrition lead to low school enrolment, high absenteeism, poor classroom performance and educational wastage. Hence the Framework for Action resulted in Focusing Resources on Effective School Health (FRESH). In 2000 at the World Education Forum, the World Bank, World Health Organisation, United Nations Educational, Scientific and Cultural Organisation (UNESCO), United Nations Children’s Fund (UNICEF), and Education International signal the commitment to assist national governments to implement school-based health programmes in efficient, realistic and results-oriented ways (Strickland, 2011:6).

The Focusing Resources on Effective School Health (FRESH) framework was incorporated as a generic framework for monitoring and evaluation of school health interventions (Strickland, 2011:16). Furthermore, the Focusing Resources on Effective School Health (FRESH) framework is based on agreement among the collaborating agencies that there is a core group of cost effective activities which, implemented together, provide a sound basis and point of departure for further action to make schools healthier for learners, learners more able to learn, and Education for All (EFA) more likely to be achieved (Bundy, 2011:7).

The Focusing Resources on Effective School Health (FRESH) Framework clearly states that the success of school health programmes requires an effective partnership between the ministries of education and health and between the educators and health workers. Furthermore, the success of school-based health education programmes depends in large on educators, because educators are not only implementers under the Focusing Resources on Effective School Health (FRESH) Framework, but they are also expected beneficiaries. Therefore their morale and professionalism is particularly critical to their role in carrying out activities under the Focusing Resources on Effective School Health (FRESH) Framework.

2.2.2 India

The Government of India launched the National Rural Health Mission in 2005 to focus on bottom-up planning and flexible funding to deal with the local needs (Prasad, Bhatia & Agrawal, 2013:1). The school health programme is the only public sector programme specifically focused on children of school going age. The National Rural Health Mission (NRHM) offers a fresh opportunity to strengthen the school health programme in order to deal with the needs of the children of school going age. The mandate of the National Rural Health Mission is that a close collaboration with education sector is essential at all levels while increasing the coverage of the school health programme (Prasad *et al.*, 2013:1).

There is decentralised framework of implementation of the school health programme that enables various states to devise and implement their version of the school health

programme. Developed on the premise that comprehensive school health programmes resulted in weak and fragmented implementation of its components, which in turn led to a lack of holistic approach (Nazar, 2011:10). Therefore, each state implements its school health programme; the programme at the national level is developed to provide uniformity or guidance to states that are already implementing or plan to implement their own versions of programme.

Therefore, one of the innovations of the school health programme in India is the running of school based out-patient clinics set up in schools. Apart from the educators screening the learners, area multi-purpose workers visit one school every week on an average for detailed screening and treatment of minor ailments and required referral. In addition, a medical officer also visits one school per week for additional screening, treatment and referral. Another model which is relatively unique is an educator-driven service operating in the state of Chandigarh in India, where educators are trained in basic healthcare interventions and are provided with a school kit, including a manual and first aid supplies.

2.2.3 Brazil

Brazil is acknowledged as being one of the best “performers” amongst health systems (Kolbe, Kann, Collins, Small, Pateman, & Warren, 2010:341).The school health component of health promotion in Brazil is considered in the context of both educational and the health systems, and in accordance with legislation established by the 1988 National Constitution. The Brazilians use the integrated school health and nutrition programme, hence South Africa adopted the integrated school health programme from them. The Brazilians believe school health services are essential to the success of their system, in fact, building citizenship is increasingly understood as the backbone of school education.

In 2008, the Brazil Department of Education launched the Fit for School Programme which started as a local community programme in one of the provinces of Mindanao and was scaled up to become a National flagship programme (Benzian, Monse, Belizario, Schratz, Sahim, Van Palenstein & Helderman, 2012:151). School managers are primarily

concerned with academic achievement of the learners by emphasising the significant role of health in the learner's learning.

The rationale is simple, scalable and sustainable as the simple interventions in school health are based on the best possible evidence as they are cost-effective, more likely to achieve high impact. A set of simple enabling principles is helping to bridge the gap between well-intended policy and real life implementation in a practical way. The scalable Fit for School approach shows that large scale implementation is possible if intervention follows a modular structure and is based on uniform templates (Benzian *et al.*, 2012:151). Using existing structure and resources is an essential part of scalability such as relying on a few simple interventions implemented by educators and healthcare workers. The sustainability of any programme in the long term is the one which is not donor dependent and actively involve the communities and parents in the programme through a participative monitoring and evaluation process.

The academic performance of a learner directly correlates with his or her health and nutritional status (Jamorabo-Ruiz, Amparo & Guiking, 2013:638). Another justification for the Department of Education to assume responsibility of health and nutrition in school is because it would enable better coordination among various players involved, like school health personnel, principals, educators, and parents. And more importantly, the Department of Education receives the biggest budget allocation from the National government, thus giving it more accountability to provide the basic services for all the learners.

2.2.4 Nigeria

The Federal Ministry of Health (FMOH) in Nigeria is the apex body responsible for the health of the citizenry. In 2001, the Federal Ministry of Health and the Federal Ministry of Education in collaboration with the World Health Organisation took the initial step by conducting a Rapid Assessment and Action Planning Process (RAAP) of the School Health System in Nigeria to ascertain the status of school health (Whitman & Aldinger, 2009:68). The assessment noted several health problems among learners, the lack of health and sanitation facilities in schools, and the need for urgent action in school health.

Through the Rapid Assessment and Action Planning Process, Nigeria identified significant gaps in federal-level management, policy, and the capacity to provide school health programmes (Whitman & Aldinger, 2009:68).

The Rapid Assessment and Action Planning Process also identified the need for a section on school health to be part of the school policy; it also set the foundation and sowed the seed for the introduction of the school health initiative in Nigeria. The National School Health Policy was then introduced in 2006 to improve the state of school health services in the country (Federal Ministry of Education Nigeria, 2006:8). Prior to the formulation of the National School Health Policy in 2006, a School Health Programme in Nigeria had been grossly neglected. The major weakness of school health programmes in Nigeria is the dearth of school health in the last three decades, due to political instability and economic depression (Toma, Oyeboade, Toma & Agaba, 2014:86). Government involvement in the implementation of a school health programme ranged from minimal involvement to no involvement at all.

Many of the school managers and educators had never heard of the 2006 National School Health Policy and government involvement in the implementation of school health programmes ranged from minimal involvement to no involvement at all. (Federal Ministry of Education Nigeria, 2006:8). The majority of the school managers indicated a lack of awareness of the National School Health Policy, and the school health programme is being implemented in the schools based on the in-school and on-the-job-training of the educators (Ademokun, Osungbade & Obembe, 2014:1085). Most of the school managers attested to it that community members are not in any way involved in the promotion of the school health programme because of the general belief that the schools are government owned. School managers also stated that no mobilisation had been instituted because of inability to foretell governmental predispositions towards the mobilisation. The lack of a cordial relationship between the community members and the school could be attributed to the poor awareness of the 2006 National School Health Policy, which actually favours and promotes community mobilisation in its policy (Ademokun *et al.*, 2014:1085).

2.2.5 Tanzania

The World Health Organisation believes that there are millions of learners plagued by health threats who drop out of school early or do not attend at all. School health services in Tanzania date back to 1921, while the year 1967 marks the start of the independent Tanzania's Primary Health Care Strategy, based on the World Health Organisation's definition of health, including learner's health. Tanzania's current health system includes school-based health promotion as a part of a decentralised system. The guidelines for implementing the National School Health Programme include an organisational chart at village level. In their study Borge, Manongi, Masatu and Klepp (2008:85) report a wide gap between the official school health guidelines in Tanzania and the current practice toward learners. The burden of poverty, as clearly stated by the respondents and observed by the investigators, obviously influences the quality of school health services.

However, the interpretations and experience of the healthcare workers of the current school health programme and working instructions indicate a need for clarification of the official guidelines. Furthermore, healthcare workers clearly need to be offered courses in health promotion linked to school health activities as part of their continuing education. The healthcare workers are professionally educated resource persons, and their role in school health services should be expected and encouraged to be far more active than this study indicates their current practices to be. To successfully establish an integrated school health service, the working relationship between schools, health centres, and the community, including parents and the traditional health sector clearly needs improvement (Borge *et al.*, 2008:84).

2.2.6 China

In 1995, the National Conference on School Health was held in Beijing. The conference focused on strengthening and enlarging China's efforts in promoting school health and explored the feasibility of developing health-promoting schools in China. In their study Xin-Wei, Li-Qun, Xue-Hai, Jun-Xiang, Xue-Dong, Aldinger, Sen-Hai and Jones (2008:220) examined the success of health promoting schools that depended heavily on the training of educators. However the study showed that educators thought mainly about

school health in terms of curriculum. Lee (2010:17) revealed that nurses as health leaders adopted a leadership role and their working relationships with others influenced how this role was executed.

2.3 LESSONS FROM THE GLOBAL AREAS

Taking cognisance of their Constitution, South Africans should be open to learn from the experiences and strategies of others, especially issues in the following countries.

2.3.1 United States of America

It is important that South Africa adopts a principle of integrated learning that is, moving from practices that rely mainly on classroom-based health education models to a more comprehensive, integrated construct of school health that focuses both on learner's health, attitudes and behaviours and their environment (Bundy, 2011:6). This is done through nurses being part of the school system as the backbone of the school health. Through this approach closer links to encourage greater implementation of school health are created.

In South Africa, the minimum criteria for policy implementation differ according to phases, which means that the healthcare workers perform Grade R and Grade 1 health assessments, have access to referral facilities to manage identified problems and perform health promotion activities with Grade R and Grade 1 learners at least once a year. Lastly, a school health team has a learner ratio of 1:5 000 (for health assessments) and 1:20 000 for twelve health promotion activities and a minimum number of one school visit per year is recommended (Department of Health, 2003:5). South Africa may learn that there is a need for a clear distribution of responsibilities between the school managers and primary healthcare facility managers, for example the problem of overloading the school manager with additional responsibility, entrusting them with too many school health related matters. Thus, the school managers must not be overloaded and diverting their energies and time from their task of teaching. Some tasks also require specific qualifications and are better performed by experts in their own field like the primary healthcare facility manager.

The Focusing Resources on Effective School Health (FRESH) framework utilised in United States of America, is an intersectoral partnership and was launched at the World Education Forum in Dakar in 2000. It highlights the importance of school health for the achievement of the education Millennium Development Goals and provides the context for developing effective school health programmes (United Nations Educational, Scientific and Cultural Organisation, 2013:7). The main purpose of the core indicators of the Focusing Resources on Effective School Health (FRESH) for example is to assess and monitor national and local level progress in implementing a comprehensive school health programme, the extent to which schools have a safe school environment and the proportion of schools that implement regular skills-based health education.

The Focusing Resources on Effective School Health (FRESH) Model assesses the school's ability to meet national standards. That depends on a number of factors, like school leadership's (school managers) awareness of the standards and their commitment and capacity to implement the standards. South Africa may learn by creating and maintaining strong partnerships between government's donor agencies, schools and communities which have proven to be vital to a successful implementation of school health. Partnerships have generally proven most effective when established in the early planning stages of activities, allowing widespread buy-in and participation by all stakeholders in the planning and implementation processes.

South African may learn from this model to be used for monitoring and evaluation since the Integrated School Health Policy is not yet monitored. Again, the South African government needs greater coordination in donors, clear feedback and support from the international level. There is a strong recognition of the importance of involving communities and parents to increase their understanding of what is at stake in school health and to mobilise their support. This is difficult since it implies working with each village but ensures sustainability of the programme.

2.3.2 India

The Indian experience shows that the National Rural Health Mission was tailored to focus on the bottom–planning and flexible funding to deal with the local needs. Therefore, the

South African Government can learn from the Indians because they have a decentralised framework of school health (Nazar, 2011:10). Each state implements its school health programme, the programme at the national level is developed to provide uniformity or guidance to states that are already implementing or plan to implement their own versions of the school health programme. Unlike in South Africa there is a centralised framework of policy implementation. Every province implements the school health programme based on the national policy, but according to the needs. Provinces don't plan or implement their own version of the programme, the provincial coordinators wait for the mandate from national level for them to implement the policy.

According to Bundy (2011:160), analysis of an attempted expansion of a school health nurse programme in KwaZulu-Natal in South Africa showed that despite a relatively high investment (a cost per target learner of R11,50), coverage was inadequate and almost no cases of detected ill-health resulted in effective referral and treatment. Furthermore, the South African school health nurse only comes once a year if there is an immunisation campaign, for example for the Human Papilloma Virus Vaccine campaign to vaccinate the learners (Mohlaba *et al.*, 2010:253), whereas in India there is a healthcare provider who visits the schools once a week. The South African government could learn from the Indian government of another model which is relatively unique. It is an educator-driven service operating; these trained educators assist learners with basic health problems and refer them to health facilities as required (Shung-King *et al.*, 2014:65).

2.3.3 Brazil

The Brazilians uses the Fit for School approach. The rationale is simple, scalable and sustainable. The simple rationale is that the interventions in school health must be based on best possible evidence, should be cost-effective and are more likely to achieve high impact if the focus is on only a few key diseases and the interventions are packaged to make implementation as easy as possible. Scalable rationale is that the Fit for School approach shows that large-scale implementation is possible if interventions follow a modular structure and are based on uniform templates. Using existing structures and resources is an essential part of scalability, such as relying on a few simple interventions

implemented by teachers, rather than health professionals. The sustainable rationale is that any programme will only be successful in the long run if it is not donor-dependent.

The Fit for School approach is based on the principle of sustained government funding after an initial start-up phase. It also actively involves communities and parents in the programme through a participative monitoring and evaluation process or through the construction of required group washing facilities (Benzian *et al.*, 2012:2). South Africa can learn from this strategy, because the Fit for School approach raises issues of funding which is mobilised by governments and partners. Furthermore, the policy implementers get cooperation and support within its communities and parents.

From the previous experiences, the South African government deemed it fit that the delivery of school health and nutrition services should be a function of the Department of Basic Education and not the Department of Health. Thus, the responsibility is lodged in Department of Basic Education (Jamorabo-Ruiz *et al.*, 2013: 638). The South African government needs to learn from Brazilians as school health occurs at school and not at the primary healthcare facilities. This is understandable since the implementation of the school health and nutrition needs the full support from school managers and that managers are accountable for the safety within the school. Significantly, the lack of primary healthcare workers is considered to be a very serious problem for the school managers, but less serious for the primary healthcare facility manager. As observed by the researcher this is really a very serious problem since there was no primary healthcare worker available in the school and health section (Jamorabo-Ruiz *et al.*, 2013:638).The country provides an excellent example of comprehensive school health and school health services integrated into the curricula and programmes in all elementary and secondary schools throughout the country. South Africa can learn that there is a need to deal with school health programmes with simple low-cost planning through the Fit for School approach.

2.3.4 Nigeria

There is a true reflection that there is a dearth of school health in the last three decades (Toma *et al.*, 2014:86). The deterioration was mainly due to the economic depression and

political instability during the period. All efforts at dealing with the issue of a school health programme in Nigeria have remained largely at policy level, with minimal implementation. Ademokun *et al.* (2014:1078) report that there is no grant set aside by the government for the implementation of the promoting of school health. Furthermore, the fact is widely accepted that funding from the government that is explicitly targeted at the implementation of a school health programme existed in the past. Where any in implementation has been attempted, the emphasis has been outside, rather than within the schools.

Factors such as a lack of understanding policy implementation worked against the effective implementation of a school health programme. In Nigeria many authors have observed that generally, the School Health Programme is a neglected aspect of the health and education sectors of the country. From the review of the programme in Nigeria, it appears that the programme was functional at the onset but then started to decline in the late seventies. This may be due to the economic downturn and political instability in the country in the last three decades. There is paucity of data on the evaluation of school health services in Nigeria, especially in the North (Toma *et al.*, 2014:87).

A lack of awareness and understanding of policy implementation is the major challenge. South Africa can learn that policy decision-makers need to bear in mind that the pace and complexity at which change is introduced can at times be overwhelming. Another major challenge would be to make the links between theory and practice. If the policy proposes how the implementation should be set out and conducted, it also informs the managers as to what is expected. The data collected in Nigeria has shown that policy implementers (school managers and primary healthcare facility managers) do not have a common understanding of the implementation of the policy, therefore they need to find ways to ensure the management skills and so to make sure that they collaborate effectively (Oyinlade, Ogunkunle & Olanrewaju, 2014:340).

In turn the lack of understanding is influenced by the way the school managers and primary healthcare facility managers interpret what the policy requires. Managers need not only to understand a concept, but should also be thinking about it, as this could be a useful method of highlighting their beliefs or attitudes towards the policy. The primary

healthcare facility managers in Nigeria viewed the policy as a government document and it is noted that they never understood the concept and it influenced the decisions made. The school managers also reported the absence of a relationship between the school and the community, as the community members see the schools as government property rather than theirs (Ademokun *et al.*, 2014:1081).

Furthermore, the school managers have not tried to involve the community members because the government does not approve and they assume that community members do not have any roles to play in the implementation. This is one of the examples that South Africa can learn from because the relationship between the school and the community in which the school is situated is important for buy-in and support. That is why the Human Papilloma Virus Vaccine campaign in South Africa had its obstacles due to the lack of support from the community.

2.3.5 Tanzania

Poverty is a key consideration in the design of school health and nutrition programmes (Kwesigabo, Mwangi, Kakoko, Warriner, Mkony, Killewo, Macfarlane, Kaaya & Freeman, 2012:2). Learners who are enrolled at a school and are targeted by school health and school feeding programmes, generally come from households with lower income levels. The researcher has learned that there is a wide gap between the official school health guidelines in Tanzania and the current practice directed at school learners. South Africa should recognise the importance of this wide gap, as the country also has a wide gap in understanding between the district level staff and the school level staff which is affecting the implementation of the Integrated School Health Policy (Restless Development South Africa, 2013:17). The burden of poverty influences the quality of school health services and a lack of clarification of official guidelines is noted (Borge *et al.*, 2008:84). To successfully establish an integrated school health service, the working relationship between schools, primary healthcare facilities, and the community, including parents and the traditional health sector, clearly needs improvement.

2.3.6 China

In China the success of the promoting of school health depends on teacher's training. They think mainly about school health in terms of curriculum. The key determinant of the successful and efficient implementation of health and education programmes is the ability of the educators to understand the basic concepts and communicate their meaning to others. The focus is based on the interaction of the formal and informal school curriculum. The educators however have little understanding of how community partnerships work and have little pre-service and in-service training (Xin-Wei *et al.*, 2008:220).

The school management team relies on the school nurse's expertise to develop a protocol and respond to the need for appropriate management of learner health conditions by implementing school health services (Lee, 2010:17). School health nurses work with a high degree of autonomy and professional accountability and have the ability to provide specialist knowledge and advice. The South African government can learn from the Chinese government on how the school management use the school nurses to be part of the curriculum.

2.4 HISTORICAL BACKGROUND OF THE SCHOOL HEALTH POLICY IN SOUTH AFRICA

It is important to have a picture of the overall integrated school health service context in South Africa. Since the election of the first democratic government in 1994, several important changes have taken place within the health and education system of South Africa. One of the changes is that South Africa pledges to put children first, thereby giving their needs the highest priority (Department of Health, 2012:5). Until 1994, school health services were organised and structured as part of the overall health system. The National School Health Policy 2003 was formulated in South Africa and the need for support and the documenting of good practices in the development of school health became a priority.

Then the failure of the policy compelled the South African government (Department of Health and the Department of Basic Education) to introduce the Integrated School Health Policy as the first step in dealing with the health needs of learners, with the aim of ensuring

that a strong school health service operates according to clear standards across the country (Department of Health, 2012:1). Hence, the launch of the Integrated School Health Programme, took place under the theme: “Taking responsibility for our learners health and well-being” effectively means that barriers to successful learning will be a thing of the past. Comprehensive school health services with regard to this research indicate coordination by using the skills and capacity of the school managers and primary healthcare facility managers. The vision is intended to move from a centralised decision-making system (top-down) to one that adheres to the principles of a primary level approach (bottom-up) and is managed and organised within the service provision level.

2.5 IMPLEMENTATION LEVELS OF THE INTEGRATED SCHOOL HEALTH POLICY

In the following the various levels at which the Integrated School Health Policy can be implemented are identified and discussed extensively.

2.5.1 The national level

The national level is responsible for formulating policy and providing guidelines on how the provinces should implement the policy. According to Nederveen (2010:17) the development of school health policies at the national level, requires a framework of responsibilities, and action that is agreed upon by the key government departments (such as the health and education department) to provide input and take responsibility for school health programming. Nederveen (2010:17) argues that the school health policy should be clearly defined and inscribed in a common statement that indicates who would be responsible for the interventions planned and who would be implementing those interventions. This implies that the roles and responsibilities of the people implementing the policy should be clearly stated in the policy. Therefore, for the purpose of this research, strong intersectoral cooperation is required to plan, implement and monitor a sustainable school health programme.

The National Department of Health and the Department of Basic Education oversee nine provincial departments and the decisions that are made at this level may have an impact on or can be influenced by the school managers and primary healthcare facility managers.

This implies that decisions flow from decision-makers at the top to grassroots implementers at the bottom. The proper inter-sectoral coordination between the Department of Health and the Department of Basic Education is fundamental to the efficient functioning of the school health services. Nederveen's (2010:17) opinion is that the school health policy should be clearly defined and inscribed in a common statement that indicates who would be responsible for the interventions planned and who would be implementing those interventions. The cooperation and communication strategy between the implementers (school managers and primary healthcare facility managers) should be written down in a memorandum of understanding between the Department of Health and the Department of Basic Education during policy formulation.

2.5.2 Provincial level

The provinces implement policy according to their provincial needs, as accepted by the National Department of Health and the Department of Basic Education. The provincial task team develop implementation plans for school health programme taking into account the need to cover all school and all learners as outlined in the school health policy. The provincial task team also integrates health services within the primary healthcare approach. The provincial level is the coordination level, but still excludes the primary healthcare facility manager and school manager because decisions made at this level may influence or be influenced by what happens in this setting.

The way in which particular provinces provide support depends on identified local needs and available resources. In each of the nine provinces the policy on integrated school health is being implemented differently, according to provincial needs. Each provincial Department of Health has dedicated coordinators for school health and there is an equivalent person in the Department of Basic Education, but in a number of provinces this person has multiple responsibilities beyond health (Shung-King *et al.*, 2014:66). For the purpose of this research the school manager and primary healthcare facility manager should have clarification of roles and responsibilities so that the various provinces employ different strategies in making sure that the vision of the policy is realised.

2.5.3 District level

The district implements the policy according to their needs and is the channel through which support services should be provided. There is District-Based Support Team which develop implementation plans that fit into the district's integrated development plan, with clear objectives and indicators. Many (but not yet all) districts in both health and education have districts coordinators in each department, although the district coordinators of the Department of Basic Education are not exclusively allocated to school health (Shung-King *et al.*,2014:68). The researcher argues that the district system needs to be organised so that it can provide various levels and kinds of support to the school managers and primary healthcare facility managers. Furthermore, how will the district provide support when the coordinators are not exclusively allocated to school health?

Shung-King (2009:56; 2013:896) maintains that school health in South Arica is regarded as the “stepchild of primary healthcare” because of a lack of a formal structured relationship between the school managers and primary healthcare facility managers. Furthermore, Shung-King *et al.* (2014:66) state that poorly structured relationships among key policy actors (school manager and primary healthcare facility manager) and absent policy translation processes result in insufficient understanding and prioritisation of school health by school managers and primary healthcare facility managers. Despite the Department of Education having had some representation on the national policy task team, as well as in provincial and national workshops during which the policy content and direction was debated, no formal agreement or structured relationship was reached between the two departments at national, or provincial level. This situation is duplicated at district level, where good and effective relationships between primary healthcare facilities and schools depend mainly on the commitment and enthusiasm of school managers.

2.5.4 Service provision level (school and primary healthcare management level)

According to the South African Schools Act 84 of 1996, the school manager is the head teacher or principal who is placed in a position of authority in relation to the school community and has the mandated power to execute leadership (South Africa,

1996:1). Implementation of the Integrated School Health Policy at school level is the responsibility of the School-Based Support Team under the guidance of the school manager. At the primary healthcare level, the School Health Team is managed by the primary healthcare facility manager.

The school managers and primary healthcare facility managers are pivotal persons at the service level who have authority for programme administration, implementation, evaluation, and accountability. De Klerk (2013:79) notes that the school has a caring approach towards its learners' health, therefore school managers act as facilitators by referring learners to health facilities. Both the school manager and the primary healthcare facility manager might experience an increasing workload, leading to possible resistance. Therefore a close collaboration between the educators and healthcare professionals is essential to maintain a positive and open relationship (Mohlabi *et al.*, 2010:6; De Klerk, 2013:79).

According to Brynard (2007:37) policy may be good but if the implementers are unwilling to carry it out or lack the skills, implementation will not occur. However, the school managers cannot be able to provide such support if he or she does not have the necessary information and knowledge of the Integrated School Health Policy. Thus, Mazibuko (2007:90) is of the opinion that school managers also require and deserve all the help available to turn the avalanche of reforms into workable practices. The policy requires of the school managers to ensure that all components of the Integrated School Health Policy package are to be provided to all learners, according to the Department of Health and the Department of Basic Education, but it is not clear whether school managers fully understand what is required (Mohlabi *et al.*, 2010:253).

Policies that are merely imposed from the top-down are likely to be resisted by implementers. In this research implementers are the school managers and primary healthcare facility managers who always find themselves at the receiving end of policy implementation. Wedell (2009:39) argues that without a proper prior understanding of the planned changes, school managers and primary healthcare facility managers will find it difficult to know how to install them in the specific context of their schools. For a policy like the Integrated School Health Policy to be successful, the commitment from its

implementers is essential. Appropriate understanding of the policy concerned is required. More importantly, it seems that the success or failure of policy implementation depends on the meaning that school managers and primary healthcare facility managers attach to it, and a resultant understanding of the leadership role that they need to play in the transformational process (Johannes, 2009:2).

2.6 LEGISLATIVE FRAMEWORK ON THE INTEGRATED SCHOOL HEALTH POLICY

The National Department of Health has been involved in formulating policies for school health within the public service. Hence, it formulated the Integrated School Health Policy to realise the educational and health rights of all learners, through schools becoming the inclusive centres for learning, care and support. The Integrated School Health Policy is supported by “top-down” legislation that coordinates and integrates school health at a national level, thus strengthening the existing integrated school health services through the following legislative framework.

2.6.1 The Constitution of South Africa, 1996

According to Section 28(1)(c) of the Constitution 1996, every child has the right to basic healthcare, Section 29(1)(a), further states that every child has the right to basic education, provided through reasonable measures and made progressively available and accessible. The Constitution also mandates a healthy environment for all citizens including the learner. Section 9(3) and 9(4) of the Constitution 1996; stipulate that “no person (including learners) may be directly or indirectly discriminated against on the basis of race, gender, colour, ethnic or social origin.” The Integrated School Health Policy is thus an approach which outlines the role of Department Health and Department of Basic Education in addressing the health and education needs of the learners.

The approach aims to ensure that learners’ rights are upheld, and that the provision is made to enable all learners to reach their full potential. Furthermore, the Constitution (Section 9(2)) emphasises equality that includes equal enjoyment of all rights and freedom. The equity in this respect indicates that all learners must be fairly and equally

treated. All learners must be given the same opportunity to access learning content and assessment through integrated school health services.

2.6.2 The Children's Act 38 of 2005

The Department of Health and the Department of Basic Education has shown commitment towards improving the welfare of its children by taking a pledge of putting children's rights first when signing the Convention on the Rights of the Child with the United Nations in 1989. Section 6(2) (d) of the Children's Act (38 of 2005), state that all proceedings, actions or decisions in a matter concerning the child must protect the child from unfair discrimination on any grounds, including the grounds of health status. Section 6(2) (f) further recognises and creates an enabling environment to respond to the special needs that the child has.

The Children's Act gives an indication that the welfare of children is considered a priority and this includes the establishment of the Integrated School Health Policy to deal with the health needs of school-going children. Section 13(1) state that every child has the right to have access to information on health promotion and the prevention and treatment of disease.

2.6.3 South African Schools Act 84 of 1996

The South African Schools Act covers issues of attendance, thus identifying learner at risk (Section 3(1)). The South African Schools Act further state that if the learner fails to attend the school the Head of the Department (school manager) may investigate the circumstances of the learner's absence from school and take appropriate measures to remedy the situation (Section 5 (a)(b)). In this regard the school manager may refer the learner to the primary healthcare facility manager for further intervention in the learner's health needs that are maybe the cause of absenteeism.

The South African Schools Act has the effect that the Integrated School Health Policy helps to increase school attendance and academic performance and decreases school drop-out rates by handling the health needs of the learners. According to South African Schools Act Section 16 A (2) (a) (vi) the principal, who is the school manager, must in

undertaking the professional management of a public school, carry duties such as the implementation of policy and legislation. The implementation of policy includes among others, the implementation of the Integrated School Health Policy. The South African Schools Act completely opposes unfair discrimination at schools and all learners experiencing health barriers to learning must be admitted. In terms of curbing the discrimination against learners with health barriers primary healthcare facility managers are encouraged to make their facilities accessible and the school manager must make the necessary arrangements to provide the learners with the environment which is supportive (South African, 1996: s 5(1)).

2.6.4 The Mental Health Care Act 17 of 2002

Mental health is a fundamental component of health and the Mental Health Care Act (17 of 2002) recognises that mental health services should be provided as part of primary healthcare services. Thus, the Integrated School Health Policy includes mental health assessment in identifying and responding to internal injuries and child abuse at primary level which is at schools (Department of Health, 2012:18). It is surprising to note that the mental services are considered “additional services that are added” in spite of the fact that they have been noted as health issues that are on the rise among learners of five (5) to fourteen (14) years in South Africa (Department of Health, 2003:14).

Strickland (2011:1) and Bundy (2011:29) note that the benefits that come from integrated school health interventions provide necessary building blocks for educational attainment, from improving cognitive capacity and cumulative memory of learners necessary for learning to read and attendance at school. The Mental Health Care Act (17 of 2002) further recognises that there is a need to promote the provision of healthcare services in a manner which promotes the maximum mental well-being. Mental illness have an effect on school enrolment, hence mental health assessment ensures that learners are ready to learn and enrol on time, thereby reducing drop-out rates, keeping learners in school by enhancing attendance, improving learning at school and by enhancing cognition and educational achievement (Bundy, 2011:35).

2.6.5 The National Health Act 61 of 2003

Health is one of the most important drivers of the development of an individual. In terms of section 2 (c) (i) of the National Health Act (61 of 2003), everyone has a right of access to primary healthcare services, and it is the responsibility of the state to ensure that this right is realised. The key principles underpinning the Integrated School Health Policy are that it should be established within the framework of health promoting schools, uphold primary healthcare principles, and that school health services should be an integrated and not a vertical service (Department of Health, 2012:3).

Furthermore, the Integrated School Health Policy ensures that all the learners have access to primary healthcare services and are able to exercise the right to go to school and stay in school long enough without experiencing health barriers to learning. Preventive services include main health assessments of all grades R and Grade 1 learners, and constitute the core of the services that are provided at phase one of policy implementation (Department of Health, 2003:14).

2.7 PREREQUISITES FOR POLICY IMPLEMENTATION

The successful implementation of the Integrated School Health Policy depends on a number of critical factors also known as prerequisites for policy implementation. Each of these factors are linked to, and influenced by, the others, depending to a varying extent on the specific implementation situation. Policy implementation is when the implementers enter the effective phase of a policy; therefore failure to implement policies often lies in the policy's content, context, commitment and coalitions of clients.

2.7.1 Policy content

The content of the policy is regarded as a crucial factor in establishing the parameters and directives for implementation, although it does not determine the exact course of implementation. The content of the policy is important not only in the means it employs to achieve its ends, but also in its determination of the ends themselves and in how it chooses the specific means to reach those ends. This elaborates the understanding that the content of the policy includes what it sets out to do (objectives), how it relates to the

problem to be solved (causal theory) and how it aims to solve the problem (methods). If the school managers and primary healthcare facility managers possess an awareness of resources available to create a comprehensive programme they become effective programme managers.

The school managers and primary healthcare facility managers as the implementers who participate in a programme at the school level could interpret the policy content in relation to their own understanding, desires, values and purposes, and in relation to the means available to them and the ways of working they prefer. In short the school managers and primary healthcare facility managers may ask the following questions: are the objectives clear and consistent; realistic; accurate and have the participants reached the consensus on the meaning of the policy? Mediating the choice of ends and means is the content of the policy (Stofile, 2008:82).

2.7.2 Policy commitment

Commitment is important not only at the implementation level (school level) but at all levels through which the policy passes. In essence, commitment refers to an ability to maintain. The focus is on an initiative from its inception through to its delivery (Brynard, 2009:561). Commitment means pledging oneself to a certain purpose or line of action (Stofile, 2008:83) therefore, the success of policy implementation at school level depends heavily on the commitment of the school managers and the primary healthcare facility managers must ensure that relevant services are provided for all the learners at the school and that the policy is properly implemented (hence a call for a sound knowledge of the policy). Stofile (2008:83) notes that a policy may be good, but if the implementers are not committed to or unwilling to carry it out, implementation would not occur.

It is important to mention that commitment to the policy should be ensured through a consultative process as well as ensuring that employee motivation has been dealt with through recognition and reward. The benefits to the broader department by virtue of the provision of valuable information which will in turn lead to improved service delivery which will be beneficial to the citizens.

2.7.3 Policy capacity-building

Capacity is generally defined as the ability to perform functions, solve problems and set and achieve objectives. Capacity refers to the availability of tangible resources such as human, financial, logistical, and others and intangible resources such as leadership, commitment and motivation amongst others. The policy objectives may be clear, accurate and consistent but if the implementers lack the resources; policy-makers will be disappointed in the outcomes.

Restless Development South Africa (2013:13) note that the healthcare workers that have the overall responsibility of the implementation of school health do not understand the Integrated School Health Policy. The success of the implementation of the Integrated School Health Policy is possible if the resources such as finance, staffing, transport, equipment and medication are made available at school level. National grants have been made available to support the recruitment of additional nurses for school health and transport is still incumbent in other districts (Shung-King *et al.*, 2014:64).

For the purpose of this study, capacity-building for integrated school health programmes depends on other government departments to be included in the implementation of a national school health programme, which includes the Department of Treasury to provide funds, the Department of Agriculture to provide food aid and the Department of Transport to provide transport. According to Restless Development South Africa (2013:13) and Shasha, Taylor, Dlamini and Aldous-Mycock (2011:301) transport was noted as a fundamental problem by all school managers and primary healthcare facility managers as a main challenge in providing a comprehensive support.

Re-orientation and training of primary healthcare personnel to assist and support the delivery of the school health service within the Integrated School Health Policy will be the responsibility of Department of Health. The Department of Planning, Monitoring and Evaluation will be responsible to design and have assessment tools that can help the country identify the problems, objectives and expected outcome of the Integrated School Health Programme that is context-specific. The development of the capacity of school communities to take responsibility for their own schools locally regarding health and

incorporate parental or community contributions which reach beyond schools, is of cardinal importance.

2.7.4 Policy context

Policy implementation is affected by the context in which policies are implemented. The Restless Development South Africa (2013:14) note that no school management staff claimed to have any in-depth knowledge of the Integrated School Health Policy. Furthermore, no school health team was in place in any of the schools, citing a lack of understanding in how to set up the system and what roles should be assigned to whom. So the context in which the policy was developed and placed is of no use to the school managers and primary healthcare facility managers. Stofile (2008:85) stresses that the context under which a policy is being implemented may impact on the process positively or negatively. So it is important that the contextuality of policy implementation is a factor to be expounded for policy implementation. Stofile (2008:85) mentions that the context of the formulated policy will also be influenced by the institutional mechanism it has to pass through in order to become enacted.

2.7.5 Policy clients and coalitions

Focusing on clients and coalitions strengthens the implementation process in the sense that it seeks to identify potentially influential clients and coalitions that are vital to the policy implementation process. Furthermore, the process of policy implementation needs to take into consideration the needs and interests of interest groups and individuals who were not consulted or involved in the formulation of the policy. To get a successful policy implementation in the long term, policies have to be co-owned by all the stakeholders who have a direct interest in the school. Restless Development South Africa (2013:15) note that the capacity within the school governing bodies is very low, and there is a real concern that the school governing bodies need to understand fully the basis of their roles and responsibilities in order to map out the steps needed to implement the programme. However, employing this critical variable is susceptible to leaving out the key actors in the policy implementation process, as the identification of clients and coalitions tend to limit the scope (Mthethwa, 2014:58).

With the Integrated School Health Policy the multi-partner teams are still to be established at district level for coordinated planning of school based interventions. The community based teams which are health and school based are required to work together. Therefore embarking on implementing this critical variable suggests that it should be cautiously done to ensure that it does not create a climate of non-support and non-ownership by actors at all levels. The importance of having coalitions of interest groups, leaders and other actors outside the government, is to support implementation for example, during the launch of the Integrated School Health Policy, all the major education bodies including the teachers union, national governing bodies and principal associations expressed strong support for the policy (Shung-King *et al.*, 2014:60).

2.8 STAGES OF POLICY IMPLEMENTATION

When policy has been accepted and approved, the next step is to implement the policy because the success of the policy will be influenced by the way in which policy is implemented. This means that implementers need to plan thoroughly and reach decisions on how the policy will be implemented. As the primary focus of policy implementation comprises the stages and these stages are integral factors in seeking to establish what the public policy entails. Therefore, the researcher identifies five stages of the implementation maturity model because the implementation maturity model is the institution's potential for growth in capability and capacity to implement public policies (Mthethwa, 2014:22). This is subsequently discussed.

2.8.1 Level O (Initial stage)

On the first level, the institution may lack a stable internal environment for the implementation of the new policy. The school managers and primary healthcare facility managers may give directives for the implementation of the policy in an ad hoc way and there is still no interconnection between identified policies. Implementation lacks internal structure and control and its efficiency depends on the individual skills of implementers as well as the knowledge and motivation of individual implementers, thus the bureaucracy (Mohlabi *et al.*, 2010:253). There is an absence of institutional goals and poor communication between the public policy implementers (Mthethwa, 2014:36).

2.8.2 Level A (Repeatable stage)

On the second level policy implementation activities are based on the results of the successful or unsuccessful implementation of previous policies. Mthethwa (2014:36) affirms that those involved in the implementation processes are at the novice stage of implementing public policies and are, consequently, beginning to learn policy implementation principles at the hand of previous successes. Old or new implementations, actions and knowledge are thus considered by the implementers during the implementation of the policy.

The old policy (National School Health Policy 2003) was not consistently implemented in all the provinces. Each school manager and primary healthcare facility manager in all the provinces administered the school health service differently and with less resources. The unsuccessful implementation of the National School Health Policy in 2003 led to the beginning of learning about policy implementation principles and thus the Integrated School Health Policy was formulated (Department of Health, 2011:3).

2.8.3 Level B (Defined stage)

On the third level of the implementation maturity model, the implementation activities are coordinated and documented throughout the institution. Mthethwa (2014:36) agrees that the implementation of the policy follows defined institutional goals and the implementation of the policy is guided by operational standards. This suggests that the implementation will be preceded by preparations to assure that conformity with institutional processes, procedures and goals are adhered to. The Integrated School Health Policy clearly states that funding of school health services is adequate in the departments and this causes the school managers and primary healthcare facility managers to plan and implement health services effectively (Department of Health and Basic Education, 2012:17). The implication is that scarcity of resources led to poor service and the institutional goals were not met.

2.8.4 Level C (Managed stage)

On this level of implementation of the maturity model, policies are started, supervised and implemented by processes of change management and process management.

Implementing becomes predictable and the institution is able to develop rules and conditions on the hand of which policies are implemented (Mthethwa, 2014:37). Deviation in the implementation of the policy will be immediately detected and corrected. Policy implementation becomes the way of life.

2.8.5 Level D (Optimising stage)

On level D the whole institution is focusing on the continuous improvement of the implementation processes. The institution possesses the means to detect weaknesses in the implementation of the policy and processes and is able to strengthen the implementation process immediately (Mthethwa, 2014:37). This stage also marks the continuous analysis carried out to find the causes of any errors and mistakes. The policy will be evaluated after the closure to prevent the occurrence of known mistakes when policies are implemented; this consequently implies that the level of implementation maturity is at its optimum level.

2.9 APPROACHES TO POLICY IMPLEMENTATION

A review of literature on policy implementation reveals that two schools of thought have evolved. According to Kapti (2009:51), the top-down and bottom-up schools of thought are seen as providing the most effective methods for studying and describing policy implementation. Top-down theorists see policy-makers as the central actors and concentrate on factors that can be controlled at a central level. Bottom-up theorists emphasise a focus on participants and service providers, arguing that policy is made at the local level (Stofile, 2008:39).

2.9.1 Top-down approach

The top-down approach puts the main emphasis on the ability of the decision-makers to produce unequivocal policy objectives and on controlling the implementation stage. This implies that top-down approaches take policy decisions as their starting point in the analysis and thus fails to consider the significance of actions taken during other stages of the implementation process. Stofile (2008:39) argues that policies are not simply created by national officials and then routinely implemented by state and local governments as if

they were unquestioning automatons in some Weberian machine. Adequate bureaucratic procedures should be established to ensure that policy is executed as accurately as possible.

Thus, there are structures in place at national, provincial and district level to execute the Integrated School Health Policy. While not yet fully functional, of importance is the presence of health and education officials in these structures, which indicates a growing relationship between these two crucial departments (Shung-King *et al.*, 2013:66).

The top-down approach starts with the policy decision-makers at the top of the governance structure, and sees implementation as occurring in a chain. Another recurring criticism of policy implementation is the orientation towards centralisation. Hence at the national level of the Integrated School Health Policy there is an intersectoral task team responsible for the overall planning and development of the policy (Shung-King *et al.*, 2013:66). All the authorisation resource allocation starts at the national level (Department of Health, 2012:17). This means that policies and plans are developed in the national sphere with little consultation with the final implementers (the school managers and primary healthcare facility managers). For this reason, policy often fails to capture the subtleties of initiatives at grassroots level, and therefore appears to be alien to the implementers of the policy.

The distance of policy-makers from practice not only causes problems for the managers of the policy, but also creates a lack of harmony among the different elements of the same policy, and among the different units of machinery of government (Brynard, 2007:36). The smooth transition from policy implementation to practice remains a challenge. The researcher argues that this approach has a tendency to neglect the local implementing of officials' initiatives and to underestimate the strategies used by implementing actors to divert central policy for their own purposes.

2.9.2 Bottom-up approach

The bottom-up approach starts by mapping the network of actors in the actual field where implementation is to take place and asks them about their goals, strategies, activities, and contact persons. This, according to Stofile (2008:40), provides a vehicle for moving

from the actors at the bottom to policy-makers at the top. Stofile (2008:40) argues that successful implementation depends more on the skills of local implementers than upon efforts of central government officials. The process confirms the fact that sometimes the policy outcome is very different from what the planners conceived due to the process of change and conflict occurring in the implementation stage (Brynard, 2007:38). In many cases, this requires implementers to be trained in the content of the policies and required skills. For example, the implementers of the Integrated School Health Policy need appropriate training to achieve its goals by national, provincial and district departments.

The implementation of an integrated school health programme is vested in the district level, with accompanying responsibility to ensure that the programme is implemented in all sub-districts and reaches all schools and learners. At this level this is where the school managers and primary healthcare facility managers are part of the School-Based Support Team and they play an important role in the implementation process. This includes ensuring progressive coverage of all schools and learners (starting with the most disadvantaged schools), coordination of other partners who provide components of the school health package and reporting on school health activities to both the Department of Health and Basic Education (Department of Health, 2012:19).

The Bottom-up model stresses the lowest level of the implementation process or the school as the level that informs the implementation process. As this approach makes every unit aware of the ability and resources required to achieve the targeted behaviour. It implies that being closer to the source of the problem creates greater ability to influence it. In addition, maximising discretion at the school where the problem is most immediate solves the problem better than the hierarchical control.

2.10 REASONS FOR FAILURE IN POLICY IMPLEMENTATION

Brauns and Wallis (2014:203) quoting Pressman and Wildavsky, state that implementation cannot succeed or fail without a goal against which to judge it. A policy is successful if it achieves the goals that the proponent sets out to achieve, attracts no criticism of any significance, and support is virtually universal (McConnell, 2010:356). Policy failure is the mirror image of success. Once policies have been formulated, the

process of implementation is not always guaranteed to succeed. Another factor is that many policies are overambitious (thus lacking quality and therefore unrealistic). Furthermore, an important point to consider is insufficient and ineffective actions at all spheres of government that has contributed toward unsuccessful policy implementation (Brauns & Wallis, 2014:204).

2.10.1 Lack of effective communication

The successful implementation of the policy is largely determined by the way in which communication takes place amongst the key actors implementing it. The Department of Health and the Department of Basic Education is mainly responsible for the development of policies such as the Integrated School Health Policy. The policy is then communicated to schools through the Provincial Basic Education Department; it then becomes the responsibility of the school managers to implement the policy. In many cases, however, there seems to be a lack of communication between the department and schools as well as inadequate training of school managers with respect to policy implementation (Van Wyk & Pelsler, 2014:834; Mohlabi *et al.*, 2010:253)

Effective communication helps the managers to communicate effectively with all the stakeholders and further ensures that the information received is understood correctly. Closed and inconsistent communication lines between the managers result in delays that are detrimental to implementation. The creation of effective and efficient communication channels can serve to clarify any uncertainties with regard to guidelines and the interpretation of policy that is implemented (Makhalemele, 2008:18).

2.10.2 Lack of proper intersectoral collaboration

Lack of proper intersectoral collaboration was a key explanatory factor for the 2003 National School Health Policy implementation failure (Mohlabi *et al.*, 2010:252). Therefore close collaboration between all role-players, with joint responsibility by the Department of Health and the Department of Basic Education to ensure that the integrated school health services reaches all learners in all schools is proposed by the new Integrated School Health Policy (Department of Health, 2012:7). Importantly, school health services are delivered by the National Department of Health. In the domain of the Department of Basic

Education the emphasis is on the need for coordination and interconnectedness between the school managers and primary healthcare facility managers.

2.10.3 Lack of understanding

A prerequisite for agreement to participate in policy implementation is that all the key actors should understand the origins and contents of a policy. Policies are ineffective not because they are badly implemented but because they may be based upon inadequate understanding of the problem, its causes and the possible solutions. Uugwanga (2007:104) and Mohlabi *et al.*, (2010:253) further state that those who are responsible to implement the policies are not adequately trained to thoroughly understand them and to be excited about the changes.

Furthermore, policies seem to be based more on assumptions than the reality of the practice on the ground. If the theory underpinning the policy fundamentally is incorrect, the policy implementation will fail. The key actors in policy implementation need to ask themselves these questions: Are policy objectives clear, consistent, realistic and have the implementers reached a consensus on the meaning of policy? Furthermore, key actors must be informed about new developments of the policy implementation so that they can look for practical ways to implement it.

2.10.4 Lack of clarity of roles

It is important to know that school managers and primary healthcare facility managers roles in the implementation of Integrated School Health Policy should not be underestimated or undervalued. With their participation these managers can enhance a sense of fairness and trust in the school because they are usually seen to have the best interest of the learners at heart (Mohlabi *et al.*, 2010:253). Furthermore, they are closely linked to the main business of the school and they are in the position to judge the fairness of policy that will at the same time achieve improved learning outcomes.

Restless Development South Africa (2013:13) note that all the district officials reported good awareness of the Integrated School Health Policy and acknowledged that they had been trained on the programme, but the school managers and primary healthcare facility

managers didn't know which role to play in the implementation of the policy because they were not trained. Instead all the districts reported a lack of support and cooperation because it was not a unified programme with all the key actors working together to deliver integrated school health.

2.10.5 Attitudes of implementers towards the policy

Lessons from policy implementation research show that the education system can provide good policy, education support, and resources and build the capacity of participants to implement the policy, but if attitudes have not changed, the implementation will fail (Stofile, 2008:90). Success of any policy implementation depends on two broad factors: local capacity and will. Stofile (2008:90) argues that training can be offered, consultants can be hired and funds can be made available, but if there is no willingness on the part of the implementers, implementation will not be successful.

2.10.6 Lack of monitoring and support

The present institutional arrangements within the Department of Health and Basic Education lack monitoring and evaluation systems to measure performance and evaluate policy outcomes. Indicators are still under construction (Shung-King *et al.*, 2014:64). In addition, they are not flexible to give immediate feedback to policy-makers and implementers since monitoring and evaluation should take place on a regular basis to enable departments to assess the extent to which change is taking place. Hundred percent of school managers admitted that no audit was completed of the schools to implement the programme effectively, and they understood that there was a monitoring plan for the programme and only school managers at the Amathole District in South Africa confirmed that data is stored in school for viewing (Restless Development South Africa, 2013:13).

2.11 POLICY-MONITORING AND EVALUATION

The success of any policy is measured by how it is implemented and its effect. However, the full impact and outcomes of a policy can only be determined once policy has been implemented and executed. Mbelu (2011:27) perceives monitoring as a process that

entails determining how the public policies implemented reach its intended targets. This implies that public policy monitoring is the radar that guides and shapes the implementation processes in order for the pre-set objectives to be achieved. The policy must be evaluated in order to determine whether the original problem has been resolved. The results of monitoring and evaluation not only measure a programme success in meeting its goals but also provide information for planning future programme activities. This will also help the school managers and primary healthcare facility managers to better understand their programme needs and assets to establish priorities and to use their resources more effectively.

The school managers and primary healthcare facility managers can use process evaluation whereby accurate and organised records of the school health programme activities are central to the ability of them to effectively monitor and report on their activities. Furthermore, they will be able to assess that these activities met their goals and objectives. Outcome evaluation can also be used to assess the impact of school health programme activities on their participants, including changes in their knowledge, attitudes, skills and behaviour, both following programme activities and over the long term. School managers and primary healthcare facility managers should provide their reports on the implementation of integrated school health programmes. The school managers and primary healthcare facility managers as the initial planning team meet again and discuss whether or not the goals were met and makes appropriate modifications.

2.12 SUMMARY

Schools can be a cost-effective platform for the delivery of health interventions. However, the school system cannot replace the health system. Rather, the school system should complement the traditional health care delivery system in order to increase coverage to reach all the learners. Developed countries like the United States of America are implementing the promotion of school health through the Focusing Resources on Effective School Health framework which evaluate the effectiveness of the programme. It

also provides funds for the state and Department of Education and Health to help schools in their jurisdiction to implement the promotion of school health.

Furthermore, the researcher noticed that implementation of any health activity in the United States of America is informed and supervised by health experts like the school health nurses, but the education sector leads on activities that promote education and learning outcomes. In India, there is a decentralised framework for the implementation of school health whereby each state implements its own version of the school health programme. Brazilians use the integrated school health and nutrition programme, hence South Africa adopted the integrated school health programme from them. The government decided that it is best that the delivery of school health and nutrition services should be a function of the Department Education and not of the Department of Health. Thus, the responsibility is vested in the Department of Education.

The South African government needed to learn from this country that school health occurs at school and not at the clinics. China uses a model which is relatively unique. It is an educator-driven service operating where educators are trained in basic healthcare interventions. The experiences of both Nigeria and Tanzania have shown that there is a wide gap between the school health guidelines and the current practice toward school health. To successfully establish an integrated school health service needs the intervention of all stakeholders involved and the government should play a leading role.

This chapter looked at levels of policy implementation on collaborative partnership between the primary healthcare facility manager from the Department of Health and school managers from the Department of Basic Education. In South Africa there is a centralised framework of policy implementation. Every province implements the school health programme based on the national policy, but according to the needs. Provinces don't plan or implement their own version of the programme; the provincial coordinators wait for the mandate from national level for them to implement the policy. However, there are gaps identified in communication between school and primary healthcare levels.

This research uses implementation variables to understand process of implementation from the views of top-down and bottom-up structures. The top-down approach is

characterised by its hierarchical and control themes. The broad aim is to improve performance, thus to achieve the top's goals. For the bottom-up approach, policy is dependent upon the interaction between the key actors at the local level and the aim is to explain what actually happens when policies are implemented. The effective implementation requires the collaboration of the policy decision-makers from national, provincial and district level. The school and primary healthcare level is where the implementation is and the key actors need support from top-down spheres of government. The commitment is important not only at the school and primary healthcare level but at all levels through which the Integrated School Health Policy passes.

The legislative framework has a direct influence on the enactment of the Integrated School Health Policy. Without the knowledge or understanding of the legislative framework the implementers (school managers and primary healthcare facility managers) will be unable to implement the Integrated School Health Policy. It is therefore important for the implementer's to pay attention to the legislation that governs the Integrated School Health Policy such as the Constitution, the South African Schools Act, the Mental Health Care, and the National Health Acts. An analyses of these legislations together with the results on the Integrated School Health Policy indicate that the rights of the learners are first priority across the country.

Towards a successful implementation of the policy, consideration should be given to variables such as commitment, context concept, capacity-building and clients and coalitions. The target should be the involvement of the implementers at the formulation stage in order for them to have an input on what affects their lives. This will give them a sense of belonging and therefore a sense of commitment. Attention should be paid to manpower through training and recruitment and financial resources which will be needed to implement the policy. Provision should be made for the involvement of the community in which the schools are situated so that policy implementation can yield better results.

Policy has no value if it is not properly implemented and if the actual problem is not dealt with. When implementing the policy, the implementers (school managers and primary healthcare facility managers) should make sure that the policy is successfully implemented, hence implementation of maturity model acts as an instrument that may

help the implementers to be able to assess and determine the degree of maturity that exist in an institution through the stages of implementation. As an instrument it also guides implementers (school managers and primary healthcare facility managers) to determine whether the specific changes are needed before the policy can be implemented with success.

The above discussion tried to explain why policy implementation fails at the implementation stage. The study indicates that policy implementation fails as a result of many factors, which could arise from the policy itself or the environment in which the policy has been made. In addition, other reasons given for the failure of policy implementation are a lack of effective communication, a lack of intersectoral collaboration, a lack of understanding, a lack of clarity of roles, the attitudes of the implementers and a lack of monitoring and support. It is apparent that the Integrated School Health Policy is rolled out in South Africa without achieving the desired results. Lastly, considering the manner in which monitoring and evaluation of the school health programme is undertaken in South Africa, some measurable, attainable and realistic goals should be set within a specific timeframes. In fact, the progress made in policy implementation should be measured against the set objectives during the evaluation and monitoring process of the policy. The next chapter deals with the research design, methodology and techniques utilised in gathering relevant data.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

The purpose of this chapter is to describe and justify the research design and method of the study. The selected research design serves to enhance trustworthiness of the research study. The objectives of the research are restated in this chapter in order to justify the fact that the selected research methods are viable in attaining the research goals. The study focuses on the explanation and description of the implementation of the Integrated School Health Policy in the public primary schools of Region C in the Gauteng Province. This chapter includes data collection methods that are employed in the study and a further exposition is made with regard to the manner in which the sample has been drawn. Measures to ensure trustworthiness and which explains the procedures to be followed during field work, including the discussion of ethical considerations are included. The chapter concludes by stating how data has been captured, analysed and interpreted.

3.2 OBJECTIVES OF THE RESEARCH

The aim of this research is to describe and explain the extent to which school managers and primary healthcare facility managers possess knowledge and awareness of their roles in the implementation of the Integrated School Health Policy in Region C in the Gauteng Department of Basic Education.

The following objectives have been stated:

- to describe the extent to which school managers and primary health care facility managers possess knowledge about the implementation of the Integrated School Health Policy.
- to explain the systems that can be introduced to assist the school managers and primary healthcare facility managers in the implementation of the Integrated School Health Policy.

- to describe and explain the roles played by the school managers and primary healthcare facility managers in relation to the delivery of integrated school health services.

In order to attain the above stated objectives the researcher has identified various data collection methods that are discussed below.

3.3 RESEARCH APPROACHES

Research approaches is the technique used to structure a study and to gather and analyse information in a systematic fashion (Polit & Beck, 2012:731). In this research, the qualitative research method was seen as an appropriate method in order to generate answers to the research questions. Furthermore, the research approaches involve choosing research methods and strategies of data collection and sampling.

3.3.1 Qualitative method

This study adopted a qualitative research method to investigate the phenomena of interest. The choice why the methodology was adopted depended on the objectives the researcher has identified for the study. Furthermore, a qualitative research method takes place in the natural world, is interactive, context focused, humanistic, emergent and basically interpretative (Marshall & Rossman, 2011: 3; Polit & Beck, 2012:14). A qualitative research method was chosen for this particular study because it allowed for an in-depth collection of information from participants via conversation and observation (O'Sullivan & Rassel, 2008:39). Furthermore, Polit and Beck (2012:752) state that a qualitative research method displays how events and things are put together, more or less coherently and consciously into frameworks that makes sense of their experiences.

In this study, the school managers and primary healthcare facility managers had the opportunity to respond more elaborately and in greater detail about their experiences of the implementation of the Integrated School Health Policy. In the qualitative research method researchers sometimes study the phenomena about which little is known, therefore in this study the phenomenon has yet to be clearly identified or has been

inadequately defined. Therefore, the in-depth probing nature of qualitative research is well suited to the task of answering the research question.

3.4 RESEARCH DESIGN

A research design is a general plan that describes how the research study will be conducted. May (2011:98) and Van Thiel (2014:57) assert that a research design is a complete strategy for data collection while Kumar (2005:84) and O'Sullivan and Rassel (2008:39), explain that a research design is a plan, structure and strategy of investigation so conceived as to obtain answers to the research question or problem. The research design for this study therefore enabled the researcher to obtain answers to the research questions and helped the researcher to deal with challenges that arose during the research process. In fact, the research design is essentially the architectural backbone of the study as it enabled the researcher to anticipate what the appropriate research decisions should be, so as to collect and analyse data about the implementation of the Integrated School Health Policy in Region C in the Gauteng Province.

Explanatory and descriptive designs were followed in this study. These designs describe and explain the extent to which school managers and primary healthcare facility managers possess knowledge and awareness of their roles in the implementation of the Integrated School Health Policy in Region C in the Gauteng Provincial Department of Basic Education. The explanatory and descriptive design afforded the researcher with a chance to interact with participants to gain first-hand information of their roles in the implementation of the Integrated School Health Policy.

3.4.1 Explanatory

The term “explanatory research” implies that the research in question is intended to explain, rather than simply to describe the phenomena studied. An explanation tells the researcher not only what happens but also why. Explanatory research design is often linked to theories, which represent a method of deriving, organising and integrating ideas about the manner in which phenomena are interrelated (Polit & Beck, 2012:20; McNabb 2013:109; Van Thiel, 2014:109). In this research the main aim of the research is to

describe and explain the extent to which school managers and primary healthcare facility managers possess knowledge and awareness of their roles in the implementation of the Integrated School Health Policy in Region C in the Gauteng Provincial Department of Basic Education and how the delivery of integrated school health has been happening (McNabb, 2013:303). The researcher asked for an explanation about how or why a phenomenon exists or what a phenomena means as a basis for developing a theory that is grounded in rich, in-depth experiential evidence.

3.4.2 Descriptive design

Descriptive research design is used to describe situations and events. It provides a detailed picture of a subject. In this regard, a researcher observes and then describes what was observed or measured at a given time and environment (McNabb, 2013:106). Burns and Grove (2009: 237) state that descriptive study gains more information about the characteristics within a particular field of study, and its purpose is to provide a picture of situations as they naturally occur (Burns, Grove & Gray, 2009:237). Furthermore, Burns *et al.* (2009:237–238), state that descriptive study strives to acquire factual knowledge from data, facts, empirical, generalisations, and narratives, by providing truthful descriptions of the phenomenon being studied.

The data gathered through semi-structured interviews was described in order to provide a comprehensive understanding of the implementation of the Integrated School Health Policy in the public primary schools of Region C in the Gauteng Province. The study strives to describe accurately the information acquired from the implementation of the Integrated School Health Policy in the public primary schools of Region C in the Gauteng Province, based on the data obtained from the participants.

3.5 DATA COLLECTION

Data collection is a method that the researcher used to collect data to answer the research questions. Data collection refers to gathering of information to deal with a research problem (Polit & Beck, 2012:25). In addition, it entails precise, systematic gathering of

information relevant to the research purpose or the specific objectives of and questions regarding a research.

3.5.1 Interviews

Interviews attempt to understand the participant's point of view. According to Polit and Beck (2010:752) a qualitative research method displays how events and things are put together, more or less coherently and consciously into frameworks that makes sense of experiences. McNabb (2013:323) is of the opinion that the respondents are free to provide answers that comes to mind. The interviews for the present study were semi-structured to allow for open-ended answers and therefore the interviewer was flexible in terms of the order of the topics and the interviewees were at liberty to elaborate on the points of interests on their own terms (Denscombe, 2007:176; May, 2011:135; Van Thiel, 2014:93).

Semi-structured interviews were used because the researcher regarded it as a strength to help the researcher focus on the purpose of the research. Semi-structured interviews enabled the researcher to compare the responses from interviewees, as there was a variation in the quality of information that was generated from each interview. Furthermore, the researcher allowed the conversation to take its natural course as the best way of collecting optimal amount of data. One- on-one interviews were conducted where open-ended questions were asked to give participants opportunities to respond to questions in depth. One-on-one interviews not exceeding one hour were conducted after working hours until data saturation was reached as new data yielded redundant information. All the interviews were audio-taped after obtaining permission from each participant.

3.6 SAMPLING

Sampling is a what to determine who would form the units of analysis of the study concerned, because it is hardly ever possible to include all potential units of the study, which means that a certain selection has to be made. Sampling refers to the elements in the population considered for inclusion in the study. According to O'Sullivan and Rassel (2008:158) and Bhattacharjee (2012:66), sampling is the process of choosing actual data

sources from a larger set of possibilities. While, Polit and Beck (2012:275) May (2011:98), Newby (2010:59) and Van Thiel (2014:45) assert that sampling is the process of selecting a portion of the population to represent the entire population under study so that accurate conclusions are drawn. A sample is studied in an effort to understand the population from which it was drawn.

Sample size in a qualitative study depends on data saturation. Therefore, the sample size was ten participants but only three school managers and four primary healthcare facility managers responded to the invitation to be part of the study and they consented to and voluntarily participated in the study. The interviews continued until no new information was gathered, that is until data saturation was reached (Polit & Beck, 2012:521; Kumar, 2011:213). Region C in the Gauteng Province was selected because it has two health promoting schools and also the Gauteng Province was chosen as the pilot study for the Integrated School Health Policy. The study site was the primary schools and primary healthcare facilities in Region C in the Gauteng Province in South Africa.

3.6.1 Purposive sampling

The present study employed purposive sampling as a common technique in qualitative research where researcher used judgment to select a sample. Purposive sampling is a technique used to select certain persons, settings or events on the grounds that they can provide the information desired (Newby, 2010:59; Denscombe, 2007:17). The sample was useful in answering the questions raised by the researcher, which in qualitative research involves purposefully choosing participants or sites that best achieve the aim. These are knowledgeable participants who reflect most of the characteristics, experience, representation or typical attributes of the population. In this regard, all participants in this study were individuals who had direct or indirect experience and knowledge about the implementation of the Integrated School Health Policy.

Furthermore, purposive sampling was used because the school managers and primary healthcare facility managers had rich information about the implementation of the Integrated School Health Policy in the public primary schools. The researcher employed purposive sampling only on schools that implement the Integrated School Health Policy

and have information as they could provide the best information as well as their first-hand experiences on the implementation of the Integrated School Health Policy.

3.7 TRUSTWORTHINESS

Trustworthiness is a method of ensuring rigour in qualitative research without sacrificing relevance. Polit and Beck (2012:745) and Creswell (2014:201) state that trustworthiness is the degree of confidence qualitative researchers maintain in their reporting. Furthermore, trustworthiness requires that the research approaches, instruments and methods used by the qualitative researcher should produce valid observations, sound analysis and interpretation of study findings, and should be generalisable (Bhattacharjee, 2012:8). The researcher strived to adhere to the principles of trustworthiness throughout the research using the criteria of credibility, transferability, dependability, conformability (objectivity) and authenticity. The findings of the research presented real issues with which the school managers and primary healthcare facility managers are faced with in the implementation of the Integrated School Health Policy, without leaving out any information. The five criteria to ensure trustworthiness and their relevance in the study are discussed.

3.7.1 Credibility

Credibility is the confidence in the truth of the data and interpretation thereof. Credibility refers to the extent to which a research account is believable and appropriate, with particular reference to the level of agreement between participants and the researcher (Denscombe, 2007:292). Credibility deals with the question of whether the research has established the confidence in the truth and authenticity of the results. To ensure that the study was credible, the researcher clearly reported on how integrated school health is implemented in the primary schools of Region C in the Gauteng Province.

The researcher conducted semi-structured interviews with school managers and primary healthcare facility managers who had been in these posts since the policy was launched. Interviews allowed the researcher to gather as much information as possible and gave the respondents the opportunity to verbalise their views. The researcher took 45 to 60

minutes with each of the participants, allowing for a rapport to be built, and trust and confidence to be gained, a process referred to as “prolonged engagement” (Mahlo, 2011:97). Data collected was transcribed verbatim and the audio tapes were made available to the supervisor in case verification of data was needed.

3.7.2 Transferability

Transferability is the extent to which research findings can be applied to other settings and contexts. Polit and Beck (2012:745) are of the opinion that transferability refers to the ability to generalise or extrapolate data to the extent to which the findings from data can be transferred to other settings or groups. The researcher aimed for transferability by providing detailed and rich descriptions on the experiences of the school managers and primary healthcare facility managers in the implementation of the Integrated School Health Policy. The use of a purposeful sampling method increased transferability as it ensured that participants rich with information regarding the implementation of the Integrated School Health Policy were utilised in other settings. It was hoped that some experiences of the school managers and primary healthcare facility managers who were interviewed and who represented the other managers who had been the system since the policy was launched (three years ago), could be transferred to a wider population of school and primary healthcare facility managers implementing the policy.

3.7.3 Dependability

Dependability of data is the extent to which the same findings could be repeated if the same research instruments were simulated with similar respondents under similar conditions. Dependability, according to Polit and Beck (2012:725) refers to a criterion for evaluating integrity over time and over conditions analogous to reliability in research. Dependability was achieved through rich and detailed descriptions that show how certain actions and opinions are rooted in, and develop out of, contextual interaction. The researcher used interviews to understand the experience of the school managers and primary healthcare facility managers of the implementation of the policy in Region C in the Gauteng Province, in an attempt to achieve dependability. The researcher kept field

notes related to each participant's statements, and these field notes and the audiotapes compiled during data collection were kept as a record that could be used in future studies.

3.7.4 Confirmability

Confirmability is concerned with whether data is confirmable. This means that the researcher ensured that there is no bias in the research procedure and findings. Confirmability is objectivity which has the potential to establish congruence between two or more independent people about the data's accuracy, relevance, or meaning (Polit & Beck, 2012:723). Throughout the data collection process, the keeping of a field journal allowed the researcher to record all issues that could affect the study, such as personal experiences and knowledge of the participants. Personal field notes about the participants reactions were recorded, to minimise any bias and preconceived ideas about school managers and primary healthcare facility managers in the implementation of the Integrated School Health Policy in Region C in the Gauteng Province. All interviews with participants were audio-recorded, transcribed and thematically coded for analysis and reporting of the findings.

3.7.5 Authenticity

Authenticity refers to the true description of people, events and places. In qualitative research it indicates whether the description and the explanation interconnect. It is the ability of the researcher to report a situation through the eyes of the participants and establishes the degree to which different points of views are fairly and adequately represented (Denzin & Lincoln, 2005:23). In order to enhance authenticity, the researcher asked the respondents to validate the identified themes for authenticity and ensure that their perceptions would be understood correctly, and accurately captured and reported (Denzin & Lincoln, 2013:155). Through the researcher's observation or reflective journal, data was recorded and reported on, taking into account the different social situations (McMillan & Schumacher, 2006:67). Consequently, despite professional editing of the report, the researcher used the services of a critical reader for every section of the research and wrote a final report about the study.

3.8 DATA INTERPRETATION AND ANALYSIS

Data analysis refers to the breaking up of the data into manageable themes, patterns, trends and relationships (Denscombe, 2007:290). The researcher used conventional content analysis to provide a thick description about the participant's knowledge and roles about the implementation of the Integrated School Health Policy. Polit and Beck, (2012:723) state that qualitative content analysis is a process of identifying patterns and themes in the data and drawing conclusions from them. Content analysis allowed the researcher to see which themes were major and minor ones in the discourse and again the researcher could determine which themes repeatedly came up in the responses or interviews. When analysing the data, the researcher focused on describing facts and explanations about the implementation of the Integrated School Health Policy.

The researcher analysed each recorded transcript by carefully reading and noting the interesting or significant themes. In the response patterns from the informants direct quotes were listed in order to look for any relationship between them. The connected patterns were combined and categorised, for instance those that fitted under specific theme or response patterns that emerged from the informants explanation of the experiences in the implementation of the policy. These were identified, put together with the correspondence patterns to form sub-themes and those that were similar were grouped together thematically to enable the researcher to comprehend their collective experience. The researcher had to establish how different ideas fitted together in a meaningful way when linked together. Basically, the researcher ended up with the key themes that describe the essence of the study (Macmillan & Schumacher, 2006:363). The analyses were concluded in line with the objectives set out above.

3.9 ETHICAL ISSUES

Ethical issues require that the researcher conforms to the accepted professional practices of research. Therefore, acting ethically in research ensures that the participants are treated with respect and sensitivity beyond what may be required by law. The researcher must act in a moral and responsible way, that she or he should conduct the research with care, be truthful in report findings and open to criticism and new ideas. In order to do that,

the researcher conducted the interviews in such a way that they elicited cooperation, trust, openness and acceptance as recommended by Macmillan and Schumacher (2006:384). The same two authors (2006:142) refer to ethics as typically associated with morality, and both words concern matters of right and wrong, conforming to the standards of conduct of a given profession or group. Throughout the research process, ethical considerations were implemented to ensure that the study complied with research ethics.

3.9.1 Privacy

Privacy is the right an individual has to determine the time, extent, and general circumstances under which personal information will be shared with, or withheld from others. The researcher did not coerce participants to disclose information they were not comfortable with, but the researcher was directed by research questions. All the research participants were informed of their rights to privacy whereby they could decide to decline taking part in the study. Participants have the right to refuse to participate in research (Denscombe, 2007:292). The researcher interviewed the participants while on duty and at a convenient time after obtaining permission to do so in order to prevent the invasion of privacy of the individuals. The participants rights were not violated by the researcher through usage of unauthorised cameras and microphones; only audio-tape was used to record the interview.

3.9.2 Informed consent

Research permission was requested from the Research Ethics Committee of the College of Economic and Management Sciences of the University of South Africa (Unisa). Permission was requested from the Gauteng Provincial Department of Health and the Department of Basic Education to conduct a study within the identified primary schools and primary healthcare facilities (see Appendix E). Subsequent to obtaining this permission, the researcher personally visited the schools and primary healthcare facilities to inform the school managers and primary healthcare facility managers of the nature and rationale of the study and how they would be involved.

The researcher asked the participants to complete consent letters to acknowledge their voluntary participation, that they understood the aims of the research and that they could

withdraw from the research at any time if they wished to do so. The researcher outlined the purpose of the research to all the participants before the actual interviews began and gave them the opportunity to ask questions about any matter pertaining to their participation in the research and its aims. The researcher informed the participants that their participation was entirely voluntary since participants were not compelled to participate (Bell, 2010:45). Their participation included freedom to withdraw from the research at any time without penalty. The participants were informed that the researcher would take notes during the data collection process and that they had right to withdraw from the research if they felt uncomfortable or intimidated by the presence of the audio-tape recorder. Thus, the taping of interviews wouldn't proceed without the knowledge and consent of the participants.

3.9.3 Anonymity

Anonymity is assured when a participant's identity cannot be linked to individual responses. The interviews conducted were transcribed verbatim, the real names of the participants and the name of the schools and the primary healthcare facilities were kept anonymous in order to protect their identity from unnecessary criticism or ridicule. The researcher ensured that the participants remained anonymous in such a manner that it would be difficult to track the responses of any participant and their identities wouldn't be revealed in any record or report and that there wouldn't be a link between the data and the participants (Bell, 2010:45). To ensure this, pseudonyms for participants, schools and primary healthcare facilities were used to ensure anonymity (Denscombe, 2007:292).

3.9.4 Confidentiality

Confidentiality is the researcher's management of collected information that must not be shared with others without authorisation of the participant. Confidentiality refers to access to data, not access to people directly (Denscombe, 2007:292). This means that information shared with researcher wouldn't be disclosed in a way that could publicly identify a participant. The researcher assured the participants that anything that was discussed during the research was kept confidential and wouldn't be used for any purposes other than this study. Participants were assured that all information that was

provided by them was strictly confidential, data collected was kept in a safe place which was constantly locked. The participants were informed that the interview data would be destroyed after a period of five years.

3.10 LIMITATIONS RELATING TO METHODOLOGY

The qualitative research methodology was used in collecting relevant research data. Unfortunately, the study was not able to capture that the views of most of the people affected by the implementation of the Integrated School Health Policy in Region C in the Gauteng Province. In other words, the sample was not representative of the population. Therefore, the findings of the study are only applicable to the schools and primary healthcare facilities in Region C in the Gauteng Provincial Department of Education. The results of the study cannot be generalised to other districts because the study setting and sample was not representative of the population of the whole City of Johannesburg or the Gauteng Province.

3.11 SUMMARY

This chapter presented the research methodology and design of this study. The research objectives were used to reveal what the researcher intended to achieve. The research approach was defined as the method used for data collection, analysis and interpretation and sampling. The qualitative research method was selected for this study. The research design was defined as a plan or blueprint or strategy for conducting the empirical study.

The rationale for choosing the qualitative approach is that it explored a topic area and the researcher learned more about the views of the participants. This study was undertaken for descriptive and explanatory purposes. Descriptive and explanatory analyses were made in relation to the information obtained through questionnaires. Data was collected using interviews as a method which can assist in answering the research questions. The research sites for this study were the Department of Health (primary healthcare facilities) and the Department of Basic Education (primary schools). The target population for this study was the school managers and primary healthcare facility managers. The population of this study was five school managers and five primary healthcare facility managers. A

purposive sampling strategy was used to select participants. Purposive sampling was chosen because the selection of participants was based on the information that the school managers and primary healthcare facility managers know more about integrated school health in their area of management. Content analysis was used to analyse qualitative data gathered through interviews.

This study used a data collection instrument, namely the interviews. An audio voice recorder was utilised to capture interviews from participants and the interview was transcribed and analysed for accuracy. Ethical procedures for conducting the interviews were followed. The researcher requested a permission to conduct a study from the Department of Health and the Department of Basic Education and permission was granted. The researcher followed ethical principles for safeguarding the rights of the participants such as privacy, confidentiality, anonymity, voluntary participation, and the like. Research data was properly handled by being stored in the researcher's home and protecting the data stored on the computer through the use of a password. Data will be destroyed after five years according to Unisa policy. This study used the four criteria of credibility, transferability, dependability and conformability to ensure trustworthiness of the study findings. The next chapter presents the general findings and discussion.

CHAPTER 4

FINDINGS AND DISCUSSION

4.1 INTRODUCTION

The previous chapter outlined the research design and methodology relevant for collecting research data in relation to the implementation of the Integrated School Health Policy. Therefore, this chapter presents the research findings and discussion regarding the implementation of the Integrated School Health Policy in the public primary schools of Region C in the Gauteng Province. The discussion of findings is enhanced by integration with existing literature.

In fact, this chapter focuses on the following three objectives:

- to describe the extent to which school managers and primary health care facility managers possess knowledge about the implementation of the Integrated School Health Policy.
- to explain the enabling systems that can be introduced to assist the school managers and primary healthcare facility managers in the implementation of Integrated School Health Policy.
- to describe and explain the role played by the school managers and primary healthcare facility managers in the delivery of integrated school health services.

4.2 MANAGERS KNOWLEDGE ABOUT THE IMPLEMENTATION OF THE INTEGRATED SCHOOL HEALTH POLICY

The school managers and primary healthcare facility managers demonstrated great awareness and knowledge about issues that affect the implementation of the Integrated School Health Policy. The managers raised various issues relating to communication, collaboration, resource constraints, absence of proper training, poor consultation and unrealistic workloads. These issues are discussed in the following section.

4.2.1 Communication

Communication plays a central role in any institution. Similarly, communication is vital in policy implementation. The most dominant theme that emerged from the first question of the empirical study is the fact that the policy implementation process requires communication, inevitably to create a platform for brainstorming and sharing ideas of how the Integrated School Health Policy can be successfully implemented. The response indicates that effective policy implementation requires a proper flow of information to, from and within Region C in Gauteng Province. Information regarding the Integrated School Health Policy should be communicated to all stakeholders, like policy implementers and those who are affected by such policy.

Proper communication channels should be created so that information reaches the entire stakeholder in time and in a proper manner (Mazibuko, 2007:183; Makhalemele, 2008:18). One of the primary healthcare facility managers asserts that the information about the policy is concentrated at the top level which is the provincial level, whereas the managers who are at the bottom level of the institutional structure are clueless. The other primary healthcare facility manager argues that they fall under Region C but in the district whereas other within Region C falls under the province. Moreover, proper implementation depends on how policy is communicated to the stakeholders, particularly those who implement it and there must be continuous up and down transmission of information.

Again, one of the school managers maintain that the policy is not properly communicated to them which is attributed to the fact that they are expected to implement the policy that they do not understand. This posed a problem because the Department of Health and the Department of Basic Education have different priorities, and if there is no common understanding or proper communication then implementation becomes difficult (Mohamed, 2015:70; Bundy, 2011:15; Stofile, 2008:63). The school manager expresses a concern in this regard as follows:

“Let the policy be cascaded thoroughly for schools so we fully understand what is that it entails and how best we can engage with it as schools so that we can support the program itself” (School manager 2).

With regard to the issue of stakeholders involved in the implementation of the Integrated School Health Policy, the managers indicated that there is a need to build coalition with the stakeholders such as parents of the learners, teachers and healthcare workers. However, the managers raise concerns about the manner in which policy is communicated to the stakeholders as one of the challenges or constraints. One of the school managers states that it is unlikely that they can succeed without the support of the stakeholders, especially the parents. As a result, parents need not only to understand the policy but also need to understand what role they should play during policy implementation. Hence, successful policy implementation requires democratic public participation where policy implementers and the public constantly engage in dialogue; examine the consequences for fundamental values, as well as sharing burdens and benefits (Brynard, 2009:42; Mazibuko, 2007:185). Some of the school managers articulate their opinions in this regard as follows:

“Challenges might be a failure of understanding what this program entails as parents as some of them deny their learners can be part of the program itself” (School manager 2).

“We should be the first one they tell before it attacks the school and then we will go and report it to the stakeholders or parents”(School manager 3).

At the same time the managers agree that the involvement of stakeholders can be achieved through proper communication. In support of this notion, Mthethwa (2012:218) argues that communication should be effective and be a two way process that enshrines intent of obtaining stakeholder input, advice and feedback. Managers maintain that they are not given enough time to successfully and properly determine a coalition which is important in order to ascertain the acceptance of the proposed policy. The response indicates that there should be

a clear direction from the managers to stakeholders involved as to how the programme should be implemented. The managers state that forging coalitions or partnerships with the stakeholders assist the policy to be timely implemented because the stakeholders can also feel ownership of the policy and the policy can be implemented without being rejected. In fact, managers mention that forging coalitions with the stakeholders involved is the most crucial element during policy implementation phase, because it attributes towards achieving efficiency, cost-effectiveness and transparency (Brynard, 2009:45). Equally important is focusing on coalitions as it strengthens the implementation process in the sense that it creates a climate of support and ownership by the implementers at all levels of instituting the Integrated School Health Policy:

“The preconditions of the successful implementation of the Integrated School Health Policy, I think is to have good communication with the nurses or with the health department or good relationships between the clinics as well as the school” (School manager 3).

4.2.2 Collaboration

Collaboration between the school managers and the primary healthcare facility managers is essential to achieve success in the implementation of the Integrated School Health Policy. As a matter of fact, collaboration among the teams (School-Based Support Team and Health Support Team) as well as between the Department of Health and the Department of Basic Education should be established, nurtured and sustained. In this context, collaboration refers to the bottom-up approach right from the start of programme, thus the relationship between the school managers and primary healthcare facility managers and how well they work together (Mohlabi *et al.*, 2010:252). For instance, most of the participants emphasised the significance of relationship building as one of the key roles of the managers in the implementation of the Integrated School Health Policy. This is confirmed by managers responses that, through constant face-to-face contact, collaboration will develop a good relationship with the stakeholders and also Region C in the Gauteng Province in general.

Moreover, managers suggest that regular contact provides them with the opportunity to comprehend the policy, thus enabling them to operationalise the Integrated School Health Policy. The managers felt that because the school and primary healthcare facilities are busy, it is necessary for this constant contact as well as regular mentoring, to consolidate through integrated school health services and to keep it on the agenda at the district level (Mohamed, 2015:170).

“I think we should also know the nurse that is allocated to our school and have a good relationship with the nurses and they must have given us the information of what is happening health wise” (School manager 3).

Furthermore, collaboration as a creative partnership between all the role players who work together to identify mutually defined barriers and needs seems to be lacking. The response indicates that there is no or little interplay and interaction between the managers, which is evidenced by the fact that school managers and primary healthcare facility managers have not yet called a meeting to discuss issues relating to their functions in the implementation of the Integrated School Health Policy. Again, the managers report that they are unable to share their expertise, knowledge and skills to stakeholders due to lack of collaboration.

The responses indicate that the managers are used to an environment where they work independently or in isolation. In view of this general practice, managers suggest that regular meetings should be arranged to create an information sharing platform. The responses indicate that the managers are willing to work collaboratively in order to meet the challenges presented by the policy. Furthermore, the managers indicate that one should be able to create meeting situations that allow full participation by all members of the team and make sure that goals set by the team are achieved and timeframes are adhered to. In relation to the issue of collaboration, one of the primary healthcare facility managers articulated the significance of meetings:

“I think regular meeting schedule will definitely help to establish a relationship” (Primary healthcare facility manager 4).

The Integrated School Health Policy aims to create collaboration platforms between the Department of Health and the Department of Basic Education; this is supported by other countries such as United States of America, which focuses on the model called Focusing Resources on Effective School Health (Strickland, 2011:16). People of India focus on the National Rural Health Mission for a close collaboration with the education sector which is essential at all levels while increasing the coverage of the school health programme (Prasad *et al.*, 2013:1). On one hand, in some countries like Nigeria there has been little collaboration at any level between the Department of Health and the Department of Basic Education, while on the other hand Tanzania has no collaboration attributed to weak national leadership (Ademokun *et al.*, 2014:1078; Borge *et al.*, 2008:84).

The research demonstrates that the lack of success of collaboration in Region C in the Gauteng Province as far as the managers participation is concerned, is a barrier to their development and implementation of the Integrated School Health Policy. The managers suggest that when the policy is at the formulation stage the Department of Health and Basic Education should take effort to involve them:

*“We are supposed to be there and it means they are supposed to ... introduce them to our level or just to know exactly what is happening”
(Primary healthcare facility manager 4).*

*“I could say that the constraint is that our government has got good policy but when it comes to the implementation it doesn't. It starts by doing the theory before preparing because as it is we are supposed to, when a primary healthcare clinic is a put in an area, to know that what are the functions which are going to take place, including the school nursing”
(Primary healthcare facility manager 2).*

4.2.3 Consultation

The research findings indicate there is poor interaction and lack of consultation between the school managers and primary healthcare facility managers and between the Department of Health and the Department of Basic Education. This poses a problem because the two departments have different priorities and, if there is no common

understanding or proper consultation then implementation of the Integrated School Health Policy will be difficult to achieve.

The contextual barriers for working in partnerships as experienced by the school managers and primary healthcare facility managers includes the task demands of the stakeholders involved to work in partnerships. Another challenge is that top-down imposed consultation is not likely to happen because the provincial departments that are supposed to be advocating for consultation in the programme do not take the context at implementation level into account (Mohamed, 2015:70):

“I’m not sure because we’ve not been getting that much of support but we’ve been dealing directly with the Department of Health as when they come to school we just address issues at that level and they don’t go further or get any response to that effect from the department” (School manager 2).

4.2.4 Resource availability

Appropriate resource availability and allocation are important considerations for the implementation of the policy. It is accepted that the important asset of any institution is its employees and their superiors. An institution is established to serve specific societal needs. Therefore, in order for an institution to attain its predetermined public objective, it must have managers and subordinates who are committed, motivated, educated and trained and willing to serve the public. That is, activities do not just take place, and people are responsible to see it that functions are performed. Therefore the human element is central to the success or failure of any institution in fulfilling its mandate. Stated differently, in order to implement any public policy successfully, the personnel play a crucial and decisive role.

The Department of Basic Education sets the policy framework with which the schools have to comply on the one hand, whereas the Department of Health is the main initiator of the Integrated School Health Policy on the other hand. In keeping with the settings approach, there are systems in existence which have to be considered as they influence the implementation of the policy. The availability of resources such as financial, human

and other non-monetary resources are needed to provide support in the implementation of the Integrated School Health Policy. In relation to the support for this policy, national grants are available to support the recruitment of additional nurses for school health although the transport issues in this respect are still incumbent upon the districts (Shung-King *et al.*, 2014: 64; Shasha *et al.*, 2011:301). However, the provision of necessary resources is a political problem rather than a logistical one, as it is the case with the implementation of policies (Mhizha, 2012:30).

The primary healthcare facility managers have the general view that integrated school health is not prioritised in Region C in the Gauteng Province, hence they raise concerns regarding the absence of skilled and experienced individual nurses in Region C in the Gauteng Province. The managers also highlight that highly experienced individual nurses are placed at provincial level. It appears that nurses with relevant experience in the field are placed in areas where they make little contribution, particularly in relation to the implementation of the school health policy. This situation can lead to failure in the implementation of the policy as articulated by the primary healthcare facility managers:

“Our government has got good policies but the implementation lacks especially the skilled, especially the people who are supposed to do the work, the nurses, are not enough”(Primary healthcare facility manager 2).

“It is normal for me to have four nurses and for them to have about fifty nurses that will be grossly abnormal. I think augmentation will need to be done somewhere” (Primary healthcare facility manager 1).

The responses given by the primary healthcare facility managers indicate that resources needed for implementation are of human resources in particular. In addition they affirm that no effective implementation can take place without the human resources in place. Again, it is clear that the managers know and understand that it is crucial that the performance of the managers requires that each member of a team be equipped with the necessary skills, expertise and knowledge about the policy. The participants are convinced that once these issues are dealt with appropriately, the implementation of the policy would be much easier, better and effective. In this regard, one of the primary

healthcare facility managers mentions that integrated school health is well implemented at provincial level because they have enough personnel and understand the policy. The primary healthcare facility manager articulated the following statement:

“The province or the government have their own policies and they have their own nurses” (Primary healthcare facility manager 2)

Moreover resource provision deals with the question of who gets what, when, how, where and from whom. The Department of Health as the initiator should provide the schools with school health nurses which is currently not the case, because the findings of this research indicate that the primary healthcare facility managers are entrusted with such responsibilities. Similarly, the Department of Basic Education should ensure that the school managers perform their managerial functions effectively in order for the policy to be implemented successfully (Department of Health, 2012:17). Furthermore, managers identified by the Integrated School Health Policy should have a common understanding to anticipate and influence change, make informed decisions about the policy, attract and absorb resources, manage and evaluate school health activities.

Effective implementation requires planning and the mobilisation of sufficient resources (Mthethwa, 2012:42). According to the primary healthcare facility managers, resources are not available in their primary healthcare facilities but are also not available in the community. This compounds the problem, as the primary healthcare facility managers are unable to supplement schools. As a result, the managers struggle to implement the policy successfully because of limited resources. In fact, whether or not the managers are able to achieve their goals depend on the ability to match their resources with those goals. The Integrated School Health Policy has tremendous potential to improve the quality of learners health, but it needs to be resourced more adequately. Therefore, the issue of lack of resources raised by the managers in this research needs to be handled soon:

“At the municipal level there is no school nurse, so if they can hire a school nurse, ok. They even said in the policy if ever there is no school nurse, a primary healthcare nurse can do the job but still we don’t have

enough primary healthcare trained nurses at municipality level” (Primary healthcare facility manager 2).

“Sometimes transport, because it all depends on who is going to do the outlying areas; do they have transport, are the cars available. I know the provinces have cars” (Primary healthcare facility manager 4).

“The policy speaks of the availability of a nurse and the availability of the SBST. As a result the two components in the very same policy falls within the school framework” (School manager 1).

“Where are we going to have place for having all these things of nursing because the school that we have now are not even accommodating the learners, and then if we have to do the nursing part that means we have to cut one class and put the clinic in that class” (School manager 3).

4.2.5 Unrealistic workloads

De Klerk (2013:79) notes that the school has a caring approach towards its learners health, therefore school managers act as facilitators by referring learners to primary healthcare facilities. This caused the managers to experience an increasing workload. As a matter of fact, the majority of the managers claim that they have huge workloads that prevent them from participating optimally in the implementation activities as it involves different key tasks. The responses from the managers indicate that they are unable to cope with the workloads at the facilities or clinics due to increased paper work from the department which limits their participation in the implementation of integrated school health services. In essence, the primary healthcare facility managers feel overwhelmed by the amount of work they are expected to do as regards their job.

Some of the primary healthcare facility managers cited excessive workload as the main problem because the primary healthcare workers at the primary healthcare facilities have to treat patients at the primary healthcare facilities on the one hand, whereas on the other hand they have to treat or consult with the learners referred by the provincial school health nurse from the schools:

“These patients are from schools coming to the clinic after being identified at the school. They are supposed to be at the clinic to be seen by a nurse. The child is supposed to be attended to immediately but, we don’t have skilled nurses for that” (Primary healthcare facility manager 2).

With regard to the challenges encountered in the implementation of the Integrated School Health Policy, the responses from some the school managers indicate that there is need for involving people with the necessary expertise. Furthermore, responses indicate that the school managers perceive integrated school health services as an added responsibility because after its introduction the school managers are faced with increased pressure to perform a wider set of roles than before. Again, this serves as an indication that the skills shortages is one of the factors that delay and hamper the implementation process, since most of the staff are not trained in school health components. Concerning improving the situation confronting the educators at schools as regards school health service, one of the school managers makes a suggestion:

“Adopt a health nurse to can work very closely with schools so that educators cannot become nurses at the end of the day” (School manager 3).

4.2.6 Training and development

In order for any public policy to be implemented successfully, it is important that all the implementers should undergo training which would enable them to understand what is actually expected of them. In addition, when the entire system or ways of doing things are changed, training is acutely needed. In support of this view Brynard (2009:563; 2007:37), states that training increases the implementers self-efficacy so that they believe they are more capable of performing the work at hand. Consequently, implementers are more likely to proceed if they feel confident in their ability to overcome possible barriers to transforming an intention into practice.

According to the Integrated School Health Policy, managers need to acquire the leadership skills which will enable them to perform their roles effectively during policy implementation (Department of Health, 2012:17). However, the policy does not state how

the school and primary healthcare facility managers are going to acquire the leadership skills. As a result, the managers contend that they may not appreciate the significance of the implementation of this policy or have a positive attitude due to lack of knowledge. Thus, Mohlabi *et al.*, (2010:253) and Mazibuko (2007:90) assert that school managers also require and deserve all the help available to turn the avalanche of reforms into workable practices.

Again, effective policy implementation depends on the building of capacity by relevant departments. This suggests that managers are likely to be effective if the department increases the efforts to organise training and workshops to equip the policy implementers with the necessary knowledge. However, the indication is that the managers are not well informed about the content of the public policy. The researcher is of the view that the Department of Health and the Department of Basic Education need to focus on strengthening the capacity of the managers so that they could acquire requisite skills and expertise to assist them in carrying out policy directives. The response indicates that the managers have not been trained and are not ready to implement the policy:

“So far there is nothing wrong about the Integrated School Health Policy, but I believe the only change which can be implemented to avoid these challenges is to do pre-training at school levels that can be integrated with nurses who can be deployed at schools to deal with the programme”
(School manager 1)

In the context of Region C in the Gauteng Province there is a lack of meaningful advocacy around the implementation of the Integrated School Health Policy. Also research findings indicate that there seems to be no doubt that insufficient training in the district has a deleterious effect on the development and success of policy implementation in general. Some of the managers indicate that they have not received any specific training regarding this policy and have not engaged with the actual document:

“We don’t even have the policy. It is at the second level which is provincial so we don’t even have the policy” (Primary healthcare facility manager 2).

4.3 ENABLING SYSTEMS FOR IMPLEMENTING THE INTEGRATED SCHOOL HEALTH POLICY

As noted above, successful implementation of the policy requires the creation of some enabling system. In this instance, participants reveal some of the important issues which are described below.

4.3.1 Support and capacity

The manner in which a policy is implemented or whether it is implemented at all depends heavily on the support from the upper structures of the institutions. On the question of what the Department of Health and Basic Education could do to improve the implementation of the Integrated School Health Policy, participants raise the issue of support for those who implement the policy, particularly at grass roots level. Taking into consideration the responsibilities and functions of the managers, it is evident that they are entrusted with huge functions but without support. The majority of managers indicate that lack of support to implement the Integrated School Health Policy is a major challenge in Region C in the Gauteng Province. In order to ensure that there is support for those who are responsible for implementing the policy, the establishment of district-based support as a central part for strengthening policy support services is indispensable.

It becomes clear that the schools and the primary healthcare facilities are not sufficiently resourced for the effective delivery of the programme as highlighted above. The issue of resources is a major concern in Region C in the Gauteng Province. The managers are without the necessary resources to enable them to execute their functions. Furthermore, issues such as transport, skilled staff and physical structures are some of the pervasive problems. The question that can be asked is whether there is sufficient capacity in Region C in Gauteng Province to implement the Integrated School Health Policy at schools. The issue of capacity has elicited mixed feelings from the participants:

“I don’t even have the capacity to run this clinic establishment effectively because nine times out of ten I am working, so Integrated School Health Services is something that is little bit far from here”(Primary healthcare facility manager 1).

Moreover, the findings of this research indicate that the implementation of the policy in the schools is negatively affected by lack of capacity. It is evident that the participants perceived the management’s capacity to implement the Integrated School Health Policy as one of the important factors that can ameliorate the implementation of the policy. As a matter of fact, policy implementation comes about when the administrative arm of government makes available human and financial resources to carry out the provisions of an adopted policy (Brynard, 2009:564). In this respect, the findings of this research are diametrically opposed to the argument put forward by Brynard (2009:564), because the managers report the absence of capacity building in relation to policy implementation.

4.3.2 Monitoring and evaluation

A public policy implementation process needs to be monitored in order to determine smooth implementation and to immediately deal with barriers to effective implementation. As a result, monitoring is a primary source of knowledge about policy implementation because it assists to establish whether resources and services provide intended results for specified target groups or beneficiaries. It thus provides a mirror for checking and ensuring there is a balance between efficiency and effectiveness. Whereas policy evaluation is a process of actions to determine the value or effectiveness of a policy with the aim of changing or rejecting it (Brynard, 2009:563), it also determines the continuity of policy implementation process.

In the context of this research, monitoring and evaluation involve what goes on in the schools and primary healthcare facilities to ensure that the Integrated School Health Policy is being implemented at the district or regional level. With regard to the issues of monitoring and evaluation of the Integrated School Health Policy, most of the managers state that they do not implement the policy since they struggle to obtain the resources to implement it. In fact, the research findings reveal that the majority of the school managers

and the primary healthcare facility managers have no insight in monitoring and evaluation processes.

According to Mthethwa (2012:40), monitoring and evaluation ensures accountability, improved performance and encouragement to do more. The research findings demonstrate that the school managers do not know that they should conduct monitoring and evaluation to obtain feedback about the effectiveness of the policy. A study conducted in the Amathole District in South Africa confirms that a hundred percent of school managers admitted that no audit was completed of the schools to implement the programme effectively, and they understood that there was no monitoring plan for the programme and only school managers had access to data stored in school for viewing (Restless Development South Africa, 2013:13).

Again, there is no movement from the Provincial Department of Basic Education to act as a link between the national and the district levels in ensuring that the school managers understand their roles in the implementation of the policy before monitoring and evaluation is conducted (Shung-King *et al.*, 2014:66). Besides successful monitoring and evaluation of public policy in any given area is essential, hence, information that is relevant, reliable and valid is required. Also, it is imperative to determine whether information about the Integrated School Health Policy outcomes are actually the correct indicators of what it is supposed to be measured (Brynard, Cloete & De Coning, 2011:137; Mbelu, 2011:27).

Furthermore, although the research findings indicate that school managers are clueless about monitoring and evaluation of the Integrated School Health Policy, one of the school managers regards the monitoring and evaluation as the system that aims at improving what needs to be improved in the schools, particularly with reference to the policy. A similar view was expressed by one of the primary healthcare facility managers that monitoring and evaluation is a system that needs to be re-implemented since integrated school health is not implemented in Region C in the Gauteng Province.

Regarding the strengths and weaknesses of monitoring and evaluation in the implementation of the Integrated School Health Policy, the responses of the primary

healthcare facility managers are based on what they know, especially that there should be a District Health Information System which yields school health coverage data. In essence, what they are reporting is that, until recently school health service data has been inconsistent and of poor quality, which disabled the monitoring of progress and impact as suggested by Shung-King, *et al.*, (2014:64). Furthermore, indicators are still under construction and not flexible enough to provide to give immediate feedback to managers.

In addition, it is important for the managers to be involved in the process and agreed-upon set of indicators and feedback system to track progress towards the achievement of results to facilitate a comprehensive and measurable process (Mthethwa, 2012:44; Shung-King *et al.*, 2014:64). Moreover, by receiving feedback and using information on how policy implementation progresses, implementers will be in a better position to assess interim achievements and make necessary corrections and consider themselves as part of a larger effort (Brynard *et al.*, 2011:157; Mthethwa, 2012:45). The primary healthcare facility managers recognise the importance of regular meetings, dissemination of information and use of feedback to assess progress toward achieving results:

“When we go and monitor and evaluate these things we will find out about all the problems they are having and then we will find out where we are getting to another level” (Primary healthcare facility manager 3)

One of the primary healthcare facility managers is of the opinion that the extent to which learners are assessed from schools and receive the required interventions is one of the important outcome measures of the school health service. However, given these challenges in monitoring, many of the intended outcomes and impacts of the Integrated School Health Policy can only be assessed through periodic evaluations and it will determine if it is in line with what the programme intended to accomplish:

“It should be done frequently, that’s the most important thing so as to identify problems” (Primary healthcare facility manager 3)

The primary healthcare facility managers agree that if there were monitoring and evaluation they would know by now what is expected from them in terms of implementation of the policy. In this regard, one of the primary healthcare facility

managers questions the manner in which the monitoring and evaluation approach is being implemented. On the other hand, some of the primary healthcare facility managers appear not to be opposed to the system per se but they oppose the manner in which the system is being applied.

4.4 ROLES OF MANAGERS IN THE DELIVERY OF THE INTEGRATED SCHOOL HEALTH POLICY

The managerial role of the school managers and primary healthcare facility managers refers to the different roles that the managers are required to perform in their institutions in order to ensure that the individuals and the institutional needs and goals are fulfilled. According to Mazibuko (2007:11), the managerial role of the school managers and primary healthcare facility managers as opposed to teaching and nursing, is to be the “glue” that holds the institution together. It is to direct not only the work of others but to provide guidance and direction that the institution should take.

4.4.1 Policy planning and implementation

Effective policy planning and implementation could be linked to the determination of those who are responsible for executing it. According to Brynard (2009:56) and Stofile (2008:83), if those responsible for carrying it out are unwilling or do not demonstrate any commitment, little will happen. In this regard, Brynard (2009:561) refers to commitment as the ability to maintain the focus on an initiative from its inception through to its delivery. Furthermore, Brynard (2009:56) states that commitment is mainly a top-down issue while others regard commitment as something that has to be developed from the bottom up.

Although, the school managers and primary healthcare facility managers demonstrate their understanding of their role as planners and implementers of the policy in question, the findings indicate that there is a degree of absence of commitment to the implementation of the policy, hence the managers, School-Based Support Team and the Health Support Team do not see the Integrated School Health Policy as their fundamental responsibility. Also, the participants feel that the Department of Health and the Department of Basic Education’s inability to prioritise the policy is considered to be the

main issue in Region C in the Gauteng Province. There is also a perception that nobody from Department of Health and the Department of Basic Education is held accountable for lack of proper implementation of the policy. While the managers are trying to adopt the policy the department concerned seems to be responding at a sluggish pace:

“Most of the time when you apply they take a very long time. Even if you apply for a regular thing, they take a very long time to answer, not even coming for the meetings, not even coming” (School manager 3).

“We’ve been dealing directly with the Department of Health and when they come to school we just deal with issues at that level and they don’t go further or get any response to that effect from the department” (School manager 2).

The lack of government commitment to policy implementation in Region C in the Gauteng Province is the main reason for the delay or non-implementation of the policy. However, the managers claim to be determined to commit in implementing the policy. Nevertheless, there are conditions that make it difficult for the managers to fulfil their tasks and duties in the implementation of the Integrated School Health Policy. The school managers and the primary healthcare facility managers mention that the policy content is also problematic. In fact, the primary argument is that the context in which they have to implement the Integrated School Health Policy is not conducive to their tasks as implementers. In addition, there are no clear guidelines on how they should implement the policy. This condition presumably forces them to withdraw from implementing the policy:

“Here is the programme coming to a school contradicting the very same policy and the expertise of department” (School manager 1).

With regard to the constraints that confront the managers primarily as the implementer of the policy, there are varied remarks. On the one hand, the school managers mention that the policy contradicts itself, whereas the primary healthcare facility managers say they do not have the policy. One of the school managers who manages the health promoting

school mentions that there is no condition that prevents the implementation because the provincial staff comes and implements it:

“No, there are no conditions that make it difficult because we make pre-arrangements for when visits are at school” (School manager 2).

Another important finding, yet peripheral issue to this research, is that the school managers experience a lack of parent involvement in the policy implementation process. School managers accentuate the fact that the involvement of the parents would help them to attain policy objectives. Nevertheless, that would not automatically guarantee a success, because people tend to respond differently to any policy. As a matter of fact, the response of the people toward policy implementation, determines the success or failure of that particular policy (Brynard, 2011:137). Moreover, the attitude of the people to be affected by any policy has a great impact on the implementation of that particular policy. Thus, for the implementation of the Integrated School Health Policy to succeed, all the stakeholders (including parents) should develop a positive attitude and should not only be involved at the initial stage of policy but during the implementation process as well:

“... failure of understanding what this programme entails as parents as some of them deny that their learners can be part of the problem itself” (School manager 2).

4.4.2 Decision-making and problem-solving

The school managers and the primary healthcare facility managers view their roles as decision-making and trouble-shooting, hence they express frustration pertaining to a lack of involvement in policy implementation. The responses indicate that most of the participants feel that they are limited in terms of knowledge about the policy. In fact, the situation makes it difficult for them to play an active role as decision-makers in policy processes due to their seclusion. Furthermore, the managers mention that the starting point towards dealing with their plight is to supply them with the requisite knowledge and skills:

"We must acquire more knowledge, we must be given knowledge, attend workshops, the department should give us workshops on these things"
(School manager 1)

Some of the school managers mention that there is a need in the departments concerned to prevent failures by providing clarity about the meaning and the object of the policy. Clarity about the policy could assist managers in making informed and ethical decisions as the implementers of the policy, especially when considering the fact that the policy in question targets young school children who may also be vulnerable. In this sense, Restless Development South Africa (2013:14) note that it is difficult for the school management staff to claim that they have any in-depth knowledge of the Integrated School Health Policy. Again, there are no School Health Team in place at schools, which complicates decision-making processes in as far as the policy implementation is concerned.

In fact, the context in which the policy was developed and placed is of no use to the managers. Instead this responsibility of the policy implementation is handed over to the managers. The Department of Health and the Department of Basic Education apply the top-down approach which leads to the fact that those who are responsible for implementing the policy find themselves clueless about what they need to do towards the realisation of policy goals:

"The Department of Basic Education needs to come on board and see how best they can change the situation" (School manager 1).

One of the school managers holds the view that the ambiguities in the policy document create space for multiple interpretations of the policy. The circumstances such as this complicate the manager's role in his organisations her quest to resolve problems in the course of implementing the policy:

"There are lot of contradictions in the departmental policies. Yeah what I understand is that these are two different departments in terms of health and education. Initially they were two different departments but when you look at this policy, the policy is suggesting in a way that there should be

integration. The two should be working hand in hand in terms of trying to deal with problems and challenges that are happening in the schools. What is not clear is what informs that in terms of mishaps in schools but in terms of policies to this is not clear” (School manager 1).

Furthermore, the participants feel that the contradictions between the departmental policies in terms on the implementation gap prevents the managers from effectively using and applying their own discretion regarding solutions to the problems which they detect, because of the manner in which policies are introduced with degrees of obscurity. Consequently, this leads to uncertainty about what is intended by the policy and how it should be implemented. The policies of the Department of Health and the Department of Basic Education appear to be contradicting, particularly with reference to how the Integrated School Health Policy should be implemented. Furthermore, the school managers are of the opinion that policy must be translated so that everyone involved in the implementation can fully understand and allow them to use a bottom-up approach:

“We acknowledge the fact that we are getting campaigns from Department of Health, but it would have been proper when the policy was supposed to have been mediated thoroughly so that we understand exactly what it entails”(School manager 1).

4.4.3 Policy evaluators

The managers reported that their core function is to implement the policy, but they also recognise that their roles extend beyond policy implementation. Again the managers raise a point that the effectiveness of the integrated school health programme depends on the roles played by them as they are required to function in a number of areas not necessarily their core function. Such functions include policy evaluation, which is useful in determining whether the managers have carried out their given task to achieve set objectives.

Managers describe their roles as policy evaluators because of the decisions they make during policy implementation. In this instance, the managers main focus is not only on the policy aspects that have not been working properly, but rather on what has been achieved in terms of policy evaluation. Again, such decisions determine whether to continue with

the implementation of a policy or curtail or terminate or expand it (Ramma, 2010:12). This is illustrated by the following primary healthcare facility managers comment:

“The facility manager must have the policy, she must adhere to the full policy and then she must check if whatever was delegated has been done” (Primary healthcare facility manager 2).

The research findings indicate that managers are aware that they are required by the Department of Health and the Department of Basic Education to guide and supervise the effective implementation of the policy. Moreover, managers feel that they are obliged to seek answers in an attempt to resolve the potential problems within a programme because evaluation during the implementation process the characteristics of an early warning:

“Evaluation should be done frequently to identify problems and solve them at an early stage” (Primary healthcare facility manager 3).

However, the research findings indicate that managers are uncertain about who is primarily responsible for or who has primary ownership over policy evaluation. There are perennial uncertainties regarding the execution of evaluation. Perhaps this could be attributed to the fact that there are two government departments that are given the responsibility of implementing the Integrated School Health Policy. Again, the situation could be exacerbated by the inability to track the progress made in the implementation of the policy, particularly if there are no clear indicators or standards against which progress is going to be measured. The challenge associated with who is going to be responsible for policy evaluation lies not only in what should be changed in terms of content areas, but, how the implementation phase could be enhanced by providing greater clarity on matters that currently cause some confusion.

Managers are of the opinion that their exclusion from the provincial meetings compromises the quality of policy implementation. Again, the school managers report that they still need to become familiar with the policy itself and know how to implement it because policy evaluation focuses on the process, the content and the effects or performance of the policy. The managers emphasise that if given the opportunity to

evaluate the policy, the learning experience from evaluating the policy will be greatest when the evaluation takes place during the implementation process. Furthermore, policy evaluation will assist them to get direct short term feedback which is possible between the vision and aims and those goals that are being reached:

“... to evaluate whatever discussed is being implemented and then if implemented, is it implemented in a correct way” (Primary healthcare facility manager 2).

The managers as policy evaluators can, however, only play this role if they have the insights and knowledge about the content of the policy. In fact, policy evaluators take the time needed to find out what exists and what does not. It can be argued that it should be the Department of Health and the Department of Basic Education's business to communicate the policy in such a way that the policy evaluators never have to search for the information needed.

4.5 SUMMARY

This chapter has presented the extent to which the school managers and the primary healthcare facility managers are knowledgeable about the Integrated School Health Policy in Region C in the Gauteng Province. This is demonstrated by numerous challenges facing the managers in the implementation of the above-mentioned policy, such as a lack of communication, collaboration and consultation. Managers report that policy implementation is of value if it establishes communication between all the stakeholders. Again, the message conveyed by means of communication enables all the stakeholders to achieve the purpose.

The findings reveal that the participants do not have the capacity to perform duties placed upon them by the Integrated School Health Policy. Hence, managers do not see the implementation of the Integrated School Health Policy as their fundamental responsibility due to lack of resources, unrealistic workloads, lack of training and development. Again, the success of the policy rests upon the experiences of the managers contributing greatly towards the non-implementation of the policy. The managers feel that their workloads

makes it impossible to implement the policy. In addition, the managers mention that the increasing unrealistic workload leads to the frustration of managers who have not been adequately consulted during the policy-formulation. Furthermore, managers report that they are not properly trained to implement the policy effectively, yet they are expected to ensure that the policy is successfully implemented.

Managers consider lack of support and capacity as some of the major constraints during the implementation of the policy. In fact, support is not provided to the school managers as well as the primary healthcare facility managers even when concerns are raised in this regard. The findings indicate that a minimum condition for successful implementation is to have the requisite administrative ability which is resource availability and the capacity to implement the policy.

The research findings indicate that the school managers have less insight about the enabling systems required for the successful implementation of the Integrated School Health Policy. For instance, they have minimal insight in monitoring and evaluation of the policy; although, the primary healthcare facility managers appear to have insight about monitoring and evaluation.

The findings reveal that actors charged with the implementation of the Integrated School Health Policy are not committed. This is demonstrated by an inability to prioritise the policy as the policy planners and implementers see this as the main issue in Region C in the Gauteng Province. While both implementers (school managers and primary healthcare facility managers) generally report appreciation for the value of integrated school health services, they also point to key challenges such as a lack of involvement or prioritisation of school health services by the Department of Health and the Department of Basic Education which impede their policy decision-making and problem-solving efforts.

Moreover, managers regard the Integrated School Health Policy as an added responsibility, because after its introduction they became the implementers and at the same time policy evaluators, which increased pressure to perform a wider set of roles than before. Again, school managers report that they are expected to evaluate the policy in activities concerning health matters while the primary healthcare facility managers are

expected to evaluate the policy in matters concerning the schools. The extension of the roles and responsibilities lead to the policy not being successfully implemented. The following chapter concentrates on the summary, conclusions and recommendations.

CHAPTER 5

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 INTRODUCTION

The previous chapter has presented the findings and discussion regarding the managers knowledge and role in the implementation of the Integrated School Health Policy. This chapter presents a summary of the findings, conclusion and recommendations. The summary of the findings will be related to the secondary objectives of this research whereby the emphasis is placed on the main discoveries. This is followed by a conclusion which demonstrates whether or not new evidence pertaining to the problem has been identified. Also, the implications for practice, in particular, the implementation of the Integrated School Health Policy by the Department of Basic Education and the Department of Health are clearly stated. This chapter concludes with the recommendations for implementation.

5.2 SUMMARY OF FINDINGS

The summary of the findings reflects on the secondary research objectives in order to demonstrate the extent to which the objectives have been met.

5.2.1 School managers and primary healthcare facility managers knowledge about the process of implementation of the Integrated School Health Policy

The findings of the research show that the managers shared the common goal of looking at establishing the communication channels between all the stakeholders involved. However, they had different views on how the communication is handled within Region C in the Gauteng Province because they demonstrate less understanding and knowledge about what needs to be emphasised during the implementation process. Again, managers are of the opinion that poor communication create a gap between the policy objectives and implementation. Therefore, the researcher contends that communication among all levels, especially between the managers, needs to be improved to ensure effective and successful implementation of the policy.

The school managers within Region C in the Gauteng Province indicate that there is a notable challenge in the implementation of the Integrated School Health Policy. Amongst such challenges is that collaboration between the School-Based Support Team and the Health Support Team do not exist. In addition, the managers observed the fact that collaboration amongst them is poor because of inter-departmental dynamics that exist in the schools and primary healthcare facilities. Again, the managers report that they are unable to share their expertise, knowledge and skills to stakeholders due to lack of collaboration.

The managers also note that the government should identify the stakeholders through consultation in order to influence the policy implementation process. Moreover, the managers have diverse and conflicting ideas regarding what the Integrated School Health Policy means and how it should be implemented and by whom. In fact, the availability of human resources should be the determining factor when the decisions are made as to whether to implement the policy (Stofile, 2008:89). For example, no decisions can be made in respect of policy implementation unless this is done in consideration of the availability of the resources.

Furthermore, the findings indicate that there are major gaps in the managers expertise, skills and knowledge in understanding the implementation of the Integrated School Health Policy. In addition, the managers feel that their initiatives concerning the policy implementation is not valued by the provincial Department of Health and the Department of Basic Education since such initiatives are not considered due to the demand of resources.

Although the managers do not explicitly state that they are negative towards the introduction of the Integrated School Health Policy in addition to their daily duties, the findings reveal that the majority of the managers hold underlying feelings of negativity towards the Integrated School Health Policy. This could be attributed to the lack of capacity to implement the policy because the policy requires an investment in the resources that enable the managers to cope with complexities that come with the implementation of the policy (Makhalemele, 2008:18)

The findings of the research indicate that support for the implementation of the Integrated School Health Policy is lacking from the side of the provincial Department of Health and the Department of Basic Education. This includes inadequate support for the managers who are determined to implement the policy but are not adequately empowered to do so. The provincial Department of Health and the Department of Basic Education task team do follow up to ascertain whether the managers are implementing the policy. As a matter of fact, this could be done through observation sessions of the workload at the primary healthcare facilities and schools. In essence, it is not reasonable to expect the managers who are the implementers of the policy to accept the new roles and responsibilities as well as changes prescribed by policy without empowering them through training workshops.

The need for formal training for managers needs to be emphasised, particularly when the system or ways of doing things are changed completely. To give effect to proposed changes or to enhance the level of efficiency and productivity, managers need a diversity of training and development programmes. Managers confirm that training and development at the district level is needed to increase their managerial skills. For sustainable implementation of the Integrated School Health Policy they need the skills to manage the implementation (Whitman, 2009b:56).

5.2.2 Enabling systems that can be introduced to assist the school managers and primary healthcare facility managers in the implementation of the Integrated School Health Policy.

The research participants highlight different challenges which prevent them from implementing the policy effectively and consequently failed to achieve their set objectives particularly that of reaching all learners at district level. The challenges are attributed to various factors as summarised below.

The findings indicate that the managers are not able to implement the Integrated School Health Policy as prescribed or recommended by the Department of Health and the Department of Basic Education due to various reasons such as support and capacity which are beyond their control. Therefore, the provincial Department of Health and the

Department of Basic Education should provide the necessary to the schools and the primary healthcare facilities in order to ensure success in the implementation of the policy. In fact, such a support should entail making resources (financial, non-financial and human resource) available and training those who are responsible for implementing the policy. Hence the managers call upon the Department of Health and the Department of Basic Education to create the conducive environment for the effective implementation of the policy.

Although, the findings show that the managers feel that their capacity to implement the policy is wanting. There is a degree of progress in the implementation of the policy by provincial departments since its inception. There is still more that has to be done at the district level. The managers indicate that the policy was imposed on them, which placed them under immense pressure due to lack of capacity and lack of expertise in interpreting and implementing the policy. They didn't have the time to explore different ways of implementing it.

The research findings indicate that there is no clear monitoring and evaluation tool in place to support the implementation of the Integrated School Health Policy. The researcher is of a view that the development of a monitoring and evaluation system that functions within the policy should be of great importance for the successful implementation of the policy. Furthermore, it would assist to determine whether progress is being made and the extent of the progress. This would also present the implementers with an opportunity to review their strategies in the implementation process, particularly when there is no sufficient progress. In this regard, the managers indicate that they should be consulted regarding the formulation of the monitoring and formulation of the policy concerned.

Although, policy implementation has to achieve its intended objectives, monitoring should be an on-going, coordinated process and allow other stakeholders to have an input in the process (Mthethwa, 2014:58). Thus, the managers have to generate information about the causes and consequences of public policy as well as the determination of the value or worth of policy outcomes. Monitoring and evaluation should become a regular feature

in the implementation of the policy, as it determines how the way the policy is being implemented reaches its intended targets (Mbelu, 2011:27).

All participants reveal that policy implementation monitoring and evaluation (which serves as an invaluable tool in policy management) is not done at all. A critical aspect is to review the development of new monitoring and evaluation indicators that will be used to measure the degree to which integrated school health policy goals and objectives have been achieved.

5.2.3 Roles played by the school managers and primary healthcare facility managers in relation to the delivery of integrated school health services

Integrated school health services provide an opportunity for managers to explore new and innovative ways of delivering integrated services in the schools and primary healthcare facilities. Therefore, managers explain that the new roles brought by the Integrated School Health Policy require new ways of thinking hence, managers have to work out a joint plan of how to successfully implement the policy as role players who are at the forefront of managing, delivering and receiving the school health services. However, the conditions of work do not change to accommodate the Integrated School Health Policy. It is thus regarded as an extra load to the already overloaded managers and leads to an absence of commitment.

The research findings indicate that the managers have a central role in ensuring that policy planning and implementation is taking place at the district level. In fact, managers indicate that they are identified as planners and implementers of the policy because the Department of Health and the Department of Basic Education refers everyone to them for guidance, direction and assistance. Again, managers report that it is difficult to get clarity on certain issues regarding the implementation of the policy as there are no clear guidelines on how they should implement the policy. The emphasis is placed on the role of the managers when it comes to the translation of policy initiatives into practice because the success of the policy is linked to the effectiveness of the person who plan and implement it.

Managers describe their roles when implementing the policy as participation at individual level with little or without effective involvement of the other stakeholders such as School-Based Support Team and Health Support team and parents. The unexpected finding is that the Health Support teams do not form part of the decision-making and problem-solving although the policy stipulates that the team should indeed be part of this (Department of Health, 2012:17). The non-participation of the teams in decision-making and problem-solving results in it that the role of decision-making and problem-solving is shifted to the managers. This implies that the Integrated School Health Policy is a programme that is implemented at school and primary healthcare facility level without the involvement of the teams.

The roles of the managers as stipulated in the policy is that school managers have the overall responsibility to ensure that the Integrated School Health Policy is implemented uniformly and effectively at the schools with the assistance of the primary healthcare facility managers (Department of Health, 2012:17). Hence, managers report that they should be involved at the formulation stage whereby policy decisions are translated into action in order to yield the intended outcomes. Again, the managers are of the opinion that their exclusion from the provincial meetings compromises the quality of decision-making and problem-solving during the policy implementation. Furthermore, managers believe that they will have the ability to take ownership of a policy initiative and maintain it until the intended outcomes are achieved. In this case, this will give them a sense of belonging and therefore a sense of commitment.

Managers know that their role is to evaluate the policy for the purpose of identifying the strengths and weaknesses of the policy. Hence, evaluation not only pinpoints the consequences of policy, but also helps to determine the success of policy (Mazibuko, 2007:293). Again, managers report that the context in which they operate is not the same, for example, the school managers core purpose is teaching. On the other hand the primary healthcare facility managers core purpose is nursing. Therefore, the managers as policy evaluators should take the context of one another's roles into account when conducting policy evaluation. All this is with the aim to ascertain whether there is an improvement in policy implementation or not (Makhalemele, 2010:158). Managers

indicate that although the Integrated School Health Policy is an initiative of the Department of Health and the Department of Basic Education, the departments do not interact with them to ensure that they understand their role in policy evaluation. Without the support of the provincial departments the managers are unable to identify the weaknesses and priority needs of the policy.

Managers report that policy evaluation can only take place if the implementers not only understand the policy but also understand their respective roles. Again, for policy evaluation to be successfully conducted, all those affected by it should have a clear understanding of its purpose (Mazibuko, 2008:196). The managers raise a concern that they are aware that they are required by the Department of Health and the Department of Basic Education to guide and supervise the effective implementation of the policy. However, without the understanding their role as policy evaluators it would be difficult for managers to commit. Therefore, managers should be made aware as to why they are regarded as policy evaluators and policy evaluation is their requisite role in this policy.

Partial implementation and non-implementation of the policy at Region C in the Gauteng Province is a clear indication that the managers do not have a clear sense about their roles as policy evaluators. Furthermore, the Department of Health and the Department of Basic Education do not encourage the managers to do self-evaluation prior to the external evaluation to evaluate if the policy evaluation is conducted according to the set criteria and guidelines. Hence, the researcher concurs that without policy evaluation one cannot measure whether the institution is achieving its objective or not (Mthethwa, 2014:59).

5.3 CONCLUSIONS

The main research objective was to describe and explain the extent to which school managers and primary healthcare facility managers are knowledgeable and aware of their roles in the implementation of the Integrated School Health Policy in Region C in the Gauteng Provincial Department of Basic Education. The school managers and primary healthcare facility managers demonstrate extensive knowledge about the various challenges that could impede the smooth implementation of the Integrated School Health policy in Region C in the Gauteng Province. Amongst the different challenges raised by

the managers are: poor communication, lack of collaboration, lack of consultation and lack of resources. However, the research findings reveal that the managers are uncertain about who is primarily responsible for, or who has the primary ownership over the integrated school health services. This is attributable to the fact that there are two departments (Department of Health and Department of Basic Education) that are charged with the responsibility of implementing the policy regarding the health services.

A number of questions arise from the managers regarding that in which department the school health services should be “housed” or “located” and how it should be integrated with the Care Support Teaching and Learning framework. There is a need to create collaboration between the Department of Health and the Department of Basic Education because it could enable the managers to identify what they need to do together and share their expertise.

The resultant effect is that integrated school health services do not have clear operational lines of accountability and is not well organised, coordinated or managed in Region C in the Gauteng Province. Therefore, a good relationship needs to be established with the managers to understand the objectives, conditions and constraints in order to increase efficiency and effectiveness during policy implementation. Clear guidelines, control and a clear chain of events from the Department of Health and the Department of Basic Education should be set to help the managers to understand and embrace the need for change. These guidelines and control systems can be understood by the managers if clear communication channels are established to convey additional information regarding the implementation process.

In reality, unless the Integrated School Health Policy is given some degree of specific attention by the managers, the school health services will not be delivered satisfactorily or effectively. While it appears that the Provincial Department of Health is the one responsible for implementing the policy, it is currently facing a major challenge due to insufficient resources at the regional or district level. Therefore, the district level requires concerted leadership efforts at provincial and district level to ensure that the managers are properly supported to provide the school health services.

The creation of formal service level agreements on the delivery of integrated school health services within the schools and primary healthcare facilities must be considered between the Department of Health and the Department of Basic Education as the absence of this result in a poor decision-making process. As a matter of fact, the provision of integrated school health services by one department in the “backyard” of another requires joint planning and mutual support between the Department of Health and the Department of Basic Education. Therefore, the researcher suggests that for the management of the integrated school health services, there is a need for a single management platform for the implementation of the policy. Apart from the creation of single platform for policy implementation, it is essential to ensure that there are proper monitoring and evaluation systems in place in order to track the progress that is being made. To this end, those who are responsible for monitoring and evaluation processes should be well-resourced and possess the capacity to be able to carry out such responsibilities.

Again, the school managers and primary healthcare facility managers play an important role in the implementation of school health policy, particularly as planners, implementers, decision-makers, problem-solvers and policy evaluators. Although managers are aware of their important roles; they are unable to fulfil them due to poor coordination and collaboration as indicated above. In this regard, the managers should be empowered so that they can actively perform their functions without any hindrance. In fact, they must be furnished with timely, relevant and accurate information in relation to the implementation of the policy. Importantly, there must be clear performance indicators against which progress can be measured or evaluated.

5.4 RECOMMENDATIONS

The school managers and the primary healthcare facility managers demonstrate little knowledge about what needs to happen in order to implement the Integrated School Health Policy successfully. Although the managers are more conscious about the challenges that are constant in the implementation of the policy, the Department of Health and Basic Education should ensure that managers are skilled and more knowledgeable in carrying out the policy objectives.

Workshops that are intended to equip the managers with proper managerial skills should be organised. It is important, however, that these workshops should be organised at convenient times so that most of the stakeholders could be accommodated. Furthermore, there is a need to have key stakeholders to meet regularly to discuss school health matters. Open communication is necessary among these various stakeholders to deal with and educate one another about the relevance of this policy. For example, communication channels should be created where stakeholders can raise their views and concerns about the Integrated School Health Policy and how it should be implemented. This can help to stipulate a clear chain of events for the implementation of the Integrated School Health Policy, including the plans and time frames and furthermore, collaborate with managers in an attempt to keep up with its deadlines.

The relationship between the Department of Health and the Department of Basic Education at school and primary healthcare facilities should be formalised to allow permanent structured relationship between the managers and stakeholders to increase the willingness and commitment to engage with one another. It should be the responsibility of the provincial task team to oversee training and development and ensure that all the managers are able to understand the policy and implement it effectively. Thus, the provincial task team should actively support the managers in ensuring that indeed policy implementation takes place at the school and primary healthcare facility level. Again, this can be done through reallocation of human resources to be able to deliver this essential service because the managers cannot function well without resources.

The provincial task team for integrated school health should be involved in the monitoring and evaluation of the Integrated School Health Policy by creating a system rather than relying on managers. The process of monitoring and evaluation should be undertaken on a quarterly basis and should be initiated by managers. Again, the provincial Department of Health and Basic Education should maintain an accessible provincial database on the findings from policy implementation on monitoring and evaluation that can be used to refine indicators and provide benchmark data. Benchmark data will enable the managers to compare their performance to the performance of districts having similar characteristics to their own.

The provincial task team for integrated school health should not only receive the Department of Basic Education support forms from the school managers at the end of the year for possible retainees, but should monitor and evaluate the process from the beginning of the year in collaboration with the managers. This should be done to ensure that there are officers who are held accountable for the progress of the implementation of the policy at district level as policy evaluators. The managers should have the same level of awareness and common understanding to make informed decisions in terms of policy implementation.

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APPENDIX A

INTERVIEW SCHEDULES FOR SCHOOL MANAGERS

INTERVIEW SCHEDULES FOR THE SCHOOL MANAGER

Topic: The implementation of the Integrated School Health Policy in the public primary schools of Region C in the Gauteng Province

QUESTION 1

Objective: To describe the extent to which school managers know about the implementation of integrated school health policy.

- 1.1 Would you please tell me about the preconditions for successful implementation of Integrated School Health School Policy?
- 1.2 Who are the stakeholders involved in the implementation of Integrated School Health Policy?
- 1.3 Besides the stakeholders, who are the target group of the Integrated School Health Policy?
- 1.4 What strengths and opportunities presented by the Integrated School Health Policy?
- 1.5 Again, what do you think are the challenges or constraints to the implementation of Integrated School Health Policy?
- 1.6 With due consideration of the challenges, what changes would you suggest to ensure smooth implementation of the Integrated School Health Policy?

QUESTION 2

Objective: To explain the enabling systems that can be introduced to assist the school and managers in implementation of the integrated school health policy.

- 2.1 What do you think the Department of Basic Education can do to assist schools in the implementation of Integrated School Health Policy?

2.2 Is there a way through which the Department of Basic Education can respond to the challenges encountered in the implementation of Integrated School Health Policy? Elaborate your answer?

2.3 Do you think there is capacity to implement Integrated School Health Policy at schools? What else do you think needs to be done in order to improve capacity at schools?

2.4 What do you think are the strengths and weaknesses of monitoring and evaluation in the implementation of Integrated School Health Policy?

QUESTION 3

Objective: To describe and explain the roles played by the school managers in relation to the delivery of integrated school health services.

3.1 School managers have an important role to play in the implementation of Integrated School Health Policy. What do you think primary healthcare facility manager should do as part of their involvement in policy implementation?

3.2 Do you have School Based Support Teams for implementing the integrated School Health Policy? If not, how do you ensure the progressive implementation? If you have a support team how do you ensure that School Based Support Team successfully implement the Integrated School Health Policy?

3.3 Do you think there are any conditions that make it difficult for school managers to fulfil their task/duties in the implementation of Integrated School Health Policy? Elaborate your answer?

3.4 What do you think the school managers need to prevent failures during the implementation of Integrated School Health Policy?

Question 4

Do you have any comments that you would like to add to what you have said so far?

Thank you for taking part in this interview!!!!

APPENDIX B

INTERVIEW SCHEDULES FOR PRIMARY HEALTHCARE FACILITY MANAGERS

INTERVIEW SCHEDULES FOR THE PRIMARY HEALTHCARE FACILITY MANAGER

Topic: The implementation of the Integrated School Health Policy in the public primary schools of Region C in the Gauteng Province

QUESTION 1

Objective: To describe the extent to which primary healthcare facility managers know about the implementation of integrated school health policy.

- 1.1 Would you please tell me about the preconditions for successful implementation of Integrated School Health School Policy?
- 1.2 Who are the stakeholders involved in the implementation of Integrated School Health Policy?
- 1.3 Besides the stakeholders, who are the target group of the Integrated School Health Policy?
- 1.4 What strengths and opportunities presented by the Integrated School Health Policy?
- 1.5 Again, what do you think are the challenges or constraints to the implementation of Integrated School Health Policy?
- 1.6 With due consideration of the challenges, what changes would you suggest to ensure smooth implementation of the Integrated School Health Policy?

QUESTION 2

Objective: To explain the enabling systems that can be introduced to assist the primary healthcare facility managers in implementation of the integrated school health policy.

- 2.1 What do you think the Department of Health can do to assist schools in the implementation of Integrated School Health Policy?

2.2 Is there a way through which the Department of Health can respond to the challenges encountered in the implementation of Integrated School Health Policy? Elaborate your answer?

2.3 Do you think there is capacity to implement Integrated School Health Policy at schools? What else do you think needs to be done in order to improve capacity at schools?

2.4 What do you think are the strengths and weaknesses of monitoring and evaluation in the implementation of Integrated School Health Policy?

QUESTION 3

Objective: To describe and explain the roles played by the primary healthcare facility managers in relation to the delivery of integrated school health services.

3.1 Primary healthcare facility have an important role to play in the implementation of Integrated School Health Policy. What do you think school managers should do as part of their involvement in policy implementation?

3.2 Do you have School Health Support Teams for implementing the integrated School Health Policy? If not, how do you ensure the progressive implementation? If you have a support team. How do you ensure that School Health Support Team successfully implement the Integrated School Health Policy?

3.3 Do you think there are any conditions that make it difficult for primary healthcare facility manager to fulfil their task/duties in the implementation of Integrated School Health Policy? Elaborate your answer?

3.4 What do you think the primary healthcare facility manager need to prevent failures during the implementation of Integrated School Health Policy?

Question 4

Do you have any comments that you would like to add to what you have said so far?

Thank you for taking part in this interview!!!!

APPENDIX C

PARTICIPANT INFORMATION SHEET FOR SCHOOL MANAGERS

PARTICIPANT INFORMATION SHEET

Title: The implementation of integrated school health policy in primary schools of Region C of the Gauteng Province

Dear Prospective Participant

My name is Rebecca Lenkokile and I am doing research under the supervision of Mr. P.Hlongwane and Prof.V.A. Clapper, lecturers in the Department of Public Administration and Management towards a Master's Degree at the University of South Africa. We are inviting you to participate in a study: "The implementation of Integrated School Health Policy in primary schools of Region C in the Gauteng Province"

I am conducting this research to find out how the Department of Health and Basic Education ensure effective implementation of Integrated School Health Policy. The researcher obtained the contact details of the prospective participants at the Gauteng Provincial Department of Basic Education database. The prospective participants were chosen because they can provide with the information as well as the first hand experiences on the implementation of Integrated School Health Policy. Atleast five school managers that implement the policy are invited

The study involves attending semi- structured interviews for 45-60 minutes describing and explain various ways to ensure successful implementation of the Integrated School Health Policy. The interview will be undertaken at your workplace at your most convenient time. Participating in this study is voluntary and you are under no obligation to consent to participation. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a written consent form. You are free to withdraw at any time and without giving a reason.

The study is intended to empower school managers in their leadership role in managing integrated school health services in their schools. It will particularly look at the experiences encountered by the school managers when implementing the Integrated School Health Policy. Again it will further describe and explain the extent which school managers and primary healthcare facility managers possess knowledge and awareness of their roles in the implementation of Integrated School Health Policy in Region C in the Gauteng Province. There is no risk involved, however the researcher is going to utilise their time which might cause some discomfort or inconvenience to participant who have busy schedule. The researcher will assure the participants that anything that will be discussed during the research would be kept confidential and would not be used for purposes other than this study. The recordings that will be made during the research process will ensure that the whole discussion is captured and provide complete data for analysis.



This means that cues that will be missed the first time can be recognized when listening to the recording good quality transcribing will include tone and inflection, because only a small portion of the message is communicated in actual words. Participants will be assured that all information that would be provided by them would be strictly confidential and that their identities would not be revealed in any record or report and that there would be no link between the data and the participants. To ensure this, code or pseudonym on names for participants, schools will be used to ensure anonymity.

The researcher and the supervisor will have access to your answers and may be reviewed by people responsible for making sure that research is done properly, including the transcriber, external coder, and members of the Research Ethics Review Committee. Otherwise, records that identify you will be available only to people working on the study, unless you give permission for other people to see the records. Hard copies of your answers will be stored by the researcher for a period of five years in a locked cupboard/filing cabinet for future research or academic purposes. Electronic information will be stored on a password protected computer. Future use of the stored data will be subject to further Research Ethics Review and approval if applicable. Hard copies will be shredded and/or electronic copies will be permanently deleted from the hard drive of the computer through the use of a relevant software programme. The researcher will use Unisa policy on how to destroy the electronic data. There will be no payment or reward for the study. This study has received written approval from the Research Ethics Review Committee of the Unisa and Johannesburg District Research Committee. A copy of the approval letter can be obtained from the researcher if you so wish.

If you would like to be informed of the final research findings, please contact Rebecca Lenkokile on 0722763698 lenkokiler@yahoo.com. The findings are accessible for period of 6 months. Should you require any further information or want to contact the researcher about any aspect of this study, please contact 0722763698 lenkokiler@yahoo.com.

Should you have concerns about the way in which the research has been conducted, you may contact Mr. Hlongwane the Supervisor on 0124298499 hlongp@unisa.ac.za alternatively, contact The Director: Knowledge Management and Research Mr. David Makhado on 011 355 0560 or email address on David.Makhado@gauteng.gov.za Or Deputy Chief Education Special: Research Coordination Mr. Gumani Mukatuni on 011 355 0775 /082 515 5412 or email address on Gumani.Mukatuni@gauteng.gov.za

Thank you for taking time to read this information sheet and for participating in this study.

Rebecca Lenkokile
Researcher



APPENDIX D

PARTICIPANT INFORMATION SHEET FOR PRIMARY HEALTHCARE FACILITY MANAGERS

PARTICIPANT INFORMATION SHEET

Title: The implementation of integrated school health policy in primary healthcare facilities of Region C in the Gauteng Province

Dear Prospective Participant

My name is Rebecca Lenkokile and I am doing research under the supervision of Mr. P. Hlongwane and Prof.V. A Clapper, lecturers in the Department of Public Administration and Management towards a Master's Degree at the University of South Africa. We are inviting you to participate in a study: "The implementation of Integrated School Health Policy in primary schools of Region C in the Gauteng Province"

I am conducting this research to find out how the Department of Health and Basic Education ensure effective implementation of integrated school health policy. The researcher obtained the contact details of the prospective participants at the Gauteng Provincial Department of Health database. The prospective participants were chosen because they can provide with the information as well as the first hand experiences on the implementation of Integrated School Health Policy. Atleast five primary healthcare facility managers that implement the policy are invited.

The study involves attending semi- structured interviews for 45-60 minutes describing and explain various ways to ensure successful implementation of the Integrated School Health Policy. The interview will be undertaken at your workplace at your most convenient time. Participating in this study is voluntary and you are under no obligation to consent to participation. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a written consent form. You are free to withdraw at any time and without giving a reason.

The study is intended to empower primary healthcare facility managers in their leadership role in managing integrated school health services in their schools. It will particularly look at the experiences encountered by the primary healthcare facility managers when implementing the Integrated School Health Policy. Again it will further describe and explain the extent which school managers and primary healthcare facility managers possess knowledge and awareness of their roles in the implementation of Integrated School Health Policy in Region C of the Gauteng Provincial Department of Basic Education. There is no risk involved, however the researcher is going to utilise their time which might cause some discomfort or inconvenience to participant who have busy schedule.



The researcher will assure the participants that anything that will be discussed during the research would be kept confidential and would not be used for purposes other than this study. The recordings that will be made during the research process will ensure that the whole discussion is captured and provide complete data for analysis. This means that cues that will be missed the first time can be recognized when listening to the recording good quality transcribing will include tone and inflection, because only a small portion of the message is communicated in actual words

Participants will be assured that all information that would be provided by them would be strictly confidential and that their identities would not be revealed in any record or report and that there would be no link between the data and the participants. To ensure this, code or pseudonym on names for participants, primary healthcare facilities will be used to ensure anonymity. The researcher and the supervisor will have access to your answers and may be reviewed by people responsible for making sure that research is done properly, including the transcriber, external coder, and members of the Research Ethics Review Committee. Otherwise, records that identify you will be available only to people working on the study, unless you give permission for other people to see the records.

Hard copies of your answers will be stored by the researcher for a period of five years in a locked cupboard/filing cabinet for future research or academic purposes. Electronic information will be stored on a password protected computer. Future use of the stored data will be subject to further Research Ethics Review and approval if applicable. Hard copies will be shredded and/or electronic copies will be permanently deleted from the hard drive of the computer through the use of a relevant software programme. The researcher will use Unisa policy on how to destroy the electronic data. There will be no payment or reward for the study. This study has received written approval from the Research Ethics Review Committee of the Unisa and Johannesburg Health District Research Committee. A copy of the approval letter can be obtained from the researcher if you so wish. If you would like to be informed of the final research findings, please contact Rebecca Lenkokile on 0722763698 lenkokiler@yahoo.com. The findings are accessible for period of 6 months. Should you require any further information or want to contact the researcher about any aspect of this study, please contact 0722763698 lenkokiler@yahoo.com.

Should you have concerns about the way in which the research has been conducted, you may contact Mr. Hlongwane the Supervisor on 0124298499 hlongp@unisa.ac.za alternatively, contact the research District Health Service Manager, Ms Coral Lorna Fraser on 011 407 7437 /082 550 7808 or email address on Coralf@joburg.org.za

Thank you for taking time to read this information sheet and for participating in this study.

Rebecca Lenkokile
Researcher



APPENDIX E

UNISA ETHICAL CLEARANCE LETTER

DEPARTMENT: PUBLIC ADMINISTRATION AND MANAGEMENT
RESEARCH ETHICS REVIEW COMMITTEE

Date: 16 September 2015

Ref #: PAM/2015/012 (Lenkokile)
Name of applicant: Miss R Lenkokile
Student #: 41911547

Dear Miss Lenkokile

Decision: Ethics Clearance Approval

Name: Miss Rebecca Lenkokile, lenkokiler@yahoo.com, tel: 0722763698
[Supervisor: Mr P Hlongwane, 012 429 8499, hlongp@unisa.ac.za]

Research project: The implementation of integrated school health policy in the public primary schools of Region C district of the Gauteng province: **Qualification:** MPA

Thank you for the application for **research ethics clearance** by the Department: Public Administration and Management: Research Ethics Review Committee for the above mentioned research. Final approval is granted for the duration of the project **on condition** that the written approval to conduct the research be obtained from both the Department of Basic Education and the Department of Health, and a copy of both letters be submitted to this Ethics Committee within 21 days of the date of this certificate..

The decision will be tabled at the next College RERC meeting for notification/ratification.

For full approval: The application was reviewed in compliance with the Unisa Policy on Research Ethics by the RERC on 27 October 2014. The proposed research may now commence with the proviso that:

- 1) The researcher will ensure that the research project adheres to the values and principles expressed in the Unisa Policy on Research Ethics.
- 2) Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to this Ethics Review Committee. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.
- 3) The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.

Kind regards


Prof Mike van Heerden
Chairperson:
Research Ethics Review Committee
vheerm@unisa.ac.za


Prof BT Mpfu
Acting Executive Dean: CEMS

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

APPENDIX F

**PERMISSION LETTER TO UNDERTAKE RESEARCH
FROM GAUTENG PROVINCIAL DEPARTMENT OF
EDUCATION**



For administrative use only:
Reference no: D2016 / 299
enquiries: Diane Bunting 011 843 6503

GAUTENG PROVINCE

EDUCATION
REPUBLIC OF SOUTH AFRICA

GDE RESEARCH APPROVAL LETTER

Date:	29 September 2015
Validity of Research Approval:	8 February 2016 to 30 September 2016
Name of Researcher:	Lenkokile M.R.
Address of Researcher:	18650 Platinum Close; Braamfisherville; Roodepoort; 1724
Telephone / Fax Number/s:	011 710 7152; 072 276 3698
Email address:	41911547@mylife.unisa.ac.za; rebeccalenkokile@gmail.com
Research Topic:	The implementation of Integrated School Health Policy in the public Primary schools of region C District of the Gauteng Province
Number and type of schools:	FIVE Primary Schools
District/s/HO	Johannesburg South

Re: Approval in Respect of Request to Conduct Research

This letter serves to indicate that approval is hereby granted to the above-mentioned researcher to proceed with research in respect of the study indicated above. The onus rests with the researcher to negotiate appropriate and relevant time schedules with the school/s and/or offices involved. A separate copy of this letter must be presented to the Principal, SGB and the relevant District/Head Office Senior Manager confirming that permission has been granted for the research to be conducted. However participation is VOLUNTARY.

The following conditions apply to GDE research. The researcher has agreed to and may proceed with the above study subject to the conditions listed below being met. Approval may be withdrawn should any of the conditions listed below be flouted:

CONDITIONS FOR CONDUCTING RESEARCH IN GDE

1. *The District/Head Office Senior Manager/s concerned, the Principal/s and the chairperson/s of the School Governing Body (SGB,) must be presented with a copy of this letter.*
2. *The Researcher will make every effort to obtain the goodwill and co-operation of the GDE District officials, principals, SGBs, teachers, parents and learners involved. Participation is voluntary and additional remuneration will not be paid;*

W. L. L. L.
2015/09/30

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Making education a societal priority


Office of the Director: Knowledge Management and Research

9th Floor, 111 Commissioner Street, Johannesburg, 2001

3. Research may only be conducted after school hours so that the normal school programme is not interrupted. The Principal and/or Director must be consulted about an appropriate time when the researcher/s may carry out their research at the sites that they manage.
4. Research may only commence from the second week of February and must be concluded by the end of the THIRD quarter of the academic year. If incomplete, an amended Research Approval letter may be requested to conduct research in the following year.
5. Items 6 and 7 will not apply to any research effort being undertaken on behalf of the GDE. Such research will have been commissioned and be paid for by the Gauteng Department of Education.
6. It is the researcher's responsibility to obtain written consent from the SGB/s; principal/s, educator/s, parents and learners, as applicable, before commencing with research.
7. The researcher is responsible for supplying and utilizing his/her own research resources, such as stationery, photocopies, transport, faxes and telephones and should not depend on the goodwill of the institution/s, staff and/or the office/s visited for supplying such resources.
8. The names of the GDE officials, schools, principals, parents, teachers and learners that participate in the study may not appear in the research title, report or summary.
9. On completion of the study the researcher must supply the Director: Education Research and Knowledge Management, with electronic copies of the Research Report, Thesis, Dissertation as well as a Research Summary (on the GDE Summary template).
10. The researcher may be expected to provide short presentations on the purpose, findings and recommendations of his/her research to both GDE officials and the schools concerned;
11. Should the researcher have been involved with research at a school and/or a district/head office level, the Director/s and school/s concerned must also be supplied with a brief summary of the purpose, findings and recommendations of the research study.

The Gauteng Department of Education wishes you well in this important undertaking and looks forward to examining the findings of your research study.

Kind regards


.....

Dr David Makhado

Director: Education Research and Knowledge Management

DATE: 2015/09/30
.....

APPENDIX G

**PERMISSION LETTER TO UNDERTAKE RESEARCH
FROM GAUTENG PROVINCIAL DEPARTMENT OF
HEALTH**



JOHANNESBURG HEALTH DISTRICT

18 November 2015

Ms Rebecca Lenkokile
18650 Platinum Close
Braamfisherville
41911547@mylife.unisa.ac.za

Enquiries
Hillbrow CHC Administration Building, Klein Street
Hillbrow, Johannesburg
E-mail :
[Cornlf@joburg.org.za](mailto:cornlf@joburg.org.za)
johannesburg.research@gmail.com

Dear Ms. Lenkokile

Re: ***The Implementation of Integrated School Health Policy in the public primary schools Of Region C, Gauteng Province***

Your application dated 28 September 2015 refers. The District Research Committee has reviewed your application. This letter serves as an in-principle approval to access the Districts Health facilities (mentioned below) for the above project subject to following conditions:

- The facility to be visited: Sol Plaatjie, Rex, Davidsonville, Zandspruit and Princess Clinics
- The research can only commence after you submit an ethics clearance certificate from a recognized institution.
- Please contact the Regional Health Deputy Director prior to visiting the facilities

Region	Regional Health Manager	Contact No.	Cell phone
C	Mr Tebogo Motsepe	011 761 0257	083 421 9405

- You will report to the Facility Managers before initiating the study.
- Participants' rights and confidentiality will be maintained all the time.
- No resources (Financial, material and human resources) from the above facilities will be used for the study. Neither the District nor the facility will incur any additional cost for this study.
- The study will comply with Publicly Financed Research and Development Act, 2008 (Act 51 of 2008) and its related Regulations.
- You will submit a copy (electronic and hard copy) of your final report. In addition, you will submit a six-monthly progress report to the District Research Committee. Your supervisor and University of South Africa will ensure that these reports are being submitted timeously to the District Research Committee.
- The District must be acknowledged in all the reports/publications generated from the research and a copy of these reports/publications must be submitted to the District Research Committee.

We reserve our right to withdraw our approval, if you breach any of the conditions mentioned above.

Please feel free to contact us, if you have any further queries. On behalf of the District Research Committee, we would like to thank you for choosing our District to conduct such an important study.

Regards,



Dr R Bismilla
Executive Director
City of Johannesburg

Date: 18/11/15