EVALUATION OF THE IMPLEMENTATION OF THE NATIONAL POLICY FOR SCHOOL HEALTH IN NAMIBIA

by

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DEDICATION

“In memory of my lovely mother, Taimi Lata yaSakaria, and my grandmother, Johanna Nalombwele Amutenya, who raised me and never observed my life journey, I owe a debt of gratitude to my siblings, who were a source of love and support when I was doing my thesis. I am also dedicating this to my understanding and supportive husband, Jekonia Nakashwa, and our boys, Iyaloo, Natangwe, and Tekamosha.”

DECLARATION

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I, Ndasilohenda Katangolo-Nakashwa declare that **EVALUATION OF THE IMPLEMENTATION OF THE NATIONAL POLICY FOR SCHOOL HEALTH IN NAMIBIA** is my own work that has not been previously submitted for any other degree at any other institution, and all sources that I have used or quoted have been recognized with full citations.

Signature  Date: August 2022

Ndasilohenda Katangolo-Nakashwa

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ABSTRACT

Background: A school health policy is intended to improve learners' quality of life; however, three challenges are faced in the policy implementation: i) low coverage of health assessments; (ii) poor and inequitable nurse-to-school ratios; and (iii) the lack of data collection.

Purpose: The purpose of this study was to evaluate the implementation of the national policy for school health in Namibia with the view of proposing a framework to strengthen the national school health policy (NSHP).

Setting and population: The study was conducted in three regions of Namibia. The population from which the study's sample was derived comprised school principals, primary healthcare supervisors and NSHP national and regional managers in the Khomas, Oshana and Kavango regions of Namibia.

Methods: A sequential, exploratory mixed-methods design was used for this study to evaluate the NSHP's implementation across management levels, schools and health facilities in the country. A purposive sampling method was used to select participants for interviews and focus group discussions in the qualitative strand. Non-probability convenience sampling was used to select respondents for the quantitative strand's structured questionnaires. Quantitative data from completed structured questionnaires (n=300) were analysed using SPSS. Thematic analysis was used to derive themes and subthemes from the qualitative data.

Results: Qualitative findings indicated a lack of skilled staff, training, equipment and recordkeeping as factors contributing to non-compliances with the NSHP's implementation. These findings were further described statistically by the quantitative results. The quantitative results indicated a correlation between job position and work experience in the policy's implementation. This was revealed by the study findings that managers at the national level (n=66; 100%), had sufficient knowledge and better attitudes towards the NSHP. Also, employees with more than 10 years of experience (n=114; 60.3%) had good knowledge of the policy (variation). The findings indicated poor implementation of NSHP interventions, thus assuming low compliance with Namibia's NSHP. The results show that eighty-one (n=81; 71.1%) and (n=63; 52.5%) schoolteachers from urban and rural schools indicated negative attitudes toward school health policy implementation, respectively. The results indicate that nurses who conducted health programmes at the time were completely uninformed of the NSHP (n=102; 68%), had not implemented NSHP or had never even seen the policy document.

Development of conceptual framework: The qualitative and quantitative results and literature review contributed to the formulation of an NSHP implementation conceptual framework in Namibia. The framework consists of monitoring and evaluation strategies to enhance the school health policy's implementation.

Conclusion: The study reflected a gap between policy knowledge, attitudes and implementation of the NSHP. Insufficient documentation of interventions led to poor reporting in the database system. Based on the findings, a framework was formulated to improve implementation and compliance with the NSHP.

KEYWORDS: Conceptual framework, Evaluation, Implementation, Namibian national school health policy, primary healthcare, school health, teachers.

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LIST OF ABBREVIATIONS

AIDS	-	Acquired immune deficiency syndrome
EFA	-	Education for All
FRESH	-	Focusing Resources on Effective School Health
HIV	-	Human immunodeficiency virus
DPAS	-	Diet, Physical Activity and Health
FAO	-	Food and Agricultural Organization
GPAQ	-	Global Physical Activity Questionnaire
IPAQ	-	International Physical Activity Questionnaire
MoEAC	-	Ministry of Education, Arts and Culture
MoHSS	-	Ministry of Health and Social Services
MES	-	Monitoring, Evaluation and Surveillance
NGOs	-	Non-governmental organisations
NSHP	-	National school health Policy
UNESCO	-	United Nations Educational, Scientific and Cultural Organization
UNICEF	-	United Nations Children's Education Fund
WASH	-	Water, sanitation and hygiene
WHO	-	World Health Organisation

CHAPTER 1
ORIENTATION TO THE STUDY

1.1 INTRODUCTION

A school health policy is any document that has been approved by the national government and lays out the national regulations and principles that govern school health programmes. It could be part of a larger education or health policy, or it could be on its own programme (WHO, 2020:1). A school health policy seeks to provide an essential goal and establish recommended services for all schools across the country. In the absence of a guiding policy, school health programs are less likely to be prioritised by the state, schools, and implementing partners. Furthermore, programming may be varied, influenced by competing urgencies, not evidence-based, and disorganised (WHO, 2020:1).

According to Shung-King (2017:10), school health policies encourage the education sector to improve educational, social, and economic conditions that affect health. Such policies are also vital to ensure the school-aged population's health and achieve sustainable development goals (SDGs). The mandated promotion of good health and well-being (SDG3) and guaranteeing quality education (SDG4) could only be realised by ensuring health programming reaches the targeted age group. Neglected tropical diseases can also be addressed by implementing the school health policy.

The school health policy's goal is to provide health services and programs to elementary and secondary schools. However, the provision of youth-friendly services at health institutions has not been addressed in the Reproductive Health Policy. It has also failed to meet the needs of out-of-school youths, who will be served by health facilities and other related sectors. Nevertheless, links and referral systems have been enhanced so that in- and out-of-school adolescents and youths are directed to public health services.

The Namibian school health policy (MoHSS, 2008:3) aims to ensure that health personnel are properly trained and capable of providing school-based health services;

an increase in the number of schools conducting the health-promoting intervention has been observed; increased collaboration with relevant stakeholders; and promotion of knowledge and skills for school-aged children as needed to adopt a healthy lifestyle. The policy intends to ensure that school-aged children's attitudes and habits are improved and to promote greater awareness and information about frequent childhood ailments' prevention, treatment, and care. The policy also guarantees that regular student health surveillance is conducted. UNESCO (2014:2) states that health staff primarily focus on inspecting the school environment, conducting physical examinations, and providing immunisations for primary school students. The same report indicated that secondary schools' health education was reviewed, yet a physical inspection of schools revealed that healthcare providers and educators might be unable to address sex-related concerns due to a lack of training (UNESCO, 2014:2).

Namibia began providing school health services in 1972, according to the National school health Policy (NSHP) (MoHSS, 2008:4). Several developing countries developed NSHPs in the last decade in response to the Global School Health Initiative's recommendations. However, not all NSHP implementations in Namibia have been fully shared; it was organised and delivered at the regional level by health workers, but delivery has remained varied and fragmented. Problems arose as a result of the country's colonial history. Furthermore, following Namibia's independence in 1990, the Ministry of Health and Social Services (MoHSS) developed the School and Adolescent Health Programme at the national level in collaboration with other line ministries to address the country's school health situation (MoHSS, 2008:7). This was thought to be a better approach to organising and supporting existing operational health services. The school health programme was viewed as critical in boosting services for learners, equipping learners with knowledge and skills to make the best decisions about their health, which will support and improve the quality of their lives (MoHSS, 2008:6).

In 1990, the NSHP was also launched after the Namibian government observed that school health service delivery lacked consistency and sufficiency. Policies emphasising the importance of school health, the relevance of cross-sectoral collaboration, and the organisational infrastructure required were all critical components. The NSHP (MoHSS, 2008:5) and school health guidelines were thus

developed and implemented to improve school health delivery and ensure consistency across all school health activities in the country.

Namibia has thus been challenged to enact a school policy, sometimes referred to as an educational policy. These are rules intended to enable the teaching of students in a safe and efficient environment, in accordance with set regulations (UNESCO, 2014:2). To that end, school authorities and other stakeholders have been called upon to become more accountable for implementing school health policies and interventions (Shung-King, 2017:12).

As a result, the NSHP seeks to describe how policies and programs should be implemented, their implementation strategies, target populations, result in behaviour changes, and provide long-term social, health, and economic advantages to the nation According to Saito, Keosada, Tomokawa, Akiyama, Kaewviset, Nonaka, Waikugul, Kobayashi, Souvanvixay and Jimba (2015:4), several factors at the administrative and central level influenced NSHP implementation in Lao PDR, including the existence of the national task force to scale up nationwide school health policy operations. They also stated that extensive planning is required for school health interventions and resource management in schools. Finally, school health should be prioritised and include a formalised monitoring cycle. Decentralisation could improve policy intervention by narrowing the perception gap between national and lower administrative officers. According to Saito et al. (2015:4), the same factors affect implementation at the provincial and district levels. Lastly, the study of the levels emphasised that, regardless of the level of the school, ongoing mentorship of district education officials is required to promote policy implementation.

The researcher was inspired by the aforementioned observation to evaluate the NSHP's implementation in Namibian health facilities and schools. Finally, the researcher proposed a conceptual framework to support the implementation of current and existing school health policies.

The problem statements are provided in the following sections, as are the research questions, objectives, and definitions of concepts.

1.2 RESEARCH PROBLEM

School health policy implementation is a global public health challenge, despite being identified as a cost-effective technique to reduce the disease burden among children (Shung-King, Orgill & Slemming, 2017:10; Fuller, Junge, Amaning, Faijage, Kaputa, Magwende & Dvorak, 2015:3). Policy implementation failure has resulted in poorly designed interactions among key policy actors. There is also a lack of policy translation processes, which leads to a lack of understanding and ranking of school health activities among district and facility administrators. Another observation is insufficient support and training for nurses to meet the school health policy requirements in the regions. Inadequate referral service capability, combined with insufficient capacity and resources, leads to inequitable service coverage and quality, prompting nurses to ensure that they are aligning school health as “the stepchild of primary healthcare” (WHO, 2020:5).

Furthermore, scant research has been conducted on the implementation of school health programs in sub-Saharan African nations. Consequently, there are few documented practices that can inform implementers of what others have done. According to the DHIS (2018), data on the national school health programme’s planned goals for the 2016–2017 fiscal year were not met. School health programme implementers cited the absence of school health teams as the cause for not meeting targets.

Healthcare interventions have been rendered in schools throughout Namibia. Health interventions for schools are frequently offered at health fairs that offer cholesterol and diabetes screenings, health risk assessments, and health counselling in order to promote and strengthen school counselling services. These interventions include preventive services, education, emergency treatment, and health problem management. Students and employees are immunized and tested for hepatitis B, tuberculosis, blood pressure, and cholesterol by the school or public health nurses. Connections to community resources promote referrals and case management. However, for the 2016–2017 fiscal year, the three study regions (Khomas, Oshana, and Kavango) continued to report poor performance (no data) in school health programme indicators.

According to UNESCO (2014:2), clinics in the Kavango and Caprivi areas are staffed with only one nurse each due to a staffing deficit. Teachers therefore sometimes transport students to adjacent clinics to receive health care in these circumstances since the nurse is unable to leave the clinic unsupervised. The UNESCO (2014:2) survey also reported that schools in Namibia's central and southern regions are infrequently inspected each year due to a lack of resources, such as transportation, well-paved roads, short distances to schools, and urbanization. These are just a few of the elements that make it possible to provide high-quality school health care (UNESCO, 2014:2).

Moreover, although the NSHP has been in existence since 2008, existing reports showed that implementation had not reached some of the most vulnerable schools and geographical areas as anticipated. There are issues such as low coverage of school health services in all districts, unequal distribution of services between rural and urban schools, a lack of staff and equipment, the nonexistence of a standard operating procedure for referring individuals to services, and a lack of uniformity in the implementation of school health policies. The researcher also assumed that there would be difficulties in implementing the policy at various levels. For example, rural public schools face challenges such as a lack of water, electricity, sanitary facilities, and teaching and learning materials, all of which contribute to the policy's low implementation of school health activities (UNICEF, 2016:12). However, there has been no documented empirical evaluation of the policy, and this study thus evaluated the implementation of the NSHP in Namibia.

The main research question is: How can the NSHP's implementation be strengthened in the Khomas, Oshana and Kavango regions of Namibia?

1.3 RESEARCH PURPOSE AND OBJECTIVES

In this section, the research purpose and objectives are discussed.

1.3.1 Research purpose

The purpose of this study was to evaluate the implementation of the national policy for school health in Namibia with the view of proposing a framework to strengthen the national school health policy (NSHP).

1.3.2 Research objectives

The research objectives were to:

- Explore and describe stakeholders' experiences with the implementation of the NSHP in the three regions of Namibia.
- Determine stakeholders' knowledge and attitudes regarding the NSHP's implementation process in the three regions of Namibia.
- Establish what factors are affecting the NSHP's implementation in the three regions of Namibia.
- Develop a framework to strengthen the NSHP's implementation in Namibia.

1.3.3 Research questions

- What are stakeholders' experiences with the implementation of the NSHP in the three regions of Namibia?
- What are stakeholders' knowledge of and attitudes toward the implementation of the NSHP in the three regions of Namibia?
- What factors affect the implementation of the NSHP in the three regions of Namibia?
- What can be done to strengthen the NSHP's implementation in Namibia?

1.3.4 Study hypothesis

- An effectively implemented NSHP addresses learners' health needs and consequently enhances their capacity to learn.

- School health services are intended to enhance learners' health, classify and prevent health problems and injuries, and guarantee that learners are properly cared for.

1.4 SIGNIFICANCE OF THE STUDY

By conducting an in-depth analysis of existing policies governing school health programmes, this research sought not only to identify potential gaps but also to highlight opportunities for improvement at national and regional levels. The study's findings offer insight into the challenges stakeholders involved with the NSHP's implementation face. Ultimately, it is hoped that findings will provide insight into how best practices can be adopted nationwide while considering specific regional needs; thus, improving the quality of life of families and communities, especially school children.

The study's findings informed the development of a conceptual framework to strengthen the NSHP's implementation. The proposed framework will further guide school health programmes and interventions based on the national policy, thereby improving its implementation status and coverage in the country. Various stakeholders in the public health fraternity, especially policymakers in the MoHSS, will be guided by the framework to strengthen and improve the process of implementing the NSHP. The developed conceptual framework adds to the body of knowledge on health policy evaluation and implementation.

1.5 DEFINITIONS OF KEY CONCEPTS USED IN THE STUDY

1.5.1 Conceptualisation

Conceptualisation is a process of getting to the facts by exploring, finding patterns, classifying, and generalising (Lawrence & Brown, 2015:480). In this study, this refers to a concept analysis of all the findings to clearly identify and describe concepts for inclusion in the development of the framework to guide the NSHP's implementation.

1.5.2 Evaluation

Evaluation is a method of assessing a programme's success and performance, designed to look at the goals that should be achieved and the paths that lead to those goals (WHO, 2019:12). In this study, evaluation refers to an assessment of the NSHP's implementation by school health services in the three regions of Namibia, looking at goal attainment as reflected in both successes and weaknesses,

1.5.4 Implementation

Implementation is the act of putting into effect and carrying out an activity (WHO, 2019:12). In this study, implementation refers to how the NSHP was rolled out in the school health services of the selected regions in Namibia.

1.5.5 School health policy

A school health policy refers to any document endorsed by the national government outlining the rules and principles governing school health programming nationwide (UNESCO, 2014:5). In this study, the Namibian national school health policy (NSHP) refers.

1.5.6 Integrated services

Integrated services are an array of services within the school structure, including services of substance and skill, as well as their common uses of resources (Manual for School Health Programs, 2014:4). In this study, this refers to the integration of services of substance and skill within the school structure, as well as their common uses of resources.

1.6 OPERATIONAL DEFINITIONS

The definitions in this section illustrate how the defined terms are used in this study.

1.6.1 Process indicators

Process indicators are used to track the progress of change processes. These indicators elicit information about how something was done, rather than what occurred as a result (Manual for School Health Programs, 2014:5).

1.6.2 Output indicators

Output indicators are necessary to quantify processed products. In conjunction with action plans and programmes, output indicators may support the social and physical environments of various settings to promote healthier behaviours, such as increased access to fruits or protected cycling routes (Manual for School Health Programs, 2014:5).

1.6.3 Outcome indicators

Outcome indicators are used to predict the long-term consequences of a deed. These could be short-term (for example, increased service uptake), intermediate-term (for example, condom usage), or long-term (Manual for School Health Programs, 2014:5).

1.6.4 School health

School health services include preventive education, emergency care, and health condition supervision. Schools can organise health events with cholesterol and diabetes screenings, risk assessments, and health counselling. Connections to community providers improve referrals and case management (Manual for School Health Programs, 2014:11).

1.7 THEORETICAL FOUNDATION OF THE STUDY

Rather than concentrate on procedures, researchers frequently highlight the research concerns and employ all available methodologies to know them (Creswell & Plano Clark, 2018:79). In this study, data were combined to generate fundamental concepts

that served as the foundation for creating a conceptual framework for the implementation of school health policies.

1.7.1 Paradigmatic assumption of the study

A paradigm is a frame of reference for describing a natural phenomenon. Three philosophical assumptions underpin it: the concept of certainty, modes of understanding, and the norms and value systems that guide a researcher's method of investigation (Wagner, Kawulich & Garner, 2017:100). The pragmatic paradigm was used in this study because the researcher used both quantitative and qualitative data at the same time. Pragmatism emerges from actions, situations, and consequences, not from pre-existing conditions, according to Creswell and Plano Clark (2018:90).

The study made meta-theoretical expectations about the research participants, theoretical assumptions about the researcher's tentative belief system about how the respondents experienced and perceived the phenomenon under investigation, and methodological assumptions about the nature and structure of the study.

1.7.1.1 Meta-theoretical assumptions

A meta-theory is a theory that is about theories. It is also a set of interconnected rules or narratives that describe and prescribe what is acceptable and what is not acceptable. A meta-theory is based on assumptions about the nature of knowledge (epistemology), being/existence (ontology), and values (axiology) (Ryan, 2018:41).

The researcher assumed a pragmatic worldview. Given the study's mixed-methods design, pragmatism was an appropriate approach. The researcher thus used a mix of quantitative and qualitative methods to draw freely from quantitative and qualitative assumptions. The researcher did not limit herself to quantitative or qualitative approaches but used both to gather and examine data concurrently to gain a better understanding of the evaluation of school health policy implementation in Namibia.

The researcher also listened carefully and actively to participants' knowledge of the NSHP's implementation in their respective work environments during focus group

discussions. A positivistic approach that places a premium on objectivity was taken during the study (Polit & Beck, 2019:80). This approach evaluated the school health policies' implementation in the nominated schools using a checklist. Additionally, a questionnaire was used to elicit information from officials from two ministries regarding the management of school health policy implementation.

1.7.1.2 Ontological assumptions

According to Polit and Beck (2019:100), ontology is concerned with reality's existence. The researcher established facts in this study through careful observation and in-depth interviews in the participants' natural environment (Ryan, 2018:41). While reality cannot be known with a foregone conclusion, the researcher took an unbiassed view by triangulating multiple research methods, including observations, structured interviews, and focus group discussions, to assess implementers' knowledge about school health policies. The researcher also explored government officials' management of the school health policy's implementation since 2008. The ontological assumption sought to identify meaningful indicators to determine what is going on with the problem under investigation on the ground.

1.7.1.3 Epistemological assumption

Knowledge is objective and free of the researcher's interests, and emotions (Ryan, 2018:41). The researcher generated objective knowledge in this study by observing the natural environment in which the NSHP is implemented. The researcher acted independently of the research subjects and did not influence the findings. A structured checklist for quantitative data collection, interviews with management staff using questionnaires, and focus group discussions with teachers and nurses based on the variables of the research phenomenon were used to generate knowledge. Chapter 4 interprets and presents the findings.

1.7.1.4 Axiological assumptions

According to Ryan (2018:41), axiology is concerned with values. Values are important in pragmatists' interpretation of results. At various stages of the research process, the

researcher's values were assessed. Using a diverse-method approach, the researcher approached data collection, data analysis, and data interpretation from both an objective and subjective standpoint. Throughout the study, the researcher maintained a neutral position, avoiding potential biases and errors.

1.7.1.5 Methodological assumptions

The process of selecting an appropriate approach, instruments, data collection techniques, and data analysis methods is referred to as ‘methodological assumptions’ (Creswell et al., 2018:120). The research team used a pragmatic approach, combining quantitative and qualitative research methods. A quantitative, expressive approach was used to evaluate the implementation of school health policies and describe their management. In addition, data on school health service monitoring indicators were gathered using a qualitative, exploratory approach. The methodology section discussed methods, tools for data collection, methods for analysis, and a conceptual framework.

1.7.2 Rhetorical assumptions

This assumption investigates the researcher’s use of language and writing style (Peterson, 2014). The collection of quantitative data and statistical computations is free of rhetorical assumptions. In this study, the qualitative research findings were interpreted and described using a rhetorical approach.

The researcher’s language for presenting qualitative data was personal and based on the study's findings rather than the researcher's assumptions. The findings were organized into themes and sub-themes.

1.7.3 Theoretical basis of the study

The theoretical framework is the structure that holds or supports a study’s theory (Creswell et al., 2018:12). The theoretical framework describes and presents the theory that explains why the current research problem exists (Creswell, 2018:120).

Two theories were used as the foundation for developing the model in this study, as described below:

1.7.3.1 Practice-oriented theory

Dickoff, James, and Wiedenbach's (1968) practice-oriented theory was used to develop the conceptual framework. In terms of the agent, receiver, context, dynamic, procedure, and terminus, the concepts derived from phase one (concept analysis) are defined and described in detail.

The conceptual framework, as described in Chapter 6, served as the starting point for developing the model to facilitate the implementation of school health policy as well as monitoring and evaluating the same policy.

1.7.3.2 Theory generation

Phase two saw the development of the conceptual framework, which was based on Chinn and Kramer's (2018:117) theory generation approach.

The findings of the study were used to develop a conceptual framework to support the management of school health services in the Khomas, Oshana and Kavango regions. Concept analysis, the development of relationship statements, the description and evaluation of the model, and the establishment of operationalization strategies for the model were all phases of theory generation.

The theory generation phases are schematically depicted in Figure 1.1.

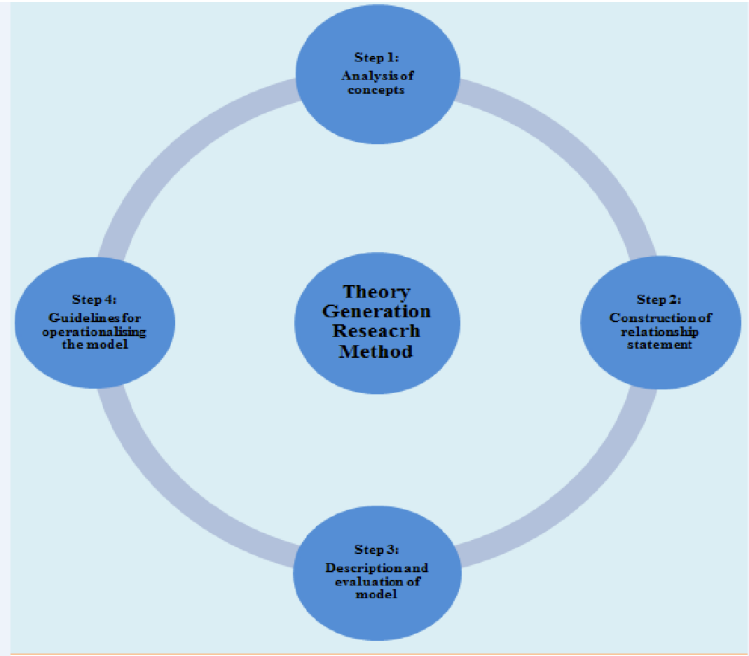

Figure 1.1: Theory generation steps by Chinn and Kramer (2008:119)

1.7.4 Research design and methods

The analysis methodology defines the nature of the investigation, describes the type of information or data obtained, and explains why the study's designs and methods were chosen (Brink, van der Walt & van Rensburg, 2019:199). For this study, an exploratory mixed-methods research design was appropriate. Using a quantitative approach, the researcher examined data rather than experience. This design allowed the researcher to investigate the topic qualitatively before quantifying the findings (Maree & Peterson, 2012 in Creswell, Ebersohn, Eloff, Ferreira, Ivankova, Jansen, Nieuwenhuis, Pietersen, Plano Clark, Van der Westhuizen in Maree & Pieterson, 2019:271). The approach also aided the researcher in combining qualitative and quantitative strategies sequentially within one study and evaluating the implementation of the school health policy.

A complete explanation of the research methodology is provided in Chapter 3.

1.7.5 Population and sample

1.7.5.1 Target population

In this study, the target population was all school health programme administrators and healthcare professionals (nurses and allied health) at the frontline, offering care to individuals in need of school health services to maximise generalisations and transferability. The senior, middle, and district managers responsible for child health and school health, as well as school health service providers from urban and rural districts, schoolteachers, health nurses, and management administrators and accessible to offer information, were used to draw sample criteria.

1.7.5.2 Sampling and sample

De Vos, Strydom, Fouché and Delport (2017:225) define sampling as the method of selecting a subset of units with specific characteristics from a population to be used as a representative sample (De Vos et al., 2017:223). Non-probability sampling is described as sampling where participants are chosen based on the researcher's decisions about their knowledge of the phenomenon (Brink et al., 2019:139). The researcher used purposive non-probability sampling to select teachers, school health nurses, and management administrators who implement the school health policy in the Khomas, Oshana and Kavango regions, totalling 300 respondents.

1.7.6 The research setting

The physical, social, or experimental context in which research occurs is referred to as the research setting (De Vos et al., 2017:225). This research was conducted in three regions, namely Oshana, Kavango and Khomas in Windhoek, the capital city of Namibia. These regions were chosen as they were accessible to the researcher and have been noted as having numerous challenges regarding school healthcare access for students. Low data availability on current school health initiatives also added impetus to investigate further. Schools from each region were randomly selected based on their geographic location and size. Ten schools from the three regions were chosen for this study.

These three regions were suitable for the researcher to evaluate the NSHP's implementation.

1.8 DATA COLLECTION

Data collection is a systematic method of gathering relevant information based on the study's research purpose and objective (Burns & Grove, 2020:52).

Qualitative strand: Purposive sampling was used to select national-level programme officers from two ministries (health and education); school health programme administrators at the district level, school principals; and school governing bodies. The sample size of participants was determined through data saturation.

Quantitative strand: A proportional stratified probability sampling method was used. According to Portney and Watkins (2015:163), a proportional stratified sample is obtained by first separating the population into classes and then drawing random or systematic samples from each region from the portion of the population. Subjects with the same category/level in each region were classified or separated into homogenous groups, which are 300 respondents in total and comprises of; healthcare professionals (nurses and allied health) involved with schools conducting health services in primary health care, life skills teachers for both rural and urban area.

1.9 ETHICAL CONSIDERATION

The research proposal for this study was submitted to the University of South Africa's (UNISA) Ethics and Higher Degrees Committee for ethical approval. Ethical approval was also sought from Namibia's Ministry of Health and Education, as well as the Human Research Council. In this study, the following ethical principles were observed:

1.9.1 Informed consent

Before signing a voluntary consent form, participants who volunteered to participate were given an information leaflet (see Annexure D). The participants were assured that the data they provided would be handled confidentially and that the data would

be accessible only to the researcher and research supervisors. The use of codes rather than names ensured that participants remained anonymous. Completed questionnaires and survey recording tools were securely stored in a designated office, and access to the records, including computerised data, was limited to survey team members and authorised individuals.

1.9.2 Autonomy

The researcher ensured the study was fully disclosed in the information letter before engaging with the participants. Participants were given the opportunity to ask questions prior to the start of data collection. The researcher made certain that the participants were aware that they would not be harmed or exploited as a result of the study. The advantages of the study were also communicated to the participants. To avoid causing participants anxiety and psychological discomfort, the researcher designed questions that were appropriate rather than judgmental.

1.10 SCOPE AND LIMITATIONS OF THE STUDY

The research was led in three regions among management staff, health professionals and schoolteachers. The study's findings were limited to the sample regions, mainly Khomas, Oshana and Kavango, as well as two ministries of interest, namely the MoHSS and the Ministry of Education. Therefore, the findings cannot be fully generalised as the homogeneity of study elements is not obvious.

1.11 STRUCTURE OF THE DISSERTATION

The research is organised into seven chapters. Each chapter includes an introduction of the content and a summary as a conclusion.

Chapter 1: Orientation to the study

The chapter introduces and describes the study's background, describes and explains the problem statement, and outlines the research objectives and research questions. It also describes the study's significance and briefly outlines its delineation and limitations.

Chapter 2: Literature review

The second chapter examines the literature on the NSHP in the Khomas, Oshana, and Kavango regions. It presents perspectives based on international findings, describes the conceptual framework, and provides the study's theoretical framework. Lessons from other related studies around the world are also provided. The chapter also includes information on the implementation of the school health policy and the evaluation of school health services provided in the Khomas, Oshana, and Kavango regions. It describes the factors that contributed to the NSHP's success or failure in Namibia.

Chapter 3: Research design and method

This chapter describes the study's methodology as well as the tools and methods used to collect and analyse data. Furthermore, the targeted population is defined, and the sampling methods used are explained. Finally, this chapter discusses ethical compliance and the justification of the data's trustworthiness.

Chapter 4: Data analysis, presentation and description of the research findings

Based on key informant responses, general findings are presented and discussed. These responses are about their roles, observations, and interventions in the Khomas, Oshana, and Kavango regions' school health policies. This chapter provides a detailed discussion of the findings, including quotes from participants' verbal responses. Furthermore, the chapter contains desk reviews on the research topic.

Chapter 5: Discussion of the findings

In Chapter 5, the general results of the investigation are presented. The chapter also addresses the research's strengths, shortcomings, and contributions. Finally, the chapter includes suggestions for future research on school health policy implementation strategies to improve learners' well-being.

Chapter 6: Development of a conceptual framework, validation and discussion

Chapter 6 presents the development and validation of the proposed framework to strengthen the NSHP's implementation in Namibia. Processes followed in the development and validation of strategies are organized, discussed and documented.

Chapter 7: Conclusions, limitations, recommendations, and contributions Chapter 7 summarises the combined findings and the study's key contributions. It also acknowledges the limitations of the study and draws conclusions in relation to the research's specific study objectives.

1.12 CONCLUSION

This chapter introduced and summarised the research. The chapter also described the problem statement and provided context for the research phenomenon. The problem stated in the problem statement is that there is no documented empirical evaluation of the NSHP, implying that there may be some issues with how the policy has been implemented at various levels. Following the problem statement, the chapter outlined the research objectives and questions, described the significance of the study, and briefly defined and limited the study. The following chapter examines the theoretical framework and related literature.

CHAPTER 2
LITERATURE REVIEW

2.1 INTRODUCTION

The chapter examines data related to the study topic. It presents the theoretical perspective and approaches to explore school health policies before focusing on local, regional and global health policies. Ultimately, the scope is narrowed to the Namibian NSHP context, incorporating the rationale for developing the policy, finalising the policy, the policy's goals, processes, and the main content of the policy.

A critical analysis of the published body of knowledge obtained from qualified researchers, including research articles, journals, monographs, and books relating to the research topic, was the focus of the study's data review. A literature review is a systematic assessment and synthesis of previous research findings on a related research topic. It is a crucial aspect of research that benefits both the researcher and the study's readers (Müller & Tranchant, 2017:1). The literature review aided the researcher in determining the scope of this study by revealing what is identified and not known about the research phenomenon. It also compared the researcher's findings to those of earlier investigations.

A literature review broadens the researcher's understanding of the subject under investigation. The literature search for this study was conducted using electronic journals such as Lancet, BMC, PubMed, Google Scholar, other health-related journals, and electronic and printed books. The search was carried out by using keywords (School health program, school health policy, policy implementation, policy evaluation, and school health policy implementation), author names, topic phrases, and the full title of the study (Cochran-Smith, Villegas, Abrams, Chávez-Moreno, Mills & Stern, 2018:439) from various search engines.

The school health policy, school health policy implementation, policy evaluation, and health policy implementation were among the concepts investigated. Moreover, the literature review included both domestic and international sources. To further

comprehend the topics used in the study, the researcher used grey and contemporary literature. Other researchers and readers will benefit from the literature review because it allows researchers to compare their findings.

2.2 SCHOOL HEALTH POLICY: AN OVERVIEW

The Namibian school health services were established in 1972 and organised and delivered at a regional level by health workers, but the delivery was inconsistent and fragmented due to the country's colonial background (MoHSS, 2008:10). In addition, following Namibia's independence in 1990, the MoHSS, in partnership with other line ministries, developed the National School and Adolescent Health Programme to address the country's school health conditions. This was seen as a better way to organise and support existing health services at the operational level. The School and Adolescent Health Programme was deemed critical to improving the quality of learners' lives by increasing the services available to them and providing them with the knowledge and skills necessary to make informed decisions about their health and well-being (MoHSS, 2008:10).

Currently, Namibia's School and Adolescent Health Programme focuses primarily on three 'traditional' areas: school health care, environmental protection, and health education. However, an integrated strategy for school health must be planned and developed. According to the MoHSS (2008:10), various institutional, political, economic status, and environmental concept variables have inhibited the development of a comprehensive approach to the School and Adolescent Health Programme. Service delivery is still done on an ad hoc basis or not at all. Meanwhile, the programme benefits only a small number of students. To overcome this disparity, it was determined that an NSHP, in partnership with line ministries and non-governmental organisations, was required. It is hoped that this strategy will help improve the health and educational services available to all Namibian students (MoHSS, 2008).

School health services, as an ongoing process of child healthcare from early childhood through adulthood, provide a safety net where early childhood care was missed and ensure that health issues that could contribute to learning barriers are detected and

dealt with early. Shung-King et al. (2014:15) further assert that the process prepares children for healthier adulthood by encouraging healthy lifestyle choices and addressing psychosocial and chronic physical health issues. Thus, improving the quality of school-aged children's health and allowing them to maximise their learning potential.

Numerous key components to school health services, according to South African data, include (i) exclusive health assessments of children who are screened for various health conditions such as vision and hearing; (ii) age-appropriate health education and promotion; (iii) psychosocial and mental health assessments; (iv) identifying and supporting children with chronic health conditions; (vi) supporting safe and healthy school environments; and (vii) providing preventive services, primarily immunizations and dozing for deworming. Importantly, school health services are provided by the National Department of Health (NDoH), and learners' social issues must be addressed by the Department of Social Development. This necessitates coordinated integration among these government agencies (Shung-King et al., 2014:8).

South Africa's lower grade school registration illustrated that school health inventiveness has the potential to reach many learners. However, the nurse-to-school ratio was 1:20 to 1:30 on average in 2008 (Shung-King et al., 2014:7). The situation was made worse by nurses' lack of transportation to schools. Due to a lack of availability, remote locations, and exorbitant transportation fees, many children were allegedly unable to obtain referral services to, for instance, optometrists and dentists. Nurses were also unable to follow up on children who were identified as having health issues (Shung-King et al., 2014:6).

School health and nutrition interventions, according to Schultz and Ruel-Bergeron (2021:20), can include routine school health services, which should be supplemented with improved water, sanitation, and hygiene (WASH) infrastructure and messaging integrated into the current curriculum. Providing school health services, on the other hand, will not improve health or learning outcomes. Rather, the quality, consistency, and relevance of services and delivery modes are critical to achieving their goals.

According to a 2009 evaluation conducted by Shung-King et al. (2014:8), district managers who distribute primary healthcare and facility managers who oversee school health teams' training, supervision, and support are critical to its implementation.

Conversely, poor managerial support hampered successful implementation due to a widespread lack of thought and obligation to school health. Individual nurses' enthusiasm and devotion were largely responsible for pockets of good practice. In addition, implementation issues were exacerbated because most regions' district health systems were still in their infancy.

The school health policy's goal is to create a shared vision, strategy, and set of recommended interventions for all schools and implementing partners across the country. According to UNESCO (2014:15), without a guiding policy, school health is less likely to be prioritised by the government, schools, health system, and development partners. Furthermore, programming may be patchy, driven by competing priorities, non-evidence-based, and disjointed; an ineffective policy may be deemed more harmful than none at all. To ensure that it addresses the health priorities of all school-aged children, an effective policy must be founded on thorough situational analyses and multi-stakeholder consultations (girls and boys, minority groups, urban and rural, pre-school through secondary schools). It must also address all four FRESH pillars: equitable school health policies, a safe learning environment, skills-based health education, and school-based health and nutrition services (UNESCO, 2014:7).

2.2.1 Evaluation of school policies around the globe

This section focuses on school health policy evaluations in selected countries, namely South Africa, Malawi, Mozambique, Maryland, the United States, the Netherlands and Tajikistan.

2.2.1.1 School health policy evaluation in South Africa

According to Shung-King et al. (2014:11), South Africa's current emphasis on school health and the resources devoted to it has the potential to restore a vertical focus,

potentially at the expense of other primary-level services. In contrast, given the history of neglect, such concentrated attention may aid in properly integrating school health policies into all other primary healthcare services. Prioritising quintiles one and two schools in the 2012 Integrated School Health Policy can improve coverage and close the inequity gap.

However, an expanded scope of the service package may negate this advantage, as school health teams' expectations may be too high. Because health-screening assessments constitute the majority of the school health service package, the absence and inaccessibility of referral services continue to be a concern. Referral services capable of responding to all identified concerns are required for mass population screening programmes, according to the National Department of Health's Integrated School Health Policy (2012:10). In the absence of such services, the efficacy and ethics of screening become murky. Because referral services will take a long time to catch up with increased screening outputs, the significant expansion of both the number of children who should be screened and the conditions for which they must be screened (as specified in the 2012 Integrated School Health Policy) necessitates careful thought and planning.

2.2.1.2 School health policy evaluation in Malawi

In Malawi, the implementation of school health policies has been instrumental in promoting health and well-being among adolescent girls. The government's efforts to train teachers and surveillance officers have facilitated the collection of monthly reports on various school-based interventions aimed at improving students' overall health status. For instance, by ensuring that iron and folate supplements are distributed weekly to adolescent girls, the country has made significant strides toward addressing nutritional deficiencies that could compromise learners' academic performance.

Moreover, by tracking all beneficiaries receiving these supplements over a given period through an efficient data management system (health information system), policymakers can determine which areas need improvement or scaling up of existing programmes. This approach underscores the importance of evidence-based policy

formulation as it ensures targeted resource allocation for maximum impact. Therefore, continued investment in strengthening monitoring mechanisms will be critical to sustainably enhancing educational outcomes while fostering healthy lifestyles among young people in Malawi (MoHSS, 2013:16).

2.2.1.3 School health policy evaluation in Mozambique

Nurses' roles in delivering health services and monitoring school health interventions provided to Mozambique's schoolchildren are crucial. The World Bank Report (2020:10) highlights the importance of effectively evaluating policies that ensure access to quality healthcare for all students. In this regard, expanding academic research on the effectiveness and impact of these initiatives can provide valuable insights to identify gaps and address the challenges nurses face while working with children at school.

Moreover, regular visits by a mobile clinic play a vital role in providing sexual and reproductive health education along with general screening among young adults who may not have easy access to medical care otherwise. Therefore, further study on how best these mobile clinics' efforts could be leveraged through collaborative programmes between different stakeholders such as non-profits or governmental organisations would be essential.

By exploring various ways to expand our academic understanding of school healthcare policies like those implemented in Mozambique, discussions among policymakers can result in innovative implementation strategies leading to efficient delivery systems, ultimately benefiting its youth population.

2.2.1.4 School health policy evaluation in Maryland, United States

In Maryland, United States, the evaluation of school health policies is critical to ensure schools provide adequate healthcare to students. School nurses are essential in implementing routine and emergency care during sponsored school activities. As such, they are well-positioned to evaluate the effectiveness of current health policies within their respective institutions.

To conduct these evaluations, school nurses generate aggregated data related to students' healthcare needs and outcomes for review by administrators. This information provides valuable insights into areas where improvements can be made regarding policy implementation or resource allocation. Furthermore, this feedback helps decision-makers make informed decisions about budgetary priorities concerning student health services. In addition to generating data on student healthcare trends at the individual school level, nurses also monitor broader patterns across local systems by coordinating with state-level departments like the Maryland Department of Health (2017). These collaborations help ensure effective management and oversight over public health initiatives aimed at improving overall population well-being.

Overall, evaluations of school-based healthcare policies are significant in promoting academic success among students. These policies help promote students' well-being and create a healthy learning environment. School nurses are at the forefront of implementing these policies by providing routine and emergency care during sponsored school activities. In Maryland, United States, regular school health policy evaluations ensure they meet their intended objectives.

School nurses have a responsibility when it comes to assessing the effectiveness of these policies through data collection and analysis. This information helps identify gaps in service delivery or areas where improvements can be made. By generating aggregated data on student health outcomes, school nurses provide valuable insights into current programmes' effectiveness in addressing different aspects of students' physical and mental well-being. Moreover, schools also employ a dedicated health coordinator who oversees all local-level healthcare services for its students. This person regularly reports to higher authorities like the state department regarding compliance with the standards related to healthcare provision among educational institutions.

2.2.1.5 School health policy evaluation in the Netherlands

Each school in the Netherlands evaluates its school's health activities on an annual basis. School children are grouped according to age and services rendered, and data

are captured at the sites. Each municipality also offers free vaccinations to school-going learners, and data are captured at the municipal health facilities for monitoring and evaluation purposes (Baltag & Saewyc, 2017:15). These vaccines can help prevent diseases from spreading among young individuals who attend schools within that area. Municipalities keep track of such data through their respective health facilities, which facilitates evaluation and policymaking decisions.

Overall, it is evident that both schools and municipalities prioritise students' physical wellness by keeping track of necessary information. This fosters positive growth and academic success as healthier children perform better academically compared to those who face chronic illnesses or other medical conditions (Basch et al., 2010:232-233).

2.2.1.6 School health policy evaluation in Tajikistan

School nurses are essential in promoting students' overall health and well-being by providing them with necessary medical care during school hours. Their responsibilities extend beyond basic first aid as they are responsible for maintaining, collecting, and submitting reports to district health facilities. By doing so, they ensure that accurate records of each student's medical history are available whenever required. Each school thus has an onsite nurse who provides care and maintains these records as per guidelines set forth by local authorities. Moreover, the presence of an onsite nurse ensures timely response to emergencies that may occur on the premises. The school nurse is equipped to handle situations such as allergic reactions or asthma attacks without having to wait for outside help. This alleviates anxiety among parents and provides reassurance that their child's needs will be met promptly.

In addition to administering immediate care when needed, school nurses actively engage in preventive measures like promoting healthy habits among students and raising awareness about common illnesses prevalent at particular times of the year (WHO 2020:3). They act as valuable resources who can educate students and staff on how best practices could limit exposure risks.

Furthermore, they educate students about healthy lifestyle practices by conducting informative sessions on topics ranging from proper nutrition habits to mental wellness strategies, which enable them to develop lifelong skills aimed at improving their overall quality of life both inside and outside the classroom. School nurses work closely with parents/guardians, teachers/administrators, along with other community partners, including public health departments and physicians' offices.

2.3 THE CONCEPT OF NAMIBIA'S SCHOOL HEALTH POLICY FRAMEWORK

The school health programme aims to achieve health and social well-being for all school-aged children. The policy's goals, objectives, and implementation strategies are based on the National Policy for Reproductive Health of 2000, the principle of a "first call for children", the MoHSS Policy Framework of 1998, and other relevant international conventions and MoHSS guiding programmes (MoHSS, 2008:5).

According to the MoHSS (2008:5), school health services should be available and accessible for all communities, with special attention directed at disadvantaged regions and underserved communities. In addition, disease prevention, health promotion, and care services should be affordable or provided free of charge. Communities should be involved in all aspects of primary healthcare programmes through communication and consultation to create ownership of healthcare programmes. All new programmes should also be subject to a thorough assessment; for example, through piloting before implementation to determine their sustainability. The MoHSS must utilise a multi-sectoral approach to healthcare programme planning; an integral part of implementation, monitoring, and evaluation is ensuring that all levels of government are consulted and involved through the formation of steering committees. Reviews, formulations, and standardised national policies, procedures, and practices are required to ensure quality services are provided through the implementation and maintenance of the policy.

The UNESCO report (2014:11) emphasises the importance of effective collaboration between the health and education sectors. While the health sector is in charge of children's health, the education sector is in charge of implementing and funding school-based interventions. However, both of these sectors must recognise their

respective roles and work together to improve children's health and educational outcomes. To coordinate actions and decision-making, cross-sectoral working groups or steering committees are typically formed at the national, district, and local levels.

2.3.1 Statements of Namibia school health policy

According to the MoHSS (2008:10), Namibia's school health policy stipulates that learners found with communicable/contagious diseases should be referred to a communicable disease specialist for relevant care as soon as possible. Where a learner is absent on a school health services day, the absence should be recorded, and the learner should be informed that they can obtain these services at a public health facility or a private practitioner.

According to the policy, all learners who have never attended school before, and those who are foreign-language learners, must receive a medical examination. In addition, screenings and vaccinations must be provided to prevent infection among school-going children. An effective NSHP emphasises that school entrants must show proof of an up-to-date vaccination schedule at the time of enrolment in school.

The school health policy's primary aims are (MoHSS, 2008):

1. To help ensure that health workers are adequately trained and available to provide primary school health services.
2. This process ensures that more schools follow the Health-Promoting Schools Initiative.
3. The main role of the school health policy is to serve learners by offering educational, values, and skill development support tailored to each child's specific needs, and in collaboration with relevant partners.
4. The school health policy ensures that the attitudes and practices of schoolchildren improve, through increased awareness and knowledge of disease prevention, treatment, care, and rehabilitation. There is a need to provide additional training for practitioners and others who interact with children and their families.
5. To ensure that student health surveillance is performed regularly.

2.3.2 Growth strategies

The above objectives could be accomplished by employing the following strategies. According to the WHO (2017:20), learners can access health education and healthcare services from the school health service. Schools are required to provide all the health services required of them by law, such as primary medical care, vision and dental care. In the case of girls, vaccinations against childhood diseases and tetanus can be given at the age of 15. Screening for common childhood ailments, including diseases prevalent in the local community, essentially serves the greater good of public health. In addition, school health programme interventions include screening for tuberculosis, schistosomiasis, malnutrition (measuring the children's weight), height measurements, and treatment for minor ailments (for example, headaches and wound dressing).

Moreover, the current policy places detailed emphasis on health promotion and education. To that end, the MoHSS must ensure learners' health by administering vaccinations, screening learners for health problems, referring learners to appropriate health facilities, and treating and intervening with learners who need medical attention. The ministry should also carry out health inspections at primary and secondary schools and hostels and provide education on personal and oral hygiene and nutrition. School health education should include classroom instruction on risk factors for health issues and other health-related subjects following the specific needs of the school and an effective national policy for school health (WHO, 2008:10).

There is a large body of evidence that shows that promoting health in schools is one of the most efficient and effective ways to improve children's well-being. School health promotion (via school health policies) promotes attitudes and behaviours that lead to long-term good health (UNESCO, 2014:20). Further, the Ministry of Education is thus required to apply the government's decentralisation strategy in implementing the school health policy at all levels. At the national level, responsibilities and activities related to functions, resources, and operational tasks that can be handled at lower levels of government must be reduced. This will cut down on the amount of bureaucracy in the communication system, thus enhancing local programmes' autonomy.

The ministry also needs to accelerate resource mobilisation by mobilising adequate resources through appropriate and sustainable methods. These objectives will be realised through advocacy activities and project proposals (WHO, 2017:12). However, primary research needs to be conducted, and a dependable data resource must be established to support school health programmes as they progress and are implemented. To make informed decisions on programme planning, implementation, and evaluation, an analysis should be undertaken at the lower levels, progressing to the national level. Research findings should then be shared with partners, the media, and communities to ensure they are informed of new developments and can offer their support (UNESCO, 2006:15).

Furthermore, the WHO Report (2017:11) recommends that school management collaborates with education stakeholders on school policy implementation challenges. For school health advocacy to be successful, the programme must have community support, which means that communities must be sensitised about the various health problems and needs of school-aged children through meetings, awareness campaigns, the media, and the dissemination of information, education, and communication (IEC) materials. To fully implement project activities, human, material, and financial resources should be greatly increased.

UNESCO (2016:22) also suggested developing operational guidelines to facilitate the effective implementation and execution of the school health policy. Furthermore, community mobilisation, participation, and support for school health promotion necessitate a mobilised community with access to pertinent information. However, because the community-based organisations have established relationships with the grassroots community, partnering with them can allow schools to increase health and environmental improvement measures for learners and personnel, promoting the school's overall well-being. A self-sustaining and effective NSHP is best achieved when a community retains ownership of the programme; thus, each player, including parents, should be involved in planning, researching, mapping, designing, implementing, and monitoring school health programmes (UNESCO, 2016:22).

School health service providers are expected to have an excellent understanding of the programme's management skills. According to the WHO (2017:10) and MoHSS

(2008:11), the primary benefit of the school policy framework is the ability to facilitate the effective provision of school health services to the school's learners. The framework added that refresher courses should be offered to the implementing team as new concepts and initiatives are implemented, and opportunities should be made available to talk to other local, national, and international officials about ideas.

To get work done collaboratively, individuals need to be connected with others. Programming is also most successful when teachers and other school personnel work together at all levels, from the neighbourhood to the state, the country, and across nations. A platform should thus be created to unite members from all levels of society to enhance their abilities and establish workable methods to share information and resources, collaborate, and provide mutual support (MoHSS, 2008:5).

The section that follows presents an overview of selected fields of policy. It helps researchers focus on the policy to better understand all components of an inclusive school health programme.

Various elements of the school service programme are used to guide the implementation of its health service component. These services aim to provide enhanced access to healthcare, refer individuals to required services, and educate patients about the proper use of primary healthcare services to contain communicable diseases and other health problems. School health services provide routine screenings, such as screening for hypertension, asthma, and diabetes; treatment for broken bones; injections against measles, mumps, and whooping cough; and referrals, including prescription medication, hospital admissions, and doctor visits (WHO, 2008:13).

Furthermore, self-diagnosis and health care in the school follow a planned sequence of instructions to address the physical, mental, emotional, and social dimensions of health, influencing learners' understanding, attitudes, and behaviours toward health practices. Personal hygiene, environmental health, sexual education, injury prevention and safety, nutrition, disease prevention and control, substance abuse, and other topics are covered in school health services. Health education inspires and assists

students in maintaining and improving their health, potentially preventing illnesses, and changing their risk-taking behaviour (WHO, 2017:10).

According to Namibia's School Feeding Policy (2019:22), a supportive school environment, rules and policies related to the use of alcohol, tobacco, and other substances (like those prohibiting the use of drugs and alcohol in schools), significantly impact learners' health practices and messages. The school environment may thus affect the health of those who work or study there. The condition of the building and surrounding areas, as well as any biological or chemical agents that are harmful to health, are all factors that influence health in a school setting.

The Namibian School Feeding Policy further stipulated that strategies are needed to combine school health interventions and community relationships/collaboration. Therefore, one of the key community services the school must provide entails promoting health in the neighbourhood. To successfully provide this service, the school must be part of the community, and the community is necessary for the school environment. It is essential for effective school health programmes, such as food and nutrition services, to have community support.

Namibia's School Feeding Policy (2019:30) also states that an essential part of assessing and managing learner nutrition is evaluating the various nutrients that learners require. School feeding programmes are vital for ensuring that people only go without food for a short period. To minimise dependency on external food supplies, food distribution programmes must employ locally sourced foods whenever possible. The food programmes for children should also make adequate nutritional supplements available, consistent with national dietary practices and food resources, and stimulate food production in the local area.

The use of quality physical education and recreational activities is also emphasised. Physical activities promote each learner's optimum physical, mental, and emotional development, and these activities promote brain growth. Recreational activities and sports that learners enjoy are also encouraged so that learners can pursue these activities throughout their lives (WHO, School Policy Framework, 2008:10).

2.4 THE THEORETICAL FRAMEWORK OF THE SCHOOL HEALTH POLICY

The theoretical framework of this study is based on the WHO's Model of School Health Policy Implementation (2021:20). It acts as a yardstick to compare and evaluate the NSHP's implementation in Namibia. It also incorporates an integrated approach to school health policy implementation in school systems.

2.4.1 Individualised institutional framework to implement Namibia's school health policy

For a school health programme to succeed, it requires a multi-sectoral approach to service delivery. The existing National Health-Promoting School Committee ensures that school health information, education and communication are coordinated. In addition, this policy clarifies the requirements to implement school health programmes among the various stakeholders and at various levels.

2.4.1.1 Responsibilities of the MoHSS

The school health programme is a subsection of the Family Health Division of the Primary Healthcare Services Directorate that has direct ties to the educational community. According to UNESCO (2016:13), national school-level health policies are most effective when accompanied by a national policy framework that articulates the national expectations of schools.

The NSHP, for example, may recommend that all schools provide safe and separate water and sanitation facilities for boys and girls, that all children be dewormed at least once a year, and that all schools establish child health clubs to increase learner participation in school health. Broad stakeholder participation benefits both national and school-level policies, including teachers, students, healthcare providers, and the community (MoHSS, 2008). To promote school health services in all schools, the following functions are required:

1. The District Primary Healthcare Supervisor should coordinate the school health activities in each district.
2. The school health nurse should be part of the outreach team; the school health team will coordinate school visits and other school health activities.
3. Continuous Attention Support for School Health Services (CASFS) budget allocations should be available.
4. Rehabilitative services should be identified, and, where possible, children with physical disabilities should be integrated into mainstream schools in collaboration with the MoE, CLASH, and other relevant organisations. For the school health programme to realise its goal, the operational level (which is the district level) should have the capacity to effectively carry out necessary activities in the communities. For that reason, the school nurse should be part of the outreach team and coordinate all school health activities.

2.4.2 Structure of the school health programme

Table 2.1: Ideal structure of the school health programme's management

	Community/ school level	District level	Regional level	National level
Title	School Health (Contract Teacher/s)	District PHC Supervisor (Registered Nurse) (1)	Senior Health Programme Administrator (1)	Senior Health Programme Administrator (1)
Main function	To organise school health services in the school	Provide health services to all schools in the district and support schools in becoming a health awareness environment.	Coordinate school health activities and support the districts (officer also charged with responsibilities of other PHC	To offer technical support to regional offices team members
				Articulate and review policies and guidelines on

			programmes)	school health services
				Strategic planning and coordinating functions in collaboration with the regional level.

2.4.3 Collaboration with the directorates for primary health care programmes

It is crucial to ensure all relevant primary healthcare programmes are coordinated to deliver adequate school health services (Schultz & Ruel-Bergeron, 2021:3). The collaboration will help increase schools' screening processes. The following is a list of the various PHC programmes that have a critical role in delivering school health services:

The **oral health** workers are expected to help the school nurse conduct screenings for learners and help the learners discover and deal with any issues that may arise concerning their oral health.

The Blindness Prevention Program: According to Saito et al. (2015:11), the NSHP's eye care officers should help the school nurse in screening learners for vision problems and, when necessary, refer them to a specialist. School eye screening must be a priority component of all health programmes, and should be integrated with all other initiatives to promptly identify, treat, and refer learners (MoHSS, 2008).

The Disability Prevention Programme: Their medical rehabilitation workers assist school nurses in screening learners for any disability, so that the disability can be detected and treated early on (MoHSS, 2008:10).

The School Feeding Programme should be brought to scale by collaborating with the Food and Agricultural Organization (FAO). The programme should be driven and supported by Food and Nutrition Action Programmes (FANAP), to implement feeding programmes in schools (MoHSS, 2008:10).

The Reproductive Health Programme aims to provide adolescents with education and information, as well as make referrals to other reproductive health services more suitable for them. A wider and more complex vaccine campaign could provide policies and procedures focused on immunisation and promote an effective NSHP in collaboration with UNICEF.

According to Saito et al. (2015:30), special efforts should be taken to provide **vaccinations** for children. The family health division should be involved in enhancing public knowledge, public education, and public communication. The development of appropriate IEC materials for learners and their communities is also an important component of IEC implementation. The research unit within the Directorate of Planning and Human Resources Development should help create research tools, data collection and analysis to capture data on the school health programme.

The vector-borne disease control programme performs periodic inspections and offers treatment to hostels for mosquito breeding sites to prevent malaria in endemic areas, and tests for intestinal worms and schistosomiasis in children. The programme also promotes the use of condoms to fight the spread of HIV/AIDS and offers guidance on proper sanitation and the construction of pit latrines, such as those found in schools (WHO, 2021:15).

To meet the school health policy's (MoHSS, 2008:3) objectives, the Directorate of Special Programs (DSP) should make education, information, and guidance available to learners and school personnel on various disorders and issues related to services, notification, confidentiality, reporting, and surveillance. In addition, it should refer learners to health facilities that provide additional services, such as information or voluntary counselling and testing for HIV, testing for tuberculosis, and screening for intestinal worms. The DSP should support school health clubs by providing them with information on HIV/AIDS (MoHSS, 2008:5). -level activities, with the government's

assistance at the national offices. Staff at the regional offices should be selected, their training needs identified, and their knowledge and skills enhanced through ongoing in-service training. Furthermore, regional staff members' recommendations for ongoing in-service training illustrate the need for further research (MoHSS, 2008:10).

The MoHSS District Coordinating Committee is in charge of coordinating all health activities among the district's schools. School health services must be provided through outreach and facility-based strategies to meet the medical needs of the school community. All district administrative offices must ensure that all relevant staff members are properly trained to provide high-quality health care. A district school health team should be formed to promote the school health policy at the district level. A nurse, a dental therapist or dentist, a medical rehabilitation worker, an ophthalmic assistant, a social worker or psychologist, a school counsellor, teachers, parents, students, and community health workers should be part of this team (MoHSS, 2008:15).

The existing community health development committees should be used to expand membership while also addressing school health issues. Each community should look for health issues that affect learners and the community as a whole to identify the common problems faced by the community. A school is a part of the community that surrounds it, and the community is an important part of the school environment. The community should thus support schools by participating in the development of school programmes and ensuring adequate financial support to carry out the school's mission, such as cleaning campaigns and feeding programmes (UNICEF, 2019:10).

According to UNICEF (2019:15), it highlighted that schools should play an important role in introducing health information and technologies to the local community through PEMS, and they should lead the community in advocating for health-promoting policies and services. Schools could also serve as parenting skill training centres where parents can learn more about child development and ineffective parenting techniques and receive support to boost their feelings of self-worth and competence.
; Ultimately, to ensure a comprehensive school health program, there is a need to go beyond the health sector to include other government ministries, the NGO sector, and

business communities (MoHSS, 2008). To that end, the following parties were involved in the implementation of the NSHP:

2.4.3.1 The Ministry of Education

According to the UNESCO report (2019:11), school health policies establish priorities, objectives, standards, and rules to protect and promote the health and safety of students and staff. Physical safety concerns, such as adequate water and sanitation facilities and a safe environment free of abuse, sexual harassment, discrimination, and bullying, should be addressed by school health policies. School health policies should also be responsive to local priorities and the needs of all children, including those from disadvantaged backgrounds. For example, in areas where teen pregnancy is common, a school health policy may prioritise the inclusion of pregnant schoolgirls and young mothers. Similarly, in areas where traffic accidents are a particular risk, the school health policy may place a premium on keeping children safe on the road. Policies governing teachers' and students' health behaviours can also reinforce health education; for example, by not smoking in school, teachers can serve as positive role models for their students. Finally, the process of developing and approving policies frequently brings these issues to light (UNESCO, 2016:14).

The MoEAC has to provide adequate space and time to screen learners, provide health promotion activities, initiatives, and projects, and advocate for feeding programmes in primary schools with learners from disadvantaged families. The department should collaborate with the MoHSS to train teachers in first aid and other basic health issues, revise curricula regularly to cater to learners' needs as they arise, and participate in liaison committees (MoHSS, 2008).

2.4.3.2 The Ministry of Information and Communication Technology

This ministry should provide information on various sectors' implementation of the school health programme through documentaries, interviews, news, and the like. It should also actively search for ways to get more young people involved in community health projects to inspire learners in public schools, advocacy organisations, and

NGOs to become more engaged in the media through activities such as poetry readings, stage plays, and televised debates (MoHSS, 2008).

2.5 GLOBAL SCHOOL HEALTH POLICY: HISTORICAL PERSPECTIVE

Although school health was recognised in the early twentieth century, the WHO launched the Global School Health Initiative in 1995 with the goal of mobilising and strengthening health promotion and education activities at the local, national, regional, and global levels. It aimed to improve the health of students, the school environment, families, and other members of the community (Shung-King et al., 2014:20).

The Ottawa Charter for Health Promotion (WHO, 1986), the first international conference on health promotion, served as the foundation for health promotion in schools. It shifted the context for health promotion away from traditional approaches to health education and toward health-promoting schools. Health promotion plans and programmes should be tailored to the specific needs and capacities of different countries and regions. Health promotion plans and programmes should be tailored to the specific needs and capacities of different countries and regions. To promote effective school health programming, the plans must also include national school health policy requirements.

Namibia established the Health-Promoting School Initiative in 1998 as a joint responsibility of the Ministries of Education, Arts, and Culture and Health and Social Services with the goal of transforming participating schools into health-promoting schools (Ministry of Education, 2018). The initiative was initially and successfully implemented in four Namibian regions: Khomas, Erongo, Omaheke and Otjozondjupa.

2.5.1 School health policy implementation categories

2.5.1.1 International perspective on school health policy monitoring and evaluation

Adequate monitoring and evaluation must be incorporated into the behaviour change process, according to the WHO's Global Strategy on Diet, Physical Activity, and Health (DPAS) framework for monitoring and evaluating implementation (WHO, 2020:18).

The five monitoring and evaluation steps, according to the WHO (2017:10), are as follows:

1. Including a framework for monitoring and evaluation in strategy development

2. Recognising current monitoring and evaluation activities

3. Choosing appropriate indicators to track progress

4. Consistent and continuous evaluation

5. Recurring evaluations

The WHO also stated that an evaluation framework should be developed in tandem with policy development. Reeve, Davis, and Humphreys (2015:6) support the concept of linking the evaluation framework with policy development, stating that the use of an evaluation framework that links policy and health service performance to health outcomes has helped health services improve performance as part of a continuous quality improvement cycle.

2.6 NAMIBIAN CONTEXT OF THE SCHOOL HEALTH POLICY

The school health policy was developed in collaboration with the MoHSS and the MoEAC. It was created after the WHO's Health-Promoting School Initiative was adopted as a key strategy for achieving the Vision 2030 goal of ensuring equity and access to quality education for all Namibians, particularly young people (Ministry of Education, 2018:10). A health-promoting school, according to the Ministry of Health's program, has as four main components, as outlined by the MoHSS (2008:5). The four components consist of toward the poverty eradication goals outlined in the United Nations Sustainable Development Goals (SDGs) (Jessani & Nasreen, 2020).

According to Olsson, Låftman, Wahlström and Modin (2021:7) and Kim and Yoonhee (2020:4), the development and implementation of health-related school policies play a critical role in promoting the well-being of students, staff members, and surrounding

communities. Academic expansion requires an integrated approach that engages different stakeholders such as teachers, administrators, parents/guardians, local authorities, and health professionals to design evidence-based policies that address emerging issues such as mental health awareness programmes or healthy eating initiatives. These efforts may also involve creating infrastructure improvements like water dispensers on campus or designated areas for physical activities. By aligning academic goals with public health objectives through policy measures within educational settings can have far-reaching benefits beyond just improving an individual's overall wellness but also strengthening social bonds within our communities at large.

Moreover, the policy outlines the framework for implementing Namibia's NSHP, which includes collaboration between the MoHSS and the Ministry of Education as well as a hierarchical structure at the national, regional, district, community, and school levels (MoHSS, 2008:7). According to the policy (MoHSS, 2008:6), each level is responsible for the following:

- *At the national level:* The MoHSS, through national health programme officers, takes the lead in providing school health services and coordinates with line ministries; mainly the Ministry of Education, NGOs, and the private sector.

- *At the regional level:* MoHSS regional management teams (regional health programme officers) plan, implement, provide training, supervise, evaluate and monitor district-level activities.

- *At the district level:* MoHSS district coordinating committees (registered nurses, psychologists and community health workers) supervise the implementation of school-based health-related activities through outreach and facility-based strategies.

- *At the community level:* The local community stakeholders (the local authorities, the business community, and parents) support schools' health-related issues and programmes.

- *At the school level:* The school, through teachers, learners, school health staff and other school authorities, develops school health policies and programmes, coordinates with the local community on school health issues, implements local school health policies, and monitors the programmes. Organisation such as:

    - A national-level steering committee of policy decision-makers and researchers.

    - A regional operational team that includes regional education authorities and regional management teams (municipal and district health authorities).

2.6.1 School health policy implementation at a local level

The local community and school form the local level for the school health policy implementation management team (WHO, 2020:15). At local levels, stakeholder organisational bodies include programme coordinators and community stakeholders, like the district management team, local education authority medical, social workers and local school teams (Darlington et al., 2018). The programme coordinators are in charge of liaising between the steering committees, the operational teams and community stakeholders, school staff and learners (Darlington et al., 2018:3).

Health-related policies at the school level establish priorities, objectives, standards, and rules to protect and promote the health and safety of students and staff (UNESCO, 2016:4). UNESCO (2016:8) states that school health policies should address physical safety issues such as ensuring adequate water and sanitation facilities as well as a safe environment to protect students and staff from abuse, sexual harassment, discrimination, and bullying.

2.7 FRAMEWORK FOR LEGAL REGULATIONS REGARDING SCHOOL HEALTH POLICY IMPLEMENTATION IN NAMIBIA

The MoHSS has been developing school health policies for the public sector. As a result, it intended to realise all learners' educational and health rights by transforming schools into inclusive centres of learning, care, and support. The School Health Policy

is backed up by “top-down” legislation that coordinates and integrates school health at the national level, thereby strengthening the already-existing school health services. It also ensures adherence to the country’s health policies, guidelines, and acts within the Namibian Constitution.

2.7.1 The Constitution of the Republic of Namibia

Article 2 of the Constitution emphasises equality, which includes equal enjoyment of all rights and liberties. In this context, equity means that all students must be treated fairly and equally. Through integrated school health services, all students must have equal access to learning content and assessment.

According to the Constitution, children have the right to be protected from economic exploitation and shall not be employed or required to perform hazardous work that interferes with their education or is harmful to their physical, mental, spiritual, moral, or social development. Individuals under the age of 16 are considered children in this sub-article.

2.7.2 National Health Act 2 of 2015

A person’s health is an important factor in their development. Everyone has a right to primary healthcare, according to Section 40(1) of the National Health Act (No. 2 of 2015), and the state is responsible for ensuring that this right is realised. According to the Act:

(1) Every person in Namibia has access to a state hospital or a state health service and is entitled to - (a) receive treatment or other medical care; and (b) benefit from any of the health services established under this Act, subject to this Act and such hospital rules as may be made as contemplated in section 34(2)(b The School Health Policy's guiding concepts include adhering to primary healthcare principles, establishing it within the context of health-promoting schools, and ensuring that school health services are integrated, not vertical (MoHSS, 2008:4).

Furthermore, the School Health Policy ensures that all students have access to

primary healthcare services and that they can exercise their right to attend and stay in school for an extended period of time without encountering health-related barriers to learning. Preventive services include comprehensive health assessments for all students in grades R and 1, and they are central to the services provided during the first phase of the policy's implementation (MoHSS, 2008:5).

2.7.3 Namibia Child Care and Protection Act, 2015

When Namibia signed the United Nations Convention on the Rights of the Child in 1989, it pledged to prioritise children's rights, demonstrating its commitment to improving the welfare of its children. These conventions state that:

- If a child refuses or is unable to consent reasonably, the Minister may consent to medical intervention or surgical operation on the child at the request of any person interested in the child's well-being.

- In the absence of consent obtained under this section and at the request of any person interested in the well-being of a child, a children's court may consent to medical intervention or surgical operation on the child in all cases where a person who is capable of consent under this section refuses or is unable to consent.

- A parent, guardian, or caretaker of a child may not refuse to assist the child or withhold consent to medical intervention or a surgical operation that would be in the child's best interests solely on religious or other beliefs, unless the parent, guardian, or caretaker can demonstrate that there is a medically accepted alternative.

- If a child is unable to consent to medical intervention or surgical operation under this section but demonstrates the capacity to express an informed opinion about such intervention or operation, the appropriate decision-maker must consider the child's opinion.

The creation of the school health policy to address learners' health needs demonstrates that the Children's Act prioritises children's welfare.

2.7.4 Approach from the top-down

The top-down approach prioritises decision-makers' ability to articulate unambiguous policy objectives and exert control over the implementation stage. This implies that top-down approaches begin their analysis with policy decisions and thus overlook the importance of actions taken at later stages of the implementation process. Policies are not created by national officials and then routinely implemented by state and local governments as if they were mindless automatons in a Weberian machine, according to Stofile (2008:39). Appropriate bureaucratic procedures should thus be in place to ensure that policies are implemented precisely. As a result, structures for implementing the School Health Policy at the national, provincial, and district levels have been established.

While these structures are not yet fully operational, the presence of officials from health and education indicates a growing relationship between these two critical departments (Shung-King et al., 2014:66). The top-down approach begins at the top of the governance hierarchy with policymakers and views implementation as a chain.

All authorisation resource allocation begins at the national level (MoHSS, 2008:5). This means that policies and plans are developed on a national scale with little input from those who will carry them out (the principals and primary healthcare facility supervisors). As a result, policy frequently fails to capture the nuances of grassroots initiatives, making policy implementers appear alien.

The disconnect between policymakers and practitioners causes not only difficulties for policy managers but also a lack of coherence among the various components of a single policy and among the various units of the government machinery (Brynard, 2019:36). The smooth transition from policy to practice remains difficult. According to the researcher, this approach overlooks local implementation of officials' initiatives and undervalues the strategies used by implementing actors to divert central policy to meet their needs.

2.7.5 Bottom-up strategy

The bottom-up approach starts by mapping the network of actors in the intended field of action and asking about their goals, strategies, activities, and contacts. Stofile (2008:40) describes this as a mechanism for moving from bottom-up actors to top-down policymakers.

According to Stofile (2008:40), successful implementation is also dependent on the abilities of local implementers rather than the efforts of central government officials. The process demonstrates that policy outcomes sometimes deviate significantly from what the planners intended as a result of change and conflict during the implementation stage (Brynard, 2019:38). This frequently necessitates policy content and skill training for implementers. For example, in order to achieve the policy's objectives, implementers of the Integrated School Health Policy require appropriate training from national, provincial, and district departments.

The district is in charge of implementing an integrated school health programme and ensuring that it is implemented in all sub-districts and reaches all schools and learners. School administrators and primary healthcare facility administrators join the school-based support team at this level and play an important role in the implementation process. This includes ensuring progressive coverage of all schools and learners (starting with the most disadvantaged), coordinating the activities of other partners who provide components of the school health package, and reporting on school health activities to both the health and basic education ministries (MoHSS, 2008:7).

Bottom-up models emphasise the lowest level of the implementation process, or the school, as the level that informs the process. This method educates each unit on the capabilities and resources required to achieve the desired behaviour. This implies that being close to the source of the problem gives you more clout. Furthermore, rather than using hierarchical control, issues are more effectively resolved by maximising discretion at the school where the issue is most pressing.

2.8 REASONS FOR POLICY IMPLEMENTATION FAILURE

According to Brauns and Wallis (2016:203), citing Pressman and Wildavsky, implementation cannot succeed or fail in the absence of a measurable target. A policy is considered successful if it achieves the goals set forth by its proponent, receives no significant criticism, and has nearly universal support (Brauns & Wallis, 2016:203). The inverse of policy success is policy failure. Policy formulation is not always followed by policy implementation. Furthermore, many policies are overly ambitious (and thus lack quality and are unrealistic), and insufficient and ineffective actions at all levels of government have also contributed to policy implementation failure (Brauns & Wallis, 2016:204).

2.8.1 Lack of effective communication

A policy's success is heavily influenced by how it is communicated among the policy's key actors. The ministries of health and basic education are primarily responsible for developing policies such as the NSHP. The policy is then communicated to schools by the Provincial Department of Basic Education; it is then up to school administrators to put the policy into action. However, there appears to be a breakdown in communication between the department and schools in many cases, as well as insufficient policy implementation training among school administrators (Van Wyk & Pelser, 2014:834; Mohlabi, Van Aswegen & Mokoena, 2010:253).

Effective communication enables managers to effectively communicate with all stakeholders and ensures that the information received is properly understood. Managers' communication channels are closed and inconsistent, resulting in implementation delays. Establishing effective and efficient communication channels can ultimately help to dispel any doubts about guidelines and policy interpretation (Brauns & Wallis, 2016:204).

2.8.2 Inadequate intersectoral collaboration

Inadequate intersectoral collaboration was a major contributor to the 2003 NSHP's implementation failure (Mohlabi et al., 2010:252). As a result, the new Integrated

School Health Policy advocates for close collaboration among all stakeholders, with the Departments of Health and Basic Education sharing responsibility for ensuring that integrated school health services reach all learners in all schools (NDoH, 2012:7). The NDoH, in particular, provides school health services. The Department further stated that policies also appear to be based on assumptions rather than the reality on the ground. If the theory underlying the policy is fundamentally flawed, the policy will not be implemented. Thus, key actors involved in policy implementation should bear the following in mind: Are policy objectives clear, consistent, and attainable, and have policy implementers agreed on the meaning of the policy? Furthermore, key actors must be kept up to date on new developments in policy implementation in order to identify practical ways to implement the policy. Furthermore, in South Africa (2017:13), while all district officials were aware of the School Health Policy and acknowledged receiving training on the programme, school administrators and primary healthcare supervisors were unsure of their roles in the policy's implementation due to a lack of training. Furthermore, due to the lack of a unified programme with all key stakeholders collaborating to deliver the school health policy, all districts reported a lack of support and cooperation.

2.8.3 Implementers' attitudes toward the policy

Policy implementation research has revealed that, while the education system can provide sound policies, educational support, and resources, as well as build respondents' capacity to implement the policy, implementation will fail if attitudes remain unchanged (Stofile, 2008:90). The success of any policy is determined by two broad factors: local capacity and will. Stofile (2008:90) contends that even if training is provided, consultants are hired, and funds are made available, implementation will fail due to the implementers' lack of willingness.

2.8.4 Inadequate monitoring and evaluation of the school health policy

The current institutional arrangements of the Departments of Health and Basic Education lack monitoring and evaluation systems for measuring performance and evaluating policy outcomes; these indicators are still being developed (Shung-King et al., 2014:64). Furthermore, they lack the flexibility required to provide immediate

feedback to policymakers and implementers, as monitoring and evaluation should take place on a consistent basis so departments can assess the extent to which change is taking place.

One hundred percent of school administrators admitted that no audit of their schools was conducted to ensure that the programme was being implemented effectively. They were aware that the programme had a monitoring plan in place, but only school administrators in South Africa's Amathole District confirmed that data is stored in schools for viewing (Restless Development South Africa, 2017:13).

2.9 MONITORING AND EVALUATION OF SCHOOL HEALTH POLICIES

The implementation and impact of any policy determine its success. However, the full impact and consequences of a policy can only be determined after it is implemented. Monitoring, according to Mbelu (2011:27), is a process that involves determining whether implemented public policies achieve their stated goals.

This implies that public policy monitoring acts as a radar, directing and shaping implementation processes to ensure pre-determined goals are met. To determine whether the underlying issue has been resolved, the policy must be evaluated.

Monitoring and evaluation results not only indicate whether a programme is meeting its objectives but also provide information for future programme activity planning. It also helps school administrators and primary healthcare facility administrators gain a better understanding of their programme's needs and assets, allowing them to set priorities and allocate resources more effectively.

Process evaluation can be used by school administrators and primary healthcare facility administrators to ensure that accurate and organised records of school health programme activities are kept. This enables them to effectively monitor and report on their activities. They will also be able to determine whether these activities met their objectives and goals.

Outcome evaluation can also be used to determine the impact of school health programme activities on respondents, such as changes in their knowledge, attitudes, skills, and behaviour both during and after the programme. School administrators and primary healthcare facility administrators should submit reports on implementing integrated school health programmes. As the initial planning team, the school administrators and primary healthcare facility administrators reconvene to discuss whether their goals were met and make necessary modifications. However, a gap has been identified; there is no responsible or accountable person who performs the evaluation on an annual basis as per the policy document, and there is no documentation that policy evaluation occurred.

2.9.1 The process of monitoring and evaluating Namibia's school health policy

It is crucial to create appropriate monitoring mechanisms for the policies and programmes to implement them according to set principles, overall goals, and objectives (Mohlabi et al., 2010:253). Some indicators must be devised to monitor and evaluate the programme.

According to Shaibu and Phaladze (2010:10) it is critical that ongoing monitoring and evaluation are done for all programmes. This will indicate the degree to which the programme impacts the target population and help allocate resources for possible modifications. This score will measure the success of the entire programme as well as how an individual learner's attitude has changed. To do this, the organisation must primarily focus on various process-oriented activities, like examining whether quality control in policy and programme implementation is maintained to move it forward as planned. Specific activities will be planned for specific targets and timeframes, while costs and outcomes must be considered (Shaibu & Phaladze, 2010:10).

To ensure the tasks in which the school engages are carried out consistently with set goals, periodic reviews and evaluations must occur through regular progress meetings and reports. Moreover, the most efficient way to supervise people at the lower levels is to make sure everyone is on board.

According to Mohlabi et al. (2010:253) some of the school health policy monitoring indicators include the number of primary schools that provide medical services, the number of children who received appropriate medical treatment, and referrals for illnesses. In addition to these indicators, the proportion of secondary schools visited by health workers to ensure health promotion during a reporting period can be utilised to measure the school health programme's performance.

2.9.2 School health policies at the implementation level

To address issues relating to improved health, child healthcare, and family-centred primary health care, the Centres for Disease Control and Prevention works with local and state organisations and various health agencies around the country to set priorities and targets that aim to improve public health. It also engages healthcare practitioners, families, and other community stakeholders in setting and accomplishing these priorities and targets (Shaibu & Phaladze, 2010:15).

2.10 CONCLUSION

The theoretical framework for the study to evaluate the NSHP's implementation in Namibia was provided in this chapter. The study's theoretical framework includes the WHO Model of School Health Policy Implementation as well as an integrated approach to school health policy implementation. The chapter also reviewed literature on the NSHP's implementation in various parts of the world. The reviewed literature covers the following topics: the historical perspective of global school health policies; school health policy implementation categories; the Namibian context of the school health policy; and studies on school health policy evaluations. The research methods used in the study are discussed in the following chapter.

CHAPTER 3
RESEARCH DESIGN AND METHOD

3.1 INTRODUCTION

This chapter narrates the approaches used to ensure the research instrument's reliability and validity (Makoelle, 2019:19). The chapter presents the research methodology, the data collection process, the selection of samples, which includes data management, how data were analysed using software, and the model of data interpretation to evaluate the NSHP's implementation in Namibia.

3.2 RESEARCH OBJECTIVES

The following objectives guided the chosen research design and methodology:

- Explore and describe stakeholders' experiences with the implementation of the NSHP in the three regions of Namibia.
- Determine stakeholders' knowledge and attitudes regarding the NSHP's implementation process in the three regions of Namibia.
- Establish what factors are affecting the NSHP's implementation in the three regions of Namibia.
- Develop a framework to strengthen the NSHP's implementation in Namibia.

3.3 RESEARCH DESIGN

According to Creswell and Plano Clark (2018:335), research is defined as a sort of inquiry that provides a particular direction for procedures in a study using qualitative, quantitative, and mixed methods. A mixed-methods study combines elements of qualitative and quantitative research approaches (for example, the use of qualitative and quantitative viewpoints, data collection, analysis, and inference techniques) for the broad and deep purpose of understanding and corroboration. According to Judith and Burke (2017:16), combining two designs for complementarity can improve the

meaning and validity of research findings by leveraging the inherent strengths of one method to compensate for the biases of another.

The term “research paradigm” or “philosophical worldview” refers to the researcher’s assumptions, beliefs, and ideals about the world and the nature of the study (Creswell & Plano Clark, 2018:39). Makoelle (2019:13) defines these as the researcher’s broad research approach and the foundation for the planned study. The research paradigm influences the methodologies used to generate evidence and determines whether the researcher prefers quantitative, qualitative, or mixed-methods research (Polit & Beck, 2019:16). The philosophical framework for this study was a pragmatic worldview. Finally, mixed-method research should help answer research questions in studies (Judith & Burke, 2017:10). Furthermore, mixed-methods research aims to increase knowledge and validity. The validity and application of the study are discussed further in this chapter.

The research design should be of sufficient quality as a product to ensure multiple validity legitimisation (Johnson, Burke & Christensen, 2017:16). In each research study, this refers to mixed-methods research that meets the relevant combination or set of quantitative, qualitative, and mixed-methods validity.

3.3.1 Mixed-method approach

Sequential exploratory mixed methods are a two-phased mixed-methods design in which the researcher collects qualitative data in the first phase, analyses the results, and then uses a quantitative phase to explain the qualitative results in the second phase (Creswell & Plano Clark, 2018:329). To investigate the current NSHP implementation, this study used a sequential, exploratory, mixed-methods design. This was done by applying the qualitative phase and quantitative phase, which are described individually.

Sequential exploratory mixed-method designs are defined as processes where the researcher starts the study with a qualitative phase to gather participants’ perspectives (Makoelle, 2019:20). The researcher thus first conducts the study’s qualitative inquiry, analyses the findings, and then elaborates on the findings using quantitative data The

preliminary qualitative stage data are needed to construct the data collection tools before the quantitative phase; this design is referred to as sequential (Makoelle, 2019:15).

In this design, the researcher collects focus group data, assesses the results, creates an instrument (or other quantitative feature, such as a website for testing), and then delivers it to a sample of the population, according to Creswell and Plano Clark (2018:306). However, in this scenario, there may not be enough instruments to measure all of the ideas that the researcher wishes to examine. In essence, the researcher employs a three-stage procedure. The first phase is exploratory; the second is instrument (or quantitative feature) development; and the third is instrument administration and testing on a population sample (Wipulanusat, Panuwatwanich, Stewart & Sunkpho, 2020:3). The application of a design in any research study is crucial as it determines the overall success and outcomes of the investigation. In this study, the researcher adopted an approach that involved conducting reviews, focus group discussions and developing questionnaires and interview tools based on the information gathered from these sessions.

The researcher conducted interviews, analysed the narratives, and collected questionnaires and checklist results to explain the final findings of the NSHP's implementation. The process began with thorough record reviews (Chapter 2) to gain insights into previous research studies on school health policies. Following this, focus group discussions were held with relevant stakeholders, including students, teachers, parents/guardians and other key players within educational institutions. The data collected during these conversations were then analysed for patterns or trends, which helped guide further inquiries through surveys/questionnaires aimed at capturing more specific details about perceptions surrounding school health policies. After collecting data from various sources, such as literature review articles and primary sources obtained via interviews/focus groups, the researcher developed several instruments designed specifically for gathering additional information. These were used to formulate appropriate recommendations based on the findings generated by the different research stages and the methodology plan.

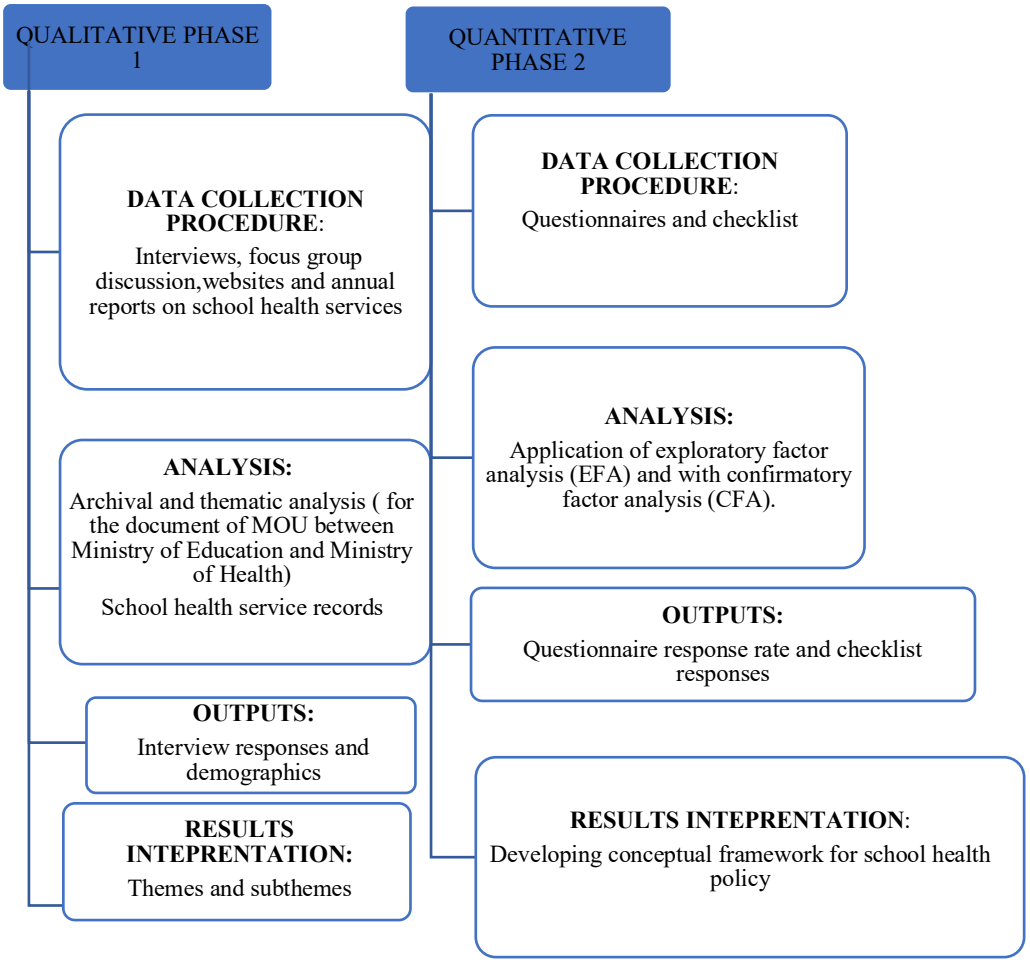

Figure 3.1: An overview of the sequential exploratory mixed-methods design (Adapted from Creswell & Clark, 2017:4)

3.4 STUDY SETTING

The research setting includes everything from the location where data on the phenomenon is gathered to other characteristics of the environment (Polit & Beck, 2019:743). The study was carried out in Oshana, Kavango and the Khomas regions in Namibia. These regions were chosen due to their accessibility and the researcher's budget. Moreover, these areas were chosen due to limited data being available concerning school health programmes and a host of challenges that have been identified within these communities. Schools from each region were randomly selected based on their geographic location and size. Ten schools were selected for this study in the three regions.

3.5 RESEARCH METHODOLOGY

A research methodology refers to the procedures and techniques followed to collect data (Polit & Beck 2019:725). Figure 3.2 illustrates an overview of this process.

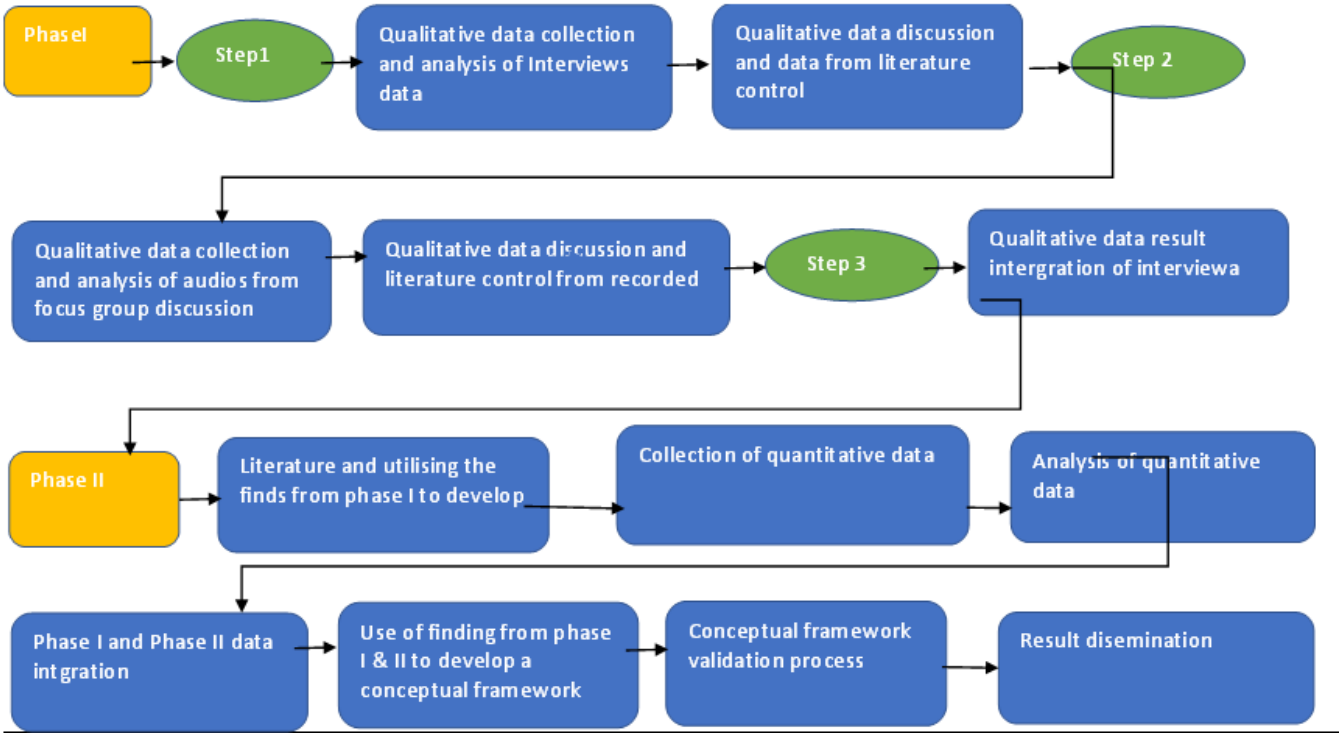

Figure 3.2: The research methodology

3.5.1 Qualitative strand

The qualitative research process entails developing questions and processes, collecting data in the context of the participants evaluating the data inductively, progressing from particulars to general themes, and producing interpretations of the data's meaning (Creswell, 2019:337). Participants' opinions and experiences in this phase provided specific and personal evidence of the NSHP's implementation at different levels. During this phase, the researcher first collected information on school health policy implementers' experiences by conducting interviews and focus group discussions; this facilitated the development of the research questionnaire and checklist used in phase two. According to Polit and Beck (2019:752), interviews are qualitative data collection methods that show how events are combined to make

sense. Interviews most commonly take place face-to-face between an interviewer and one interviewee, but some also occur over the telephone.

3.5.1.1 Population

In this study, the target population was all school health programme administrators and healthcare professionals (nurses and allied health) at the frontline, offering care to individuals in need of school health services to maximise generalisations and transferability. The senior, middle, and district managers responsible for child health and school health, as well as school health service providers from urban and rural districts, schoolteachers, health nurses, and management administrators and accessible to offer information, were used to draw samples. The key people to interview differ depending on the policy, but they may include those implementing the policy (at various levels of seniority and job roles), those receiving the policy, and stakeholders with an interest in the policy. In this study, school principals and primary healthcare supervisors were interviewed, while the national and regional managers engaged in focus group discussions on the school health policy's implementation (Table 3.1).

3.5.1.2 Sample

The sample size is determined by the informational objectives of the study, as well as the data saturation principle and the type of qualitative design (Polit & Beck, 2019:321). For example, ethnographic and case-study designs may use a sample of 2-4 people, whereas phenomenological designs require 6–10 people. The most commonly used principle to determine when sampling should be stopped is the effect of data saturation, defined as the collection of data to the point where no new information is obtained or fresh data no longer sparks new insights or reveals new properties (Creswell, 2019:189; Polit & Beck, 2019:321). This study's qualitative strand included two types of participants; as illustrated in Table 3.1, the total sample size was 24 (school principals, PHCs and both ministries' managers). School principals and managers from the two ministries were purposely chosen as good informers to reflect on and describe the phenomenon under study because the

researcher knew they were involved in implementing the NSHP in some way (Polit & Beck, 2019:516).

Table 3.1: Sample size and participants in qualitative design

School	School principals	Primary health supervisors	National level managers
Primary School i	1	1	0
Primary School ii	1	1	0
Primary School iii	1	1	0
Primary School iv	1	1	0
Primary School v	1	1	0
Primary School vi	1	1	0
Primary School vii	1	1	0
High School ix	1	1	0
High School x	1	1	0
High School xi	1	1	0
National manager			4
Total	**10**	**10**	**4**

3.5.1.3 Data collection

Creswell and Plano Clark (2018:128–129) differentiate three types of focus group interviews: self-managed, structured, and semi-structured. Data collection and interpretation were carried out concurrently. Structured interviews and focus group discussions were used in this study to collect information from participants about the implementation of the school health policy (Figure 3.1).

Non-empirical data collection

The most important component in gathering crucial non-empirical data for the investigation was the review of relevant literature. Since researchers spend most of their time reading rather than directly interacting with the people involved and impacted by the issue under investigation, non-empirical data were ontologically generated from secondary sources of knowledge that are often abstract and impersonal (Brink et al., 2017).

The literature review was properly covered in Chapter 2, which also offered diverse local and global viewpoints on the latest advancements, trends, and health promotion strategies being used in schools. In this way, the researcher increased her

understanding of the non-empirical data, which was very beneficial in describing, explaining, and interpreting events and processes that occurred during the in-depth interviews and focus group discussions, as illustrated in Figure 3.1.

Empirical data collection

The primary source of empirical data is the researcher's direct interactions with experts who have relevant experiences, perspectives, and expertise (Creswell & Plano Clark, 2018:300). The facilitation of participants' verbal responses and their involvement in choosing the outcome of their conversations and dialogues with the researcher are further ways that empirical data can be distinguished from other types of data. Because of the study's unique characteristics, which focused on participants' actual voices and perspectives, empirical data were primarily collected through in-depth interviews, focus group discussions, and participant observations to supplement both the interviews and group discussions with the study's diverse participant categories.

Interviews

According to Creswell and Plano Clark (2018:306), the quotes from interviews can be used to create variables for an instrument. The codes create characters that group the items, and themes are used to arrange the codes into scales to continue instrument development.

The following data-gathering strategies were employed in the study:

a. In-depth interviews with key informers (Annexure E)
b. Focus group discussions (Annexure F)

Each key informant was interviewed using a semi-structured interview format that focused on major themes related to the research objectives. A few scripted or closed-ended questions were used in these interviews to gather participants' comments and viewpoints regarding the school health programme (Creswell et al., 2018:300). For the participants' convenience and to enable them to express themselves fully and clearly, interviews were conducted in both their native languages and English.

During the interviews, participants were asked how the NSHP was implemented in their schools. The conversation was designed to cover the following main areas of concern:

- A description of how this policy was implemented at their school
- A description of the roles that each person had in executing the policy
- An explanation of how their school health interventions are arranged
- Successes attributable to the execution of this policy
- Participants' challenges or restrictions concerning this policy's execution

No participant was prevented from posing their own inquiries. As stated in Annexures E and F, the participants were not forced to participate in the interviews. They also gave their consent for the audio recording of their participation in and responses to the researcher's questions. All the interviews were audio-recorded to be transcribed and analysed afterwards (Figure 3.1).

Focus group discussions

Focus group interviews are conducted to gather participants' attitudes and opinions about a certain issue in a non-threatening and easy-going setting (Gray, Grove & Sutherland, 2017:233; Krueger & Casey, 2019:xiii; Polit & Beck, 2019:394). This study discussed and investigated school health policy implementers' experiences, knowledge, and attitudes (Annexure F) affecting the school health policy's implementation according to the programme guidelines. The moderator, who is also the researcher, led a focus group discussion to demonstrate her expertise in this area and to test the use of one key question while keeping probing questions on hand. The NSHP focus group conversations followed the same ethical guidelines as the formal individual interviews. For instance, the researcher, who also served as the facilitator, asked for and received permission to audio record the sessions' proceedings. Prior to signing informed consent before each session began, participants' voluntary involvement was also given top priority. The primary question was: What is the status and challenges of school health policy implementation in Namibia?

Field notes

An examination of the data gathered during the interviews and focus group discussions provided some insight into the status of school health policy implementation at schools and health facilities. Nonverbal communication interpretation was initially difficult for the researcher because her focus was on the content of the discussions; however, as the researcher gained confidence, this skill the use of memos. According to Polit and Beck (2019:405), it is crucial and ought to start in the early stages of empirical data collection, including observations that were made throughout the data's analysis. The researcher's reflective comments were captured in the field notes, and included data about the venue, seating preparation, participant behaviour, the way they spoke, and any incidents that occurred (Annexure F).

3.5.1.4 Analysis of qualitative data

Qualitative data from interviews and focus group discussions with stakeholders were analysed using thematic analysis. Thematic analysis is a technique for finding, examining, and reporting patterns (themes) in data. The following analysis steps by Braun and Clarke (2021:5) were followed in this study:

- **Transcription:** Written transcripts of the focus group discussions and audio recordings of the interviews were created (Braun & Clarke, 2021:5) to gain insight into the experiences and viewpoints of teachers and nurses working in the school health programme.
- **Reading:** repeatedly going over the individual and group transcripts allowed the research team to become comfortable with the information.
- **Coding and co-coding:** To identify and categorise significant data segments, the researcher and independent co-coder followed a systematic process. The codes were organised into broad categories or themes, such as the effectiveness of the school health policy, the challenges it faced in practice, how it impacts student health outcomes, and how stakeholders see the policy.
- **Review:** The researcher and supervisor made sure the categories and themes adequately represented the data that were analysed.

- **Refining:** After reviewing the data, themes and subthemes were refined in order to gain a final number of themes and subthemes for the discussion report.
- **Reporting:** In the presentation and discussion of the findings, verbatim quotes and examples from the data were used to support the themes and subthemes (Braun & Clarke, 2021:7).

3.5.1.5 Measures of trustworthiness

Table 3.2: Criteria of trustworthiness

Criteria	Strategies to ensure trustworthiness	Application
Credibility A true reflection and an accurate description of the data (Creswell, 2018:301)	Prolonged engagement	The researcher spent time at the schools and clinics under study, engaging with staff implementing the school health policy. This helped the researcher observe and understand some unique setups. Adequate time was spent with the verbatim transcripts.
	Triangulation	Data was collected from different stakeholders (participants) for a varied viewpoints and experiences on the implementation of the NSHP
	Member checking	Researcher kept on reflecting on the narratives of the participants to confirm whether these represented their views
	Peer examination	The research process and findings were discussed with experienced national, regional, and district managers. The researcher and an independent qualitative coder held a consensus discussion about the development of the themes, categories, and subcategories.

Criteria	Strategies to ensure trustworthiness	Application
	Researcher credibility	The researcher had previously conducted a qualitative study and was familiar with this research design and method.
Confirmability Objectivity of the presented data (Burns & Grove, 2020:203)	Reflexivity	Researcher kept reflective notes.
	Audit trail	Unprocessed data (voice recordings), field notes, theme-related documents, category and subcategory development, consensus, and manager discussions were kept as evidence in case an audit was required.
Dependability Consistency of data over time (Creswell, 2018:341)	Coexistence with credibility	The same criteria that applied to credibility also applied to dependability.
	Thick description	A thorough description of the research procedure was provided (see Figure 3.1).
Transferability Application of the research in similar circumstances (Burns & Grove, 2020:203)	Accurate description	The researcher used purposeful sampling, a type of nonprobability sampling, to maximise the collection of data on school policy implementation at the district, regional, and national levels. This is different from the information that would be gathered in aggregate in a quantitative study.
Authenticity The extent to which the realities of the participants are described (Burns & Grove, 2020:203)	Detailed description	The participants' emic perspectives were provided.

3.5.2 Quantitative strand

3.5.2.1 Sampling

This study applied the purposeful sampling approach to identify respondents who are working within the implementation of school health policy. As stated, the first-stage sampling unit comprises big units or clusters, the second-stage sampling unit is made up of smaller units, and the third and subsequent sampling units are even smaller (Polit & Beck, 2019:273). For this study to conform to the norms of sampling in quantitative research, and to estimate the size of the sample (teachers and school health nurses) for this study, the following formula was used:

Assumption:

N>= (S/100 x P)

S=10%

P=3000

N> (10/100 x 3000)

N>=0.1 x 3000

N>=300 (De Vos et al., 2014:22).

The population size was estimated based on the requirement for representativeness in quantitative research.

Inclusion criteria

The target population was all school health programme administrators and healthcare professionals (nurses) at the frontline offering care to individuals in need of school health services to maximise generalisations and transferability. In this study, teachers, school health nurses and management administrators older than 21 years, and accessible to offer information were used to draw the sample criteria.

Exclusion criteria

- Nurses and teachers who did not directly deal with school health activities.
- Nurses and teachers who appeared tired or sick on the days of data collection.

Table 3.3: Sample size and respondents in quantitative design

School	Teachers working wi	School Health Nurses
Primary School i	10	10
Primary School ii	10	10
Primary School iii	10	10
Primary School iv	10	20
Primary School v	10	10
Primary School vi	10	20
Primary School vii	10	20
High School ix	20	10
High School x	20	20
High School xi	20	10
High School xii	20	10
Total	**150**	**150**

3.5.2.2 Data collection

According to De Vos et al. (2017:203), it is necessary to track the number of times interventions are performed. The self-administered questionnaire (see Annexure G) was administered to nurses and schoolteachers, reviewing all activities indicated in the school health package the way they are stated in the school health policy. These included health-related services, like primary school assessments and the number of school health visits conducted per year.

The questionnaire permitted respondents to report on what was going on with a specific topic by indicating the:

- percentage of pre-primary learners assessed;
- the percentage of assessed learners who had difficulty and reached with at least once.
- the time between identifying a health concern as well as following up on it was explored.

The data collection procedure entails sampling individuals with relevant information on the topic and collecting data for the study (Brink et al., 2017:148). The data provided structured, often quantitative data on participants' experiences implementing school health services.

3.5.2.3 Data instrument

In this study, a checklist was used for data collection and is defined as a sort of questionnaire consisting of items that a respondent can check as applicable (De Vos et al., 2017:203). The checklist (see Annexure H) was administered to schoolteachers to extract information on the school health policy requirements. It was deemed suitable for this study based on the researcher's intention to assess the school health policy's implementation.

3.5.2.4 Data analysis

To quantify variables, the researcher developed a sheet with numerical values that were allocated to variables; for instance, 2- Documented, 1- Not documented, and 0- Not relevant. For the purpose of quantifying completeness, the researcher counted the document frequencies. A statistician also validated the calculations that were analysed using SPSS software, version 23. In Chapter 4, a summary of the findings is available in the type of frequency visuals to provide a high level of representation of all the findings.

Themes and categories from each sample were studied separately and debated prior to this approach against a literature control (see Figure 3.1). The goal of the literature control is to see if earlier research supports or contradicts the current study's conclusions (Creswell & Plano Clark, 2018:32). The combined data were presented as themes, which arose based on key challenges in the execution of school health policies. Professional nurses' and teachers' perspectives were ultimately compared to managers' experiences during the data integration process. As a result, an understanding was gained of each sample's perspective on the school health policy's implementation.

3.5.2.5 Validity and reliability

To ensure data validity, the researcher contacted topic experts to review the findings and solicited feedback on the proposed guidelines from interested groups (De Vos et al., 2017:203). The following characteristics were used to develop validation criteria:

- Managers who previously developed policies and procedures
- Educators who were active in teaching life skills to students
- Nurse supervisors who worked with learners
- Professional nurses who provided school health services

To ensure reliability, a hard-copy or electronic briefs of the suggested policy that needed to be evaluated with a set of criteria, as well as a letter that gave pertinent information and asked for participants' consent, were distributed to the respondents (Annexure D). Prior to doing the real research in this study, the researcher used twenty checklists to conduct a pilot study of the research instrument to gauge its dependability. Before the real data-gathering process was carried out, the instrument's faults were fixed. The dependability of the study instrument was further examined using an inter-rater reliability test.

3.6 INTEGRATION OF QUALITATIVE AND QUANTITATIVE DATA

When researchers conduct a mixed-method study with independent or interactive relationships, the stage at which qualitative and quantitative data are combined (also known as the point of interface) is discussed (Creswell & Plano Clark, 2018:66). The data from phases one (qualitative data) and two (quantitative data) were combined at this stage, as detailed in Chapter 6. Qualitative data reflected the participants' experiences in implementing the NSHP and their views on the status of the policy's intervention. Quantitative data were also collected on respondents' experiences of how NSHP is implemented and why it is/it is not implemented as per regulations. During the interpretation phase, the data were integrated, with qualitative findings explaining and contextualising the quantitative data results. In some cases, both phases supported the conclusions; however, in other cases, the data from one phase contradicted the data from the other phase. Integrating data from a mixed-method study necessitates bringing together results that may or may not be contradictory (Creswell & Plano Clark, 2018:70). Concluding remarks were created based on the integrated data and served as a foundation in guiding the development of the conceptual framework. The guidelines and concepts of the framework were validated

by experts in policy development, school health programme managers, nurse managers, educators, and professional nurses.

3.7 DEVELOPING A CONCEPTUAL FRAMEWORK TO EVALUATE THE IMPLEMENTATION OF SCHOOL HEALTH POLICY

This study's last objective is to propose a conceptual framework to support the NSHP's implementation in Namibia (Chapter 6). This objective is described in this section.

Newell and Burnard (2017:60) define a 'conceptual framework' as "the systematic creation of statements to aid nurse practitioners and patients in making decisions about the best health care in a specific clinical situation." Whatever process is used to produce a framework must be based on data obtained from the study (Newell & Burnard, 2017:106; Bryman & Bell, 2015:44). To develop a conceptual framework for this study, logical reasoning procedures were used to derive evidence from the combined qualitative and quantitative data (Chapter 6).

3.8 ETHICAL CONSIDERATIONS

Researchers must act ethically while conducting research. Failure to do so has a detrimental impact on the scientific process, as well as the research outcome (Bryman & Bell, 2015:288). Ethics in research are a set of guidelines to help the researcher conduct acceptable ethical research (Bryman & Bell, 2015:288). Maintaining these moralities entails an ethical effort to generally protect respondents from harm; do good; respect all respondents (beneficence); protect their privacy and independence; and demonstrate fairness in preserving respondents' self-esteem.

Ethical issues require researchers to comply with acceptable professional practices of research. Therefore, researchers are required by law to be sensitive and treat all respondents with the utmost respect. The researcher must conduct research with care, be truthful and report actual findings, and be open to criticism and new ideas. To maintain research ethics, the researcher conducted interviews in such a way that cooperation, trust, openness, and acceptance were elicited (Bryman & Bell, 2015:288).

Throughout the research, the following ethical principles were observed:

3.8.1 Permission to conduct research

The researcher obtained ethical clearance from UNISA's Ethics and Higher Degrees Committee (HSHDC/808/2017). Ethical clearance has been obtained from the Ministry of Health and Education's Human Research Council in Namibia (Annexure B). Permission letters to carry out the research were also obtained from the district health and primary healthcare managers and school principals.

3.8.2 Voluntary participation (autonomy)

Respondents were allowed to choose whether to take part in the study. This liberty is contingent on the release of satisfactory and accurate evidence from target samples. To ensure autonomy in this study, all potential participants received an information leaflet outlining the purpose of the study and the procedures that would be followed. The respondents' rights were not violated in this study because no camera was used during data collection; the researcher recorded all responses in the self-administer questionnaire.

Before engaging with the respondents, the researcher safeguarded the respondents were fully informed about the study through an information letter. Respondents had an extended opportunity to ask questions before the data collection commenced. After explaining the study, the respondents were informed to sign the consent form (Annexure D).

3.8.3 Beneficence

The researcher ensured the respondents were told that the study would not harm or exploit them. The benefits of the research were also communicated to them. The researcher formulated questions in an acceptable manner, not in a judgmental way, to avoid psychological discomfort for respondents. An introduction to the study was also provided to the respondents (Annexure C).

3.8.4 Confidentiality (non-maleficence)

The respondents were assured that the information they provided would be treated confidentially and that the data would be accessible only to the researcher and her supervisors. The use of codes rather than the names of respondents ensured anonymity. Respondents were thus reassured that their identities would not be linked to individual responses; additionally, their names and locations were kept anonymous to protect their identities from criticism.

The researcher ensured that respondents' anonymity was preserved in order to make tracing and linking their responses to them difficult. Completed questionnaires and survey recording tools were securely stored in a designated office. Access to the records, including computerised data, was restricted to survey team members and authorised individuals. This means that information shared by respondents has not been disclosed to others in any way that identifies them.

In addition, the researcher ensured that any data discussed during interviews or through questionnaires were not used for any purpose other than this study (Creswell, 2020:40).

3.8.5 Justice

In this study, the research population was treated equally. Simple unsystematic sampling methods were used to select samples. The study's findings will be shared with participants to ensure that their time was well spent.

3.8.6 Informed consent

Free and informed consent is an ethical concept that ensures respondents are protected from harm by giving them enough data about the study's objectives, procedures to be followed, and any risks and rewards. Extensive support was provided to respondents, and they received accurate information allowing them to consent or reject being involved in the research (Creswell, 2018:30). The respondents who volunteered to participate received information contained in the information leaflet

before they were asked to sign a consent form to recognise their voluntary participation, and reflect that they understood the research purposes. If they wished to withdraw from the study, they could do so any time they wished. All respondents were informed of their rights and risks of participating in the study according to the approved informed consent text located on the first page of the questionnaires (Annexure G). All respondents gave their informed consent (Annexure D) before data collection began. However, if there was some discomfort in answering some of the questions, the respondents were excused from participating without being prejudiced.

3.8.7 Scientific credibility

The research evidence should demonstrate a high level of scientific knowledge (Burns & Grove, 2020:203). The data collected for this study were thus not modified, faked, or plagiarised. This study was carried out in harmony with accepted ethical guidelines, thanks to experienced promoters in the research process. Scientific papers were acknowledged with citations and careful paraphrasing of previously published material.

3.8.8 External evaluation

Researchers may be biased when conducting a risk-benefit analysis; thus, an institutional review of the research proposal is required to ensure applicability (Burns & Grove, 2020:199). The Research and Ethics Committee of Unisa's Department of Health Studies reviewed this study for ethical approval, protecting the researcher, participants, responders, and institutions involved in the study (Annexure B).

3.9 CONCLUSION

Each research design phase’s purpose, objectives, research design, and methodologies were covered in this chapter. A discussion followed about data integration, the development and validation of guidelines for teachers’ and nurses’ implementation of the NSHP, and adherence to school health policy requirements.

The analysed data from the qualitative phase (I) are discussed in Chapter 4, backed by literature.

CHAPTER 4
DATA ANALYSIS, PRESENTATION AND DESCRIPTION OF THE RESEARCH FINDINGS

4.1 INTRODUCTION

Chapter 3 describes the research design and methodology used in this study. This chapter describes analyses of the two strands (qualitative and quantitative) of the exploratory sequential mixed method study, followed by a presentation of each strand's results. The data analysis of both qualitative and quantitative data sought to relate and ensure the attainment of the following research objectives that guided the study.

- Explore and describe stakeholders' experiences with the implementation of the NSHP in the three regions of Namibia.
- Determine stakeholders' knowledge and attitudes regarding the NSHP's implementation process in the three regions of Namibia.
- Establish what factors are affecting the NSHP's implementation in the three regions of Namibia.
- Develop a framework to strengthen the NSHP's implementation in Namibia.

4.2 DATA MANAGEMENT AND ANALYSIS

The study employed theoretical and practical approaches to analyse the NSHP's implementation. A narrative analysis of the qualitative findings was undertaken as per the grounded theory approach, while a descriptive analysis of the quantitative results was conducted. The examination and description of the site yielded qualitative data that were analysed using established theories to investigate and characterise stakeholders' experiences with policy implementation processes while identifying elements influencing its success or failure. Furthermore, verbatim participant quotes were included as part of the narrative results derived from the qualitative data gathered during the study. This helped provide an understanding of how individuals experienced the NSHP's implementation on a personal level. Direct participants' quotes, which are

italicised, constitute an essential part of the theoretical findings in this mixed-method research design.

The descriptive analysis of objective results provided valuable insights into the status of the NSHP's implementation in each region. These findings were presented using tables, graphs, and figures for easy comprehension by readers. Overall comparisons between quantitative and qualitative findings allowed the researcher to gain deeper insight into specific aspects influencing the NSHP programme delivery while confirming or refuting statistical evidence where possible. To integrate the findings based on carefully crafted frameworks, the researcher highlighted areas where further exploration might be necessary when discussing specific topics either exclusively or collectively across different themes emerging during discussions between participants following the statistical analyses.

4.3 QUALITATIVE FINDINGS

The school health management team, comprising school principals, and PHC regional and national management team who manage the school health policy's implementation in schools and health facilities, formed the sample that participated in the qualitative data collection processes. Purposive sampling was used to select a sample of twenty-seven (n=27) participating national-level managers, principals, and PHC supervisors based on the inclusion criteria. Prior to data collection, informed consent was obtained.

4.3.1 Demographic characteristics of participants in the qualitative strand

The pie graph below indicates the characteristics of participants in the qualitative strand.

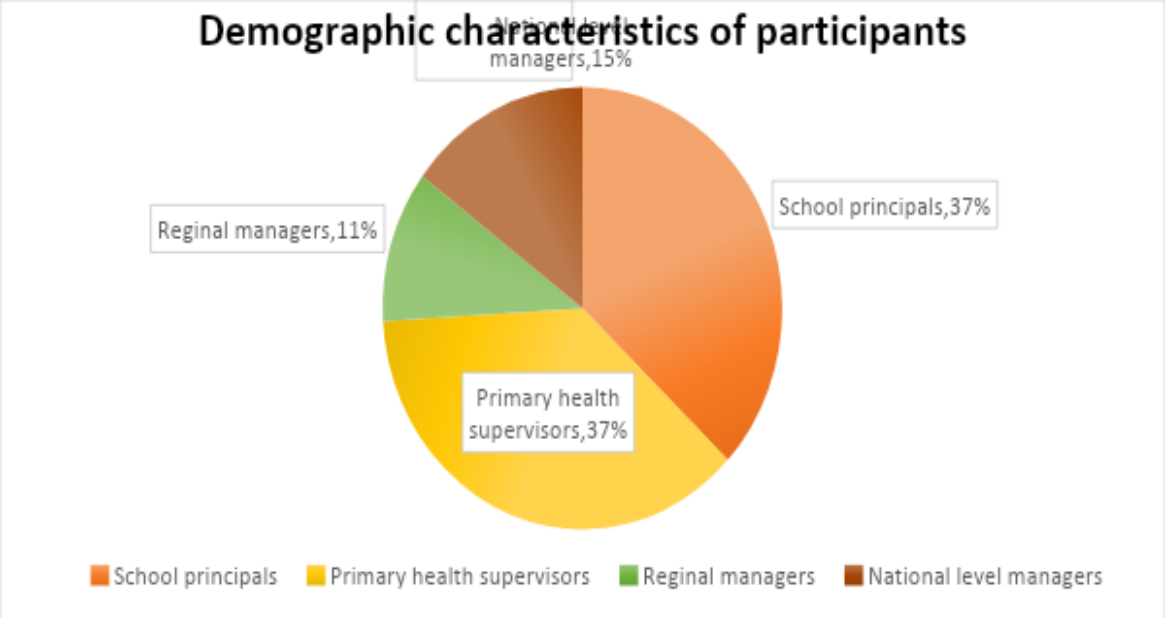

Figure 4.1: Management categories (n=27; 100%)

There were 10 (37%) PHC supervisors, 10 (37%) school principals, 3 (11%) regional managers, and 4 (15%) national managers in each discussion. In this study, neither a school health nurse nor a teacher-led nor oversaw the school health team. This demonstrates the possibility for effective leadership, but only if regional efforts are made to address other human-resource-related issues (Schultz & Ruel-Bergeron, 2021:5).

4.3.2 Stakeholders' experiences with the implementation of the NSHP in Namibia

4.3.2.1 Management's work experience

The school management team's work experience was considered to ascertain whether there is a relationship between such experience and the provision of high-quality school health services in the regions. Figure 4.2 shows the NSHP participants' employment experience.

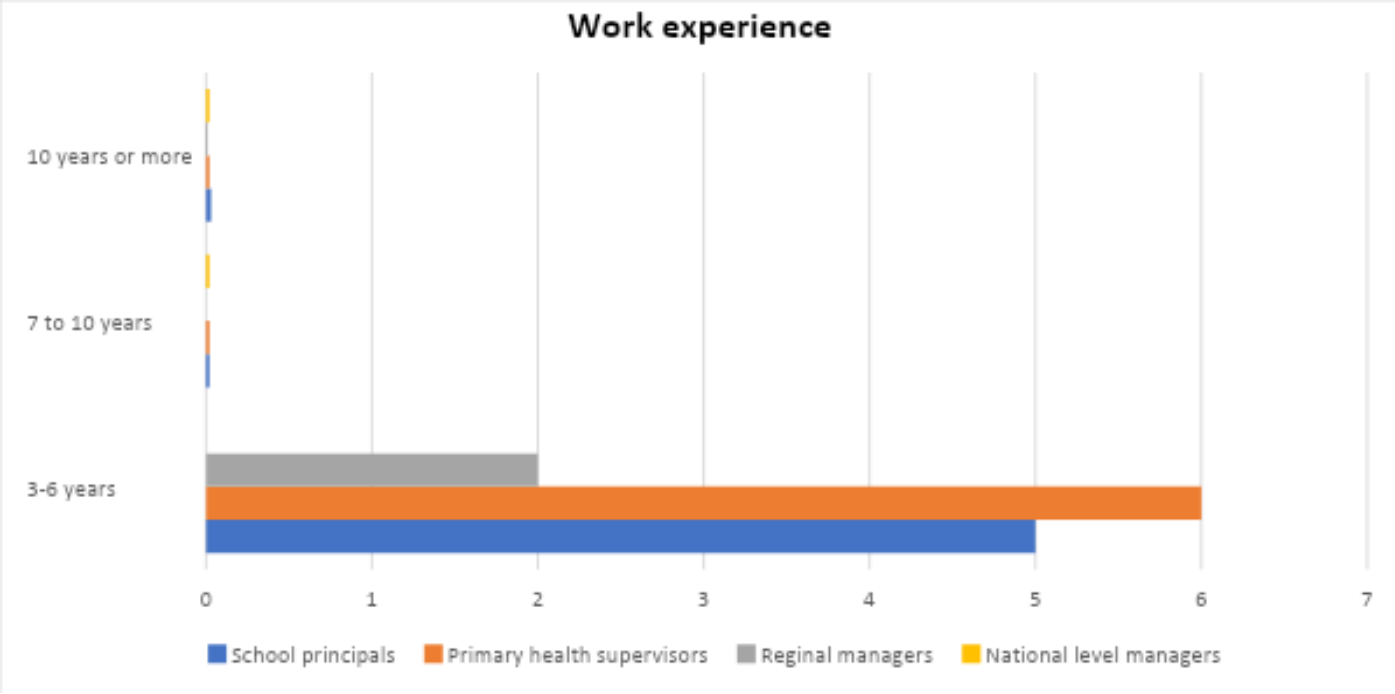

Figure 4.2: School health management team's work experience (n=27,100%)

Figure 4.2 above determines that the principal, PHC supervisors, regional managers, and national managers all had work experience ranging from three to ten years or more. Most principals (n = 5, 50%), PHC supervisors =6, 60%), regional managers (n = 3, 100%), and national managers (n= 0), had 0–4 years of work experience. Some principals (n = 3, 30%); PHC supervisors (n = 2, 20%); regional managers (n = 0,0%); and national managers (n = 1, 25%) had 5–9 years of work experience. A few principals (n=2, 20%), PHC supervisors (n=2, 20%), regional managers (n=0, 0%), and national managers (n=3, 75%) had 10 years or more professional experience, while five principals and six PHC supervisors had been on the school health policy management for less than four years. This is an indication that all categories were unfortunately underfunded, but relied on a variety of private professionals to provide various services to the learners. According to the interviewed educators, they had a positive working relationship with these health professionals.

> *"Unfortunately, we don't have nurses at the clinic recruited to do school health programs, but the staff at the clinic are always willing to assist. But they don't record the statistics." (PHC Supervisor)*

4.3.2.2 Management team's awareness of the school health policy

Table 4.1: Awareness of school health policy contents

Answer	Frequency	Percentage
Yes	20	74%
No	7	26%
Do not know	0	0%

Table 4.1 shows that 75% (n = 20) of the management teams were aware of the school health policy documents and their contents, as well as the availability of the programmes, which were interwoven into the development and implementation of the programmes. It is a tool for tracking implementation progress against programme objectives by collecting process and output-based indicators on a regular or routine basis throughout the project's life. To lay the groundwork for programme monitoring, implementers should agree on the following: (1) the problem that the project is attempting to solve; (2) the mechanism through which the project's inputs will result in desired outcomes; (3) the type of evidence needed to assess progress toward programme outcomes; and (4) the country's existing data sources and instruments (Schultz & Ruel-Bergeron, 2021:1).

A positive finding from the focus group discussion is that there is widespread awareness of the existence and broad substance of the NSHP at all levels of the healthcare system.

> *"We ensure that all facilities have at least one nurse trained in school health, but the challenge is with resignation and transfer." (National level manager)*

In addition, all national interviewees, as well as the vast majority of district-level interviewees, 'bought into' the legitimate role and relevance of school health within the PHC package. Nearly all of those who participated in the interviews expressed a desire to see the policy succeed, especially in locations where it is now non-existent.

“We have partnered up with the MOHSS district team to ensure that receiving patients receive the necessary health intervention, and sometimes we do plan together." (Principal)

Management at the district level acknowledged the need to offer school health services within their current resource base. Also, in cases where the service did not yet exist, they made pledges to offer it at a later stage if available resources enabled the manager's understanding of the precise policy content to be less than satisfactory. As evidenced by the statement of this manager, not all managers who had significant responsibilities for the school health policy requirements were familiar with the content of the policy.

“During one of our supervisory visits, we were surprised to find a clinic with no dedicated focal person for the school health program in the area and the records were not completed a significant a screened, responsibilities example” (Regional manager)

4.3.2.3 The management system: managements’ perceptions, attitudes, and support for the NSHP’s implementation

The second question in the guide focused on the managers’ responsibilities in ensuring the school health policy is implemented. The way senior managers, particularly those at the district level, perceive and thus respond to the NSHP’s school requests for the clinics to be screened on specific days. While this is an unusual approach and was deemed impractical by subsequent nurses, it demonstrates that some managers are willing to explore all options, including unconventional ones.

Nurses from various regions and districts stated that their supervisor’s level of support and dedication to facilitating the efficient execution of school health programmes varied. These nurses also complained that their managers frequently lack knowledge of school health services, are unsure of how to offer support, and make no effort to train the nurses. Concerning the lack of an assigned position and office space for administrative work, a PHC supervisor exclaimed:

“We do not conduct school health in our catchment areas; the outreach team from the district is responsible for that." "In fact, there was no training for us on the school health policy!” (PHC supervisor)

The facility manager extolled the virtues of school health services, while the nurses delivering the service felt mistreated. This demonstrates that managers’ awareness of the policy and commitment to it (as described in Table 4.1) did not always translate into practical support for the school health services and the nurses who deliver them.

There was no conducting of the report, and undercover visits were not limited to school health nurse managers. They also felt that other facility-based nurses did not always appreciate their work, as demonstrated by the following quote:

“Registered nurse training is inclusive, with community health services that form part of school health services; currently, with a low budget, we have not trained any staff in school health, but one is wedded to emphasizing health care keeping." (PHC supervisor)

Indeed, the majority of managers present at the group discussion briefly described that, in most cases, school health nurses felt isolated, alone, unappreciated, misunderstood, and unsupported, to varying degrees. It has been noticed that there is a shortage of staff in the facility, which makes it difficult to release staff for training. Managers believe the minimum qualification is a clinical nurse practitioner level due to the complexity of physical examinations and, particularly, mental health assessments. Some interviewees indicated that school health is a speciality that should be classified as such in job advertisements. Conversely, in rural areas, staff nurses were tasked with delivering school health services and were reportedly quite effective.

The level of qualification of a nurse delivering school health services is directly related to the nature of the screening and examination activities they perform. Most managers indicated that nurses examine pre-primary and grade 1 learners from head to toe, testing their vision, auditory, and oral screening. These additional chest, ear, and heart examinations, as well as attempts to ascertain learners’ mental health status, distinguished the level of professional training required to deliver school health

services. With the addition of the tetanus toxin vaccination to school health nurses' responsibilities, the school health team's leader must have, at a minimum, a professional nurse's qualification.

Divergent views were expressed regarding "how" and "by whom" the school health package's health promotion and education component should be delivered. In some areas, various groups enter schools to provide various forms of health education and promotion. An interdisciplinary team meets weekly in the Khomas region to discuss the best methods for coordinating these activities in schools. Additionally, the Department of Education has many initiatives and, through the Life Skills subject, attempts to integrate certain health promotion and education activities into the school curriculum.

One senior manager in the Khomas region pointed out, quite correctly, that educators are far more qualified to deliver health education and health promotion activities than school nurses, who visit schools only once a year. This phenomenon could be addressed through formal and structured collaboration between the Department of Education's School Health and Health Promotion Programme and the private sector.

The following staffing and human resource planning issues must be addressed to assist districts in planning and allocating sufficient and appropriate staff:

- The extent to which physical examinations are conducted, in addition to the routine screening activities that school health nurses should perform.
- The critical link in determining the leader of the team's minimum level professional qualification.
- Coordination between various school health programmes and sectors to facilitate service delivery and maximise the efficiency of existing staffing resources.

Some staffing constraints may be alleviated by addressing these issues, at least in part.

4.3.2.4 Training on data collection

The next issue frequently mentioned during focus groups was a lack of adequate training and support for nurses responsible for delivering school health services, as demonstrated by the following quote:

> *“I’m not going to lie; there was no training." "There was no orientation or training on data collection; the policy was simply read through to understand how we would proceed; otherwise, there was no orientation or training.” (Nurse in charge)*

This is less of an issue in areas where nurses who previously worked in “vertical school health services” are paired with new nurses who receive on-the-job training. This rationale is not always followed. For instance, in one district or region, three newly hired nurses received no training or supervision during their first three to nine months on the job. They were left to fend for themselves as independent practitioners who sought support from one another.

At least two of the managers in the Oshana region reported that nurses were unaware of the NSHP. At one of these locations, a nurse received in-service training from her predecessor, who maintained the traditional vertical service structure. On a supervisory visit, the following observation was revealed: when a manager asked a nurse to describe her work, she demonstrated a remarkable grasp of school health service requirements and reportedly had not performed these activities in the last few years.

4.3.2.5 Support from management

Support directly impacted the delivery of school health services. Some managers reportedly provided maximum support to ensure the services’ smooth delivery, while others allegedly obstructed delivery by repeatedly diverting nurses away from school health activities or reallocating resources, such as transportation, to other services. In general, managers stated that their nurses lacked an understanding of how the service

should be delivered and was thus unable to assist them, as confirmed by the following quote:

> *“Within the clinic staff establishment, there are no positions for school health nurses, and currently there are few at the facility who do that role, which means they need to become acquainted with the policy and learn how to implement it, as policy evaluation is concerned with the process, the content, and the effects or performance of the policy." (Principal 1)*

The managers stressed that if allowed to evaluate the policy, they would gain the most knowledge during the implementation process. Furthermore, policy evaluation will help them obtain direct short-term feedback between the policy's vision and objectives and actual achievements:

> *“I’m not familiar with the policy, but we can be mandated to assess and evaluate our own school activities and provide feedback to the region; unfortunately, we don’t have a book to record school health work.” (Principal)*

While the principals were attempting to implement the policy, the local clinic did not have the staff to implement school health services, as confirmed by the following quote:

> *“Our local clinic has only two nurses; if one is sick, the other does everything, including school health." This is impossible.” (Principal 3)*

4.3.2.6 Lack of awareness of the school health policy

One of the study's key findings was that the teachers in charge of implementing the policy had varying levels of knowledge and a unified understanding of the NSHP. Furthermore, the 2008 National School Health Policy has not been implemented in most rural schools. The NSHP document, however, is not known to educators, as evidenced by the following excerpt from an interview with a school manager:

“The school health policy is available; we don't use it much, but we also have other policies, such as the HIV and school health policies, which are both available.” (Principal 2)

As a result, school health services in the Kavango region followed the integrated school health manual rather than the NSHP's criteria. Despite a national framework for the provision of school health services, namely the 2008 National School Health Policy, the provision of school health services in urban schools highlighted the contrast and variation in the provision of such services within different public primary schools.

Prior to the focus group, some principals from historically disadvantaged schools were unaware of the existence of such a policy, as confirmed by the following quote:

“I attempted to find out what school health policy you were referring to over the phone, but I was unable to obtain any information. "Because we are a health-promoting school, the health-promoting school policy is what we encourage you to adhere to here.” (Principal)

The primary health care supervisors generally had a greater awareness of this policy than the school principals, according to the results of the focus group discussion sessions. They recognized that the two documents (the guidelines on school health promotion and the NSHP) were interconnected and complementary.

“The school health policy directs work with nurses as a school health professional, whereas at a health-promoting school, we collaborate with teachers and the entire school community so that while I am doing my job, I am also promoting health.” (National manager)

The main reason for the policy’s delay and the lack of implementation of the school health policy requirement in the Kavango region was a lack of staff commitment, training, and transportation, as well as a lack of record-keeping. However, the managers asserted a commitment to implementing the policy.

Nonetheless, some circumstances made it more difficult for managers to carry out their responsibilities and tasks related to executing the NSHP. The school principals and primary healthcare supervisors all expressed concern about the policy's content. Indeed, the primary argument was that the environment in which they must implement the NSHP is unsuitable for their implementation duties. Additionally, there were no clear guidelines for implementing the policy. This condition appears to have compelled them to both ban and implement policies.

> *"Here is a program that is coming to a school, and life skills teachers are not trained on school health policy; how does one expect effective implementations?" (Principal 4)*

Concerning the constraints managers face in their primary role as policy implementers, there are a variety of observations. On the one hand, school administrators asserted that the policy contradicts itself regarding the roles of school health policies in schools, while PHC supervisors admitted that the policy is available at the clinics and schools may ask for it.

According to one of the nurses in charge who manage the school health promotion program, there are challenges to implementing the policy because staff comes to the outreach units and implements it, as confirmed by the following quote:

> *"No, there are challenges because we schedule visits at the district in advance and the district team has to coordinate it, leaving out the local nurse without skills." (PHC supervisor)*

Another noteworthy finding, albeit tangential to this study, was that school principals reported a lack of parental involvement in policy implementation. Although school managers emphasize the importance of parental involvement in achieving policy goals, this does not guarantee success because people react differently to any policy. The public's reaction to the implementation of a policy often determines its success or failure (WHO, 2020:16). Furthermore, the attitude of those who will be affected by a policy has a significant influence on how that policy is implemented. As a result, in order for the NSHP to be successful, all stakeholders (including parents) must adopt

a positive attitude and participate not only during the policy development stage but also throughout the implementation process, as confirmed by the following quote:

> *"I noticed that some parents either forgot or refused to sign and send back the consent letters with their children." (School principal)*

4.3.2.7 Making decisions and resolving problems

School principals and PHC supervisors viewed their roles as decision-making and troubleshooting and thus expressed dissatisfaction with their lack of participation in policy implementation. Their responses indicated that most participants believed their knowledge of the policy was limited. Their seclusion also makes it difficult for them to participate actively as decision-makers in policy processes. Managers mentioned that the first step toward resolving their predicament is to provide them with the necessary knowledge and aids, as demonstrated by the following quote:

> *"We need to acquire more knowledge by updating workshop materials; we need to be given knowledge; we need to attend workshops; and the ministry should staff workshops on school policy." (National manager)*

Several school principals mentioned the importance of preventing failures in the relevant departments by clarifying the policy's meaning and purpose. Such clarity could aid managers in making informed and ethical decisions as policy implementers, particularly since the policy in question targets young schoolchildren who may be vulnerable.

In this regard, Restless Development South Africa (2017:14) observes that it is difficult for school administration staff to claim extensive knowledge of the NSHP. Ultimately, schools often lack a dedicated school health team, which complicates decision-making processes related to policy implementation.

Managers were also uninterested in the context in which the policy was developed and implemented. Instead, the responsibility for policy implementation is delegated to managers. The Departments of Health and Basic Education take a top-down

approach, which leaves those responsible for policy implementation in the dark about what they need to do to achieve policy objectives, as demonstrated by the following quote:

> *"The Department of Basic Education needs to step in and determine the best course of action for implementing school health policies in each school." (School principal)*

According to one of the school principals, the uncertainties in the policy document allow for multiple interpretations of the policy. Such circumstances complicate the manager's role in their organization's quest to resolve problems encountered while implementing the policy, as described by the following quote:

> *"The district managers from the ministry of health and education need to sit down and distribute roles and responsibilities because for now, no one can be accountable for why policy activities are not implemented." (School principal)*

Furthermore, the participants believed that because policies are introduced with varying degrees of obscurity, the contradictions between departmental policies regarding their implementation create a gap that prevents managers from effectively using and applying their discretion in resolving problems. As a result, there is confusion about the policy's intent and how it should be carried out. The ministries of health and basic education appeared to have a mutual understanding of school policies, particularly regarding how the NSHP should be implemented. Furthermore, principals believed that policies should be translated so that everyone involved in implementation fully understands them, allowing them to take a bottom-up approach, as narrated by the following quote:

> *"While we recognize that we are receiving training and workshops from the Ministry of Health, it would have been good for the document to have been thoroughly vetted so that we understand exactly what it requires from all of us." (School principal)*

4.3.3 Limitations to NSHP's implementation in Namibia

- **What limitations/obstacles or challenges (if any) do you see in implementing this policy in your local school?**

4.3.3.1 The total coverage is inadequate

Most research disciplines lack or struggle considerably with school health services in the study region, mainly Oshana and Kavango. Although the 2018–17 District Health Information Report indicated 100% district coverage for the Khomas region on school health delivery, in many of the research sites, school health service is not provided at all or is delivered for only two or three years to a single school. The objective of delivering the school health programme to 100% of districts (i.e., to all schools in the district) has not been met. This highlights how aggregate data such as "district coverage of the school health services" obscures genuine exposure in the sub-district, school, and learner spaces.

Significant disparities also exist in the provision of services between and within districts. The school health service coverage demonstrates that the primary policy objective of increasing access to health delivery remains unachieved. Despite nurses' efforts to reach out to underserved schools, most research sites in impoverished urban and rural locations lacked frequent assistance, compared to more affluent Kavango areas, as observed by the following quote:

> *"I'm not going to lie; there was no training. There was no orientation or training; the policy was simply read through to understand how we would proceed; otherwise, there was no orientation or training." (PHC supervisor)*

School health services are distributed annually to all schools in some research locations, every two or three years in other areas, and not at all in others. The nurse-to-school ratio also varies considerably, ranging from 1:40 in one school to 1:357 in another school.

“At the clinic, there is no equipment to perform eyesight, auditory, or dentary checks; how do you expect to implement a program?” (PHC supervisor)

As stated by the nurses, the service provided is of substandard quality. According to nurses, insufficient equipment to provide the service; an inability to adequately screen children in schools that lack privacy or adequate examination spaces (particularly when performing a more detailed physical exam or mental health assessment on children who may require it); and an inability to follow up on those referred all contribute to low-quality services.

4.3.3.2 Systems of referral are insufficient

The majority of interviewees in rural research areas said necessary referral systems were unavailable or frequently too remote for children to access. This renders Grade R/1 screening operations in those locations invalid, as screening is only useful if a referral service is available to address the issues detected during the screening, as demonstrated by the following quote:

“Our district hospital is 150 km away from here, making it difficult for school learners who need a doctor’s consultation because their parents do not have money for transport.” (PHC supervisor)

In addition, while most urban regions have effective referral systems, this is not always the case with mental health issues.

4.3.3.3 Inconsistency in school health service provision

The way school health services are delivered varies according to how service providers and managers interpret the policy requirements. As a result, school health policy activities vary based on how the policy is interpreted. Additionally, routine monitoring of school health service outputs varies significantly in terms of the types of forms used, the quality of the data collected, and the reporting frequency. As a result, the policy objective of delivering service with uniform norms and standards remains unachieved, as described by the following quote:

“I notice that our school's health calendar is not the same as Rundu Hospital’s services; it is also different.” (Regional manager)

The most significant problem is the health service’s failure to achieve the school health programme’s key policy objectives to date. The primary objective of providing equal coverage and quality care to all children regardless of their geographical location or socioeconomic background remains elusive.

As described by senior management, the attitude toward equity during the first few years of the post-apartheid transition was as follows:

“During the first five years, we took the subject of school health policy implementation very seriously." However, I believe it became quickly apparent that the absorptive capacity of rural areas was much different from the absorptive capacity of urban areas. "As a result, we needed to go from horizontal to vertical equity, but also to emphasize vertical equity.” (Senior health programme administrator)

In all study regions, there was a complete absence of consistency in school health intervention data collection forms, as well as in the compilation and presentation of school health coverage information. In the worst situations, nurses merely recorded numerical data (monthly statistics) in a book, while others simply jotted down the names of the children referred to them. Ultimately, standardised services must be provided at all schools, regardless of their socioeconomic situation or geographic location, among other things.

As stated in one of the school health policy’s core objectives,

“This service will respond equitably to the diverse health and development needs of the learners.” (Namibia School Health Policy,2008)

According to the policy’s implementation recommendations, an explicit appeal is made for the service to be provided in an equal manner:

"*a requirement for regions to concentrate their efforts initially on the districts with the worst health indices, such as those that coincide with the rural development and urban regeneration nodes that have been recognized as needing special attention" (National School Health Policy 2008;6)*

4.3.3.4 Staffing

Staffing issues are the primary impediment to successfully implementing school health services. This challenge was identified during individual interviews, where the availability of staff at primary-level facilities, the staffing model, and the training and support provided to nurses delivering school health services were explored, as demonstrated by the following quote:

"No chance, as they are well aware of our current staffing shortage." (Regional manager)

4.4 QUANTITATIVE FINDINGS

A standard Likert-scaled questionnaire was used to collect quantitative data. The Statistical Package for Social Science was used to analyse the data, which included the Chi-square test for independence at a significance level of 95 per cent confidence interval and relative risks (SPSS 23).

4.4.1 Demographic characteristics of the quantitative strand's respondents

Three hundred respondents participated in this study. Figure 4.3 shows the respondents' ages. All respondents were older than 18 but younger than 60 years old.

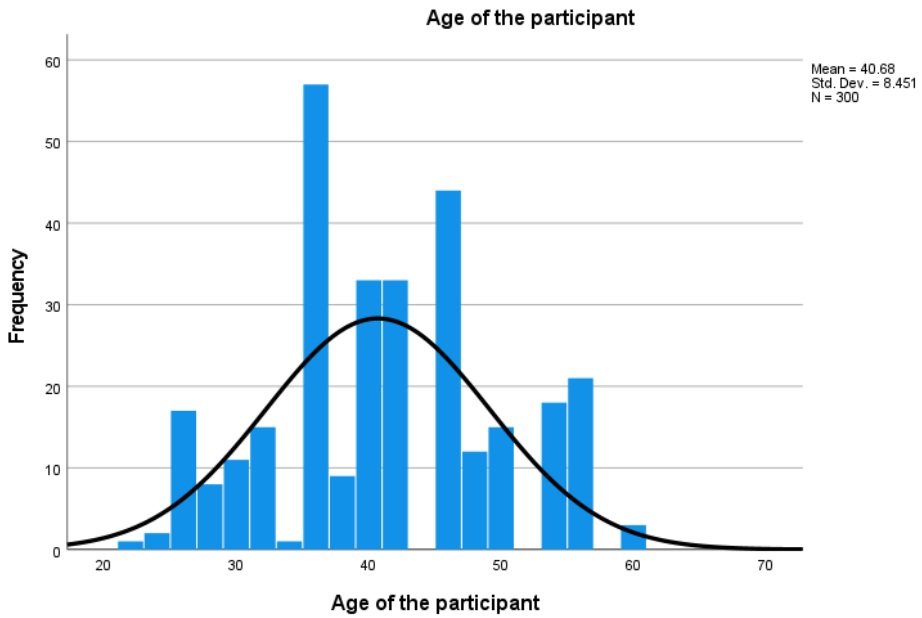

Figure 4.3: The age of respondents

A total of 300 people agreed to participate in the study, and all of them filled out a questionnaire or a checklist. The study focused on people from age 21–60; the majority indicated that they were under the age of 30 (26.5%) compared to those who are 30 (73.5%) and above. The response rate was 100%. A statistically significant relationship was discovered between respondents' awareness of the school health policy and their age.

The p-value of 0.000, which was less than the normal p-value of 0.005, confirmed this. The majority of respondents were in the age groups of 20–49 years and 50+ regulate identify the components that contribute to knowledge and attitudes of school health policy implementation.

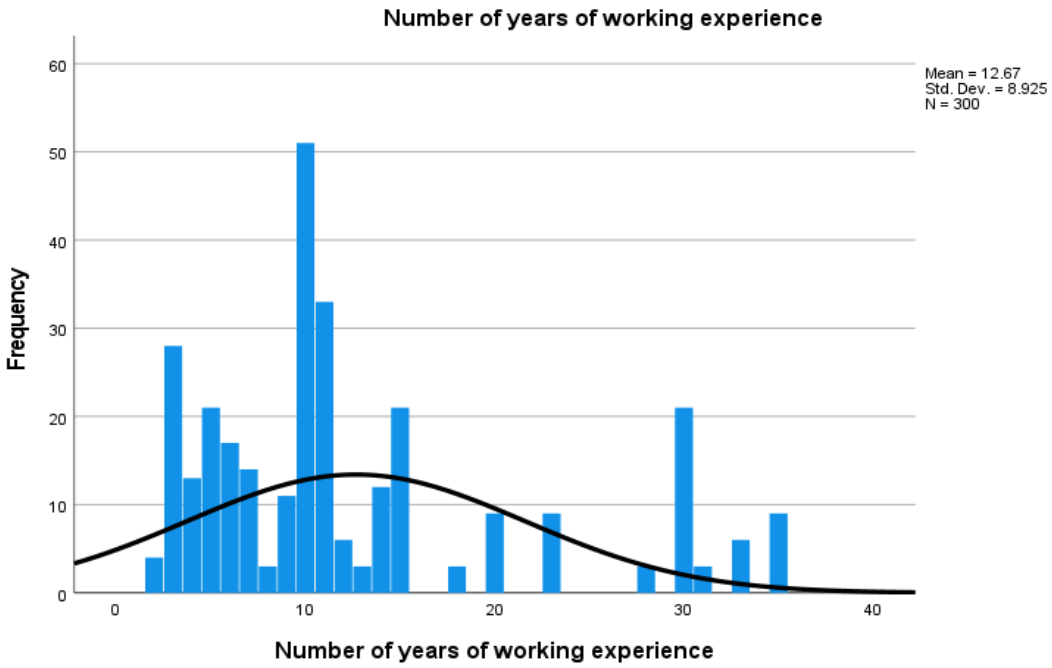

Figure 4.4: Year of experience

Figure 4.4 illustrates the largest proportion (60.3%; n = 114) of respondents who indicated they had good knowledge and attitudes towards the NSHP had attitudes about the implementation policies or experience, followed by 44% (n = 19) who had 3 to 5 years' work experience. Respondents with 5 to 10 years of work experience constituted 32% (n = 21) of the sample, showing good knowledge and attitudes towards the NSHP. Lastly, 68.2% (n = 48) of the respondents had less than 5 to 10 years of work experience and indicated poor knowledge of the NSHP. Despite the numerous benefits and connections between an effective school policy and learner health, Ramma (2010:5) discovered that only 36.8% of South African teachers were aware of the NSHP, and only 15.9% had ever seen the policy document. The normal spreading of the knowledge score in Table 4.2 shows that the respondents' score was right-skewed, indicating that a higher proportion of teachers with more than ten years of experience scored higher than the average with fewer than ten years of experience in school health policy implementation. To determine which components, contribute to the findings, a logistic regression analysis was used.

Table 4.2: Knowledge of the existence of the NSHP implementation document

Answer	Frequency	Percentage
Yes	50	17%
No	150	50%
Do not know	50	17%

In this study, it was discovered that schoolteachers and school health nurses were not very aware of the NSHP Implementation document and that it did not exist in their respective schools. According to statistics, 50% did not know, while 17% said they did (Table 4.2). Ademokun, Osungbade and Obembe (2014:5) found similar results, stating that one-third of their participating instructors had never heard of the NSHP document. This study also revealed that Delta's national school health policy (Nigeria) and school health programme were not being successfully implemented or monitored by the government or stakeholders. The mean overall score showed that 25.01% of respondents said the monitoring was satisfactory, while 74.09% were dissatisfied with the monitoring's intensity. When the variable received a score of 1.93, it fell short of the standard for satisfactory performance. Monitoring had a t-value of.435 and an alpha of.664, implying that it is not a reliable predictor of how well the NSHP or school health policy will be implemented.

4.4.2 The status of the NSHP's implementation process in Namibia

This section presents the socio-demographic characteristics of the nurses, programme health managers, primary health supervisors, and national and regional managers.

Table 4.3: Respondents' socio-demographic characteristics (n=300) and knowledge of school health policies

Characteristic	Total (%)	School health policy knowledge		P-value*
		YES**	NO	
Sex				
Female	191 (63.7%)	94 (49.2%)	97 (50.8%)	0.00*
Male	109 (36.3%)	62 (56.9%)	47 (43.1%)	
	300	**156 (52%)**	**144 (48%)**	

Characteristic	Total (%)	School health policy knowledge		P-value*
		YES**	NO	
Education Level				
Primary	0	0	0	
Secondary	0	0	0	0.0*
Tertiary	300 (100%)	156 (52%)	144 (48%)	
	300	**156**	**144**	
Job Position/Rank				
Nurses	150 (50%)	48 (32%)	102 (68%)	
Programme health managers	54 (18)	21 (38.9%)	33 (61.1%)	0.00*
Primary health supervisors	30 (10%)	21 (70%)	9 (30%)	
National and regional level for managers	66 (22%)	66 (100%)	0	
	300	**156**	**144**	
Work Experience				
3 to 5 years	42 (14%)	19 (43.9%)	23 (56.1%)	
5 years to 10 years	69 (23%)	21 (31.8%)	48 (68.2%)	0.0*
> 10 years	189 (63%)	114 (60.3%)	75 (39.7%)	
	300	**154**	**146**	

**P-value Pearson chi-square test was statistically significant at 0.05*

***Good/Appropriate knowledge of School Health Policy*

A Pearson product-moment association was conducted to evaluate the correlation between sex, school category, school location, education level, job position, work experience, and school health policy knowledge and attitudes to control the status of school health policy implementation in health sectors. Gender was more strongly positively related to knowledge of the policy, as more male respondents (n = 62; 56.9%; p<.00) knew about the school health policy than female respondents, who participated in higher numbers (n = 94; 49.2%; p<0.0).

A complete list of correlations is presented in Table 4.3. These findings indicated a correlation between job position and work experience since higher-level, employees are mindless, mindless automatons in a Weberian machine. That's why the nurses who conducted school health programmes at the time were completely uninformed of the NSHP (38.9%), had never heard of it, and had never even seen it. There is a significant statistical association between knowledge of the school health policy, work

experience (p-value 0.00), and schools' geographic location, whether urban or rural (p< .00). The p-values in all characteristics were less than 0.0, as shown in Table 4.3.

Table 4.4 reflects the socio-demographic characteristics and attitudes of the teachers, principals, and national and regional managers.

Table 4.4: Respondents' socio-demographic characteristics (n=300) and attitudes toward School Health Policy implementation

Characteristic	Total (%)	Attitudes towards School Health Policy		P-value*
		YES**	NO	
Sex				
Female	191 (63.7%)	94 (49.2%)	97 (50.8%)	0.00*
Male	109 (36.3%)	62 (56.9%)	47 (43.1%)	
	300	**156 (52%)**	**144 (48%)**	
School Location				
Location/Rural	120 (61.5%)	57 (47.5%)	63 (52.5%)	
Location/Urban	114 (38.5%)	33 (28.9%)	81 (71.1%)	0.00*
	234	**90**	**144**	
Education Level				
Primary	0	0	0	
Secondary	0	0	0	0.0*
Tertiary	300 (100%)	156 (52%)	144 (48%)	
	300	**156**	**144**	
Job Position/Rank				
Teachers	150 (50%)	48 (32%)	102 (68%)	
Principal	54 (18)	21 (38.9%)	33 (61.1%)	0.00*
Reginal manager	30 (10%)	21 (70%)	9 (30%)	
National manager	66 (22%)	66 (100%)	0	
	300	**156**	**144**	
Work Experience				
3 to 5 years	42 (14%)	19 (43.9%)	23 (56.1%)	
5 years to 10 years	69 (23%)	21 (31.8%)	48 (68.2%)	0.0*
> 10 years	189 (63%)	114 (60.3%)	75 (39.7%)	
	300	**154**	**146**	

**P-value Pearson chi-square test statistically significant at 0.05*

***Good/Appropriate attitudes on School Health Policy*

As shown in Table 4.4, 156 (52%) respondents had positive attitudes toward school health policy implementation, followed by 144 (48%) respondents were not aware of school health policy implementation.

Some respondents from rural schools (n = 63; 52.5%) indicated some negative attitudes toward school health policy implementation, and some (n = 57; 47.5%) were interested in school health policy implementation with good attitudes. In addition, 81 (71.1%) and 63 (52.5%) respondents from urban and rural schools indicated negative attitudes toward school health policy implementation, respectively.

The overall mean knowledge score among the national managers was 100%, with all the national manager respondents (n = 300; 100%) having an excellent understanding of the school health policy [Table 4.4]. The corresponding p-value of the test statistic is smaller than our chosen significance level $\alpha = 0.05$, so we can accept the null hypothesis, and conclude that there is no association between job position, work experience, and the implementation of school health policies. Based on the results, we can state that there was a significant association between job position, work experience, and the implementation of school health policy in Namibia ($p > 0.05$). However, there is an association between attitudes, job ranks, and years of experience implementing a school health policy. For example, 61% of those with negative attitudes toward school health policy implementation were principals, while 68% of schoolteachers indicated good attitudes toward implementing the school health policy (while 100% of national and regional managers indicated good attitudes toward implementing the school health policy). This demonstrates that as employees are exposed to management and gain more experience implementing policies, they are more likely to be responsible and adopt positive attitudes. During advanced training, managers also gain more knowledge. The p-value of 0.0 confirmed the significance of the association between attitude and years of experience in implementing school health policies.

There are numerous strategies for delivering and monitoring school health and nutrition services, according to Schultz and Ruel-Bergeron (2021:2), and the spectrum of appropriate treatments varies significantly between situations. As a result, no model exists for delivering and monitoring equitable school nutrition programming, and each

monitoring system will be unique to the programmes, interventions, and settings. The lack of an organised and standardised technique for measuring and reporting coverage is to blame for the existing confusion and overall lack of knowledge about coverage that prevails in the industry.

4.4.2.1 Personnel statistics and the resulting ratio of school nurses to students

Unsurprisingly, almost all interviewees believed that primary-level facilities lacked sufficient nurses to provide the required range of services. This shortage has been exacerbated by school health services, which require nurses to work outside of clinics and deliver services in the community. The ratio of school health nurses to students varies considerably across research areas, ranging from 1:8 in a Khomas urban area to 1:372 in an Oshana region.

The higher ratios were typically observed in rural areas, where a single nurse is responsible for all primary healthcare activities, including school health, in a fixed or mobile clinic (in the case of fixed clinics, school health services are not delivered as it means the clinic would have to close). In comparison, rural areas have a lower student-nurse ratio in general.

4.5 ASSOCIATIONS BETWEEN SOCIO-DEMOGRAPHIC FACTORS AND DEPENDENT VARIABLES ON A BIVARIATE BASIS (TABLE 4.2)

4.5.1 Awareness of Namibia's school health programme

Policies are not created by national officials and then routinely implemented by state and local governments as if they were mindless automatons in a Weberian machine, according to Stofile (2008:39). Although none of these differences was statistically significant, more respondents aged 50 years (43.3%) and 30-39 years (42.5%), more males (36.6%), more married respondents (38.4%), more female respondents (37.4%), more respondents with a tertiary education degree in education (38.1%), and more respondents with more than ten years of experience (44.8%) were aware of Namibia's school health policy.

4.5.2 Awareness of the school health programme

Increased awareness of school health policy implementation was facilitated by increasing age. The school health programme was most familiar among respondents aged 50 or older (59.7%), male respondents (56.9%), respondents with higher degrees (100%), and respondents with at least more than 10 years' teaching experience (61.9%). These conclusions, however, were not statistically significant [Figure 4.2].

4.5.3 Knowledge of the school health programme

Figure 4.1's results were not statistically significant. Age (P = 0.007) and level of education (0.036) were strongly related to respondents' knowledge of the school health program. Programme monitoring is ingrained in programme development and implementation, serving as a tool for tracking project implementation progress against project objectives through the frequent or routine collection of process and output-based indicators throughout the project's life. To lay the groundwork for programme monitoring, implementers should agree on the following: (1) the problem that the project is attempting to solve; (2) the mechanism by which the project's inputs will result in desired outcomes; (3) the type of evidence needed to assess progress toward programme outcomes; and (4) the country's existing data sources and instruments (Schultz & Ruel-Bergeron, 2021:12). This evidence indicates that as staff are exposed to the managerial level and gain more experience implementing a policy, they are more likely to be responsible and to have positive attitudes toward the school health policy. Managers learn more during advanced training.

4.5.4 Predictors of school health programme knowledge

Respondents over the age of 50 were twice as likely as those between the ages of 20 and 29 to have adequate knowledge of policy implementation (odds ratio [OR] = 2.00; 95% confidence interval [CI] = 1.20-4.10). [Figure 4.3]. Similarly, respondents with degrees were twice as likely as those with only a diploma in education to have superior knowledge (OR = 2.34; 95% confidence interval [CI] = 1.20–4.60). [Table 4.5]. Programme monitoring is ingrained in programme development and implementation,

serving as a tool for tracking project implementation progress against project objectives through the frequent or routine collection of process and output-based indicators throughout the project's life. To lay the groundwork for programme monitoring, implementers should agree on (1) the problem that the project is attempting to solve; (2) the mechanism by which the project's inputs will result in desired outcomes; (3) the type of evidence required to assess progress toward programme outcomes; and (4) the country's existing data sources and instruments (Schultz & Ruel-Bergeron, 2021:12).

4.5.5 The coverage of health services in schools

As a result of having equity as a policy aim, service providers and managers are required to monitor health service supply and compare it to specific targets for service delivery. This is often accomplished through the compilation of specific indicators and the collection of data.

Table 4.5 shows that 100 out of 133 respondents (58%) strongly agreed that having comprehensive school health programme training materials can influence the level of implementation of the NSHP in the Khomas, Oshana and Kavango regions. From Table 4.5, a mean of 4.186 shows that such training materials influence the level of implementation.

Table 4.5: School health policies indicators (topics covered) and association with school type using the checklist

School Health Policy Indicators Topics covered	**Total** (%)	**School Health Type**		**P-value***
		RURAL	URBAN	
Comprehensive Training Materials	133 (100%)	33 (38.5%)	100 (61.5%)	0.05
WASH - Water, Sanitation, Hygiene	133 (100%)	50 (38%)	83 (62%)	0.205
Nutrition and Healthy Lifestyle	133 (100%)	50 (38%)	83 (62%)	0.205
Training teachers to teach life skills (first aid and using fire extinguishers)	133 (100%)	33(38.5%)	100 (61.5%)	0.05
Sexual, Reproductive Health, Rights	133 (100%)	33 (38.5%)	100 (61.5%)	0.05
	133			

*P-value Pearson chi-square test statistically significant at 0.05

The corresponding p-value of the test statistic is within our chosen significance level of = 00.05, so we can accept the null hypothesis and conclude that there is an association between comprehensive training materials, teacher training on first aid and sexual reproductive health. Based on the results, we can state that there was a significant association between training and implementation of school health policy in both rural and urban schools (p >0.05). According to Schultz and Ruel-Bergeron (2021:17), there are numerous strategies for delivering and monitoring school health and nutrition services, and the spectrum of appropriate treatments varies significantly depending on the situation. As a result, there is no model for delivering and monitoring equitable school health programming, and each monitoring system will be tailored to the specific programmes, interventions, and settings.

The lack of an organised and standardised operation procedure for measuring and reporting coverage is to blame for the existing confusion and overall lack of knowledge on coverage that prevails in the implementation of school health policy.

Eighty-three percent (n=83; 62%) of the 133 respondents strongly agreed that an appropriate wash-water, hygiene, and sanitation programme in urban schools influences NSHP implementation, and (n=50; 38%) in the rural schools indicate subminimal services of WASH are lacking in the rural school. Based on the results, we can state that there was a significant association between schools (p >0.05). A mean of 4.40 indicates that most respondents agreed that increased awareness influenced the level of implementation of the NSHP.

Overall, 83 respondents (62%) agreed that introducing a nutrition and healthy lifestyle programme influences the level of NSHP implementation in urban schools. The corresponding p-value of the test statistics is higher than our chosen significance level of p = 0.05, so we can accept the null hypothesis and conclude that there is no association between embracing a nutrition and healthy lifestyle programme and the NSHP's level of in addition, it has a high standard deviation, just like the water and sanitation factors (p = 0.0205).

In terms of training teachers to teach life skills, 100 out of 133 respondents (62%) strongly agreed on the importance of such training in urban schools, and 33 out of 133

(38%) agreed on the importance of this training in rural schools, while, a mean of 4.57, has recommended that refresher courses and teacher training on sexual and reproductive health and rights issues, with a mean of 4.57, influenced the implementation of a strategic health plan and should be addressed for proper implementation. Other training factors that must be addressed include teacher training to teach life skills, learner training to give first aid and use fire extinguishers. Comprehensive school health programme training materials and training on wash-water, sanitation, and hygiene have a minor impact on policy implementation. A mean of 4.5 for all refresher courses for school personnel on emerging issues indicates that the majority of respondents strongly agreed that such a refresher course influences the implementation of the NSHP.

There are numerous strategies for delivering and monitoring school health and nutrition services, according to Schultz and Ruel-Bergeron (2021:10), and the spectrum of appropriate treatments varies significantly between situations. As a result, no model exists for delivering and monitoring equitable school health programming, and each monitoring system will be unique to the programmes, interventions, and setting. The lack of an organised and standardised technique for measuring and reporting coverage is to blame for the industry's current confusion and overall lack of knowledge on coverage.

Staff and other personnel continue to receive insufficient training regarding the school health program, negatively impacting policy implementation. The principals agreed with these findings, stating that teachers had not been properly trained to implement the policy.

Table 4.6: Factors concerning resources on the implementation of school health policy using a checklist

Description	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Total
Ablution facilities	191 (63.7%)	109 (36.3%)	0	0	0	300 (100%)
Water availability	100 (33.3%)	50 (16.7%)	50 (16,7%)	20 (7%)	30 (10%)	300 (100%)
Recreational facilities	100 (33.3%)	100 (33.3%)	50 (16.7%)	50 (16.7%)		300 (100%)
Proper garbage disposal system	50 (16.7%)	100 (33.3%)	50 (16.7%)	100 (33.3%)	0	300 (100%)

Clinical facilities including first aid	30 (10%)	20 (7%)	100 (33.3%)	100 (30%)	50 (16.7%)	300 (100%)
Availability of fire extinguishers	0	100 (33.3%)	50 (16.7%)	150 (50%)	0	300(100%)
Proper staff houses	0	20 (7%)	30 (10%)	250 (83.3%)	0	300(100%)

Concerning ablution facilities, 191 of the 300 respondents (63.7%) strongly agreed or agreed that they had ablution facilities on school grounds, which is a requirement for implementing the school health policy. As a result, the majority of respondents strongly agreed with the statement (a mean of 4.67), and a standard deviation of 0.88 indicates that there was little variation in the options.

Respondents also indicated that ablution facilities were adequate to ensure sanitary conditions at the schools. However, it was also stated that schools in rural areas lacked proper ablution facilities, putting learners' lives in danger. Some of the school employees relieved themselves in the nearby bushes.

In terms of water availability, 150 of the 300 respondents (50%) strongly agreed that it influences NSHP implementation. With a standard deviation of 0.7, a mean of 4.82 indicates that the majority of respondents strongly agreed with the statement. Water was available in all of the schools under investigation, on average. Most rural schools in the northern regions, like ablution facilities, had a water problem, and some relied solely on underground water sources.

In terms of factors relating to proper garbage disposal systems, 150 of the 300 respondents (50%) agreed that proper garbage disposal influences the level of implementation of the NSHP. The mean of 4.95 and the standard deviation of 0.22 indicate that the majority of respondents agreed with this statement. Most of the schools under investigation had proper garbage disposal systems, though some were improvised. The students were taught how to properly dispose of various types of waste. The Khomas region had good waste management practises in place, where school garbage is collected on a routine basis.

The majority of respondents strongly agreed with the statement that dumping sites influence the level of implementation of the NSHP. With a standard deviation of 0.76,

a mean of 4.65 indicates that the majority of respondents strongly agreed with the statement.

On the recreational factor, 200 out of the 300 respondents (67%) strongly agreed that sports facilities influence the NSHP's level of implementation, with a mean of 4.57. Thus, most of the respondents strongly agreed with the statement, with a standard deviation of 0.72. Though most schools under study indicated the availability of recreational facilities, some were in a deplorable state, which could easily pose bodily harm, especially the sports fields in the Oshana and the two Kavango regions.

According to Table 4.6, 100 of the 300 respondents (33.3 %) strongly agreed that the availability of fire extinguishers influences the level of NSHP implementation. A mean of 4.17 indicates that the majority of respondents agreed with this statement. The statement, however, had a high standard deviation of 0.80, indicating that respondents had mixed feelings about the impact of fire extinguishers. All schools are required to have fire extinguishers, but in this case, the majority of schools in the regions lacked functional fire extinguishers. Furthermore, little or no training was provided to staff members or the learners' leadership body on how to use fire extinguishers in the event of a fire. As a result, the risk of uncontrolled fire remains high in these schools.

Concerning clinical facilities, including first aid, 200 of the 300 respondents (67%) strongly agreed that such a facility influences the level of implementation of the NSHP. With a standard deviation of 0.0, a mean of 4.82 indicates that the majority of respondents strongly agreed with the statement. A lack of sufficient resources was cited as a constraining factor by all respondents. With only one school nurse for the entire school and insufficient medicine, proper health service delivery to the students was hampered.

Furthermore, with a mean of 4.57, 250 of the 300 respondents (83%) strongly agreed that proper staff accommodation of school children's influences the NSHP's level of implementation. With a standard deviation of 0.005, this indicates that the majority of respondents strongly agreed with the statement. Proper staff and other employee accommodations were more visible in urban areas than in rural areas. As a result, the

level of implementation of the national school health programme is unaffected by staff housing (as a resource factor).

In summary, the availability and condition of proper refuse disposal systems and clinical facilities (including first aid) were found to be the most influential resource factors, followed by water availability and ablution services. Recreational facilities have the least amount of influence. A mean of 4.3 for all resource factors indicates that the majority of respondents agreed with the statement that the availability of resources influences the implementation of the NSHP in the study regions.

4.6 A CONCEPTUAL FRAMEWORK TO STRENGTHEN THE NSHP'S IMPLEMENTATION IN NAMIBIA (CHAPTER 6)

A conceptual framework, according to Chinn and Kramer (2018:83), is a "critical process for establishing a tedious method of constructing ideas while viewing phenomena purposefully and methodically". A conceptual framework is thus an organised collection of ideas and theories that helps investigators identify study challenges accurately.

As described in Chapter 6, the conceptual framework led to the development of a model to evaluate the implementation of school health policies in the study locations.

4.7 DESKTOP REVIEW ON THE NSHP'S IMPLEMENTATION IN NAMIBIA

The researcher applied content analysis using the WHO's School Health Monitoring Framework, consisting of 12 key components (WHO,2017:18). This framework was identified as containing influential components to successful policy implementation based on reviews of a variety of papers on implementation and educational reform (WHO, 2017:18). Vision and concept, dedicated time and resources, stakeholder ownership and participation, team training and ongoing coaching, cross-sector collaboration, champions and leaders, data-driven planning and decision-making, administrative and management support, adapting to local concerns, paying attention to external forces, critical mass and supportive norms, and stage of readiness are among the 12 components (WHO, 2017:20).

These 12 components were derived from interviewee responses and document reviews. The data was then cross-tabulated by areas and levels to identify common patterns across all four regions, namely Khomas, Oshana, Kavango East and Kavango West, with region patterns emerging from each.

The school health policy's implementation in Namibia also involved different levels, as indicated by the government of the Republic of Namibia. According to the policy (MoHSS, 2008:8), each level had the responsibilities summarised below:

- At the national level: The MoHSS, through national health programme officers, takes the lead in providing school health services and coordinates with line ministries, mainly the NGOs and the private sector.

- At the regional level: MoHSS regional management teams (regional health programme officers) plan, implement, provide training, supervise, evaluate and monitor district-level activities.

- At the district level: MoHSS district coordinating committees, comprising mainly registered nurses, psychologists and community health workers, manage the implementation of school health activities through the provision of outreach.

- The community level: The local stakeholders (the local authorities, the business community, parents, etc.) provide support to the schools on health-related issues and programmes.

- At the school level: The school, through teachers, learners, school health staff and other school authorities, develop school health policies and programmes, coordinates with the local community on school health-related issues, implements local school health policy and monitors the programmes.

Comparing cases also allowed the researcher to identify the factors that aided and hindered intervention improvement (Shung-King et al., 2014:34). These factors were

then subdivided into four policy-making components that make up the 'policy triangle framework' for health-policy reform and implementation: I content, (ii) actors, (iii) processes, and (iv) context (Junko et al., 2015:20).

This framework promoted a thorough understanding of the policy triangle's components by demonstrating how each one is interconnected with the others. This framework has been used for policy analysis in many health policy studies in developing countries, including research on maternal health policies (WHO, 2017:10).

4.8 OVERVIEW OF THE RESEARCH FINDINGS

Managers interviewed (80%) cited a lack of staff, training support, and capacity as major impediments to policy implementation. Indeed, even when concerns are raised in this regard, school and PHC facility administrators are not supported. According to the findings, the availability of resources and the capacity to implement the policy is a necessary condition for successful implementation.

According to the study findings, school administrators (90%) had a limited understanding of the enabling systems required for successful NSHP implementation, especially on data management-collection, analysis and summary of the findings. Furthermore, they had limited knowledge of policy monitoring and evaluation, whereas PHC supervisors appeared to have some knowledge of policy monitoring and evaluation.

According to the findings, the implementers (60%) in charge of implementing the school health policy are disengaged. The policy's inability to prioritise demonstrates this. Policymakers and implementers see this as the most pressing issue in implementing the school health policy in the Khomas, Oshana and Kavango regions. While both sets of implementers (school principals and primary healthcare supervisors) expressed gratitude for the proposal to integrate school health services, they also identified critical challenges, such as the ministries of Health and Basic Education's lack of involvement or prioritisation of school health services, which impedes policy decision-making and problem-solving.

Furthermore, managers saw the NSHP as an additional responsibility. They simultaneously became policy implementers and policy evaluators, increasing the pressure to perform a broader set of roles than before. School administrators reported that they were expected to evaluate the policy in terms of health-related activities once more. PHC facility administrators, on the other hand, were expected to evaluate the policy in terms of school-related activities.

Furthermore, implementers (80%) reported poorly structured interactions among key policy actors, as well as a lack of a policy translation process, which resulted in insufficient knowledge and prioritisation of school health by district and facility administrators. Among the issues raised were inadequate support and training for nurses. In addition to the foregoing, insufficient capacity and funding, as well as referral service capacity, result in inequitable coverage and service quality, prompting nurses to refer to school health as “the stepchild of primary healthcare”.

Poor implementation at the regional (60%) and district levels was associated with the perception that school health is a low priority (80%). Adequate training and an established monitoring system were discovered to be critical. In addition to effective training, it was discovered that more practical aspects were important at the school level, the final point of policy implementation. It necessitates ongoing coaching for educational district executives as well as effective management skills among school administrators. The policy fails to be implemented successfully due to the expansion of roles and responsibilities.

4.9 CONCLUSION

Chapter 4 presented analysed results from the collected data. This chapter examined the extent to which teachers, school administrators, and PHC facility administrators were well-informed about the school health policy implementation in the three regions. Chapter 5 situates the study’s findings against other studies conducted in the area of evaluating school health policy implementation.

CHAPTER 5
DISCUSSION OF THE FINDINGS

5.1 INTRODUCTION

The previous chapter narrated the study's data analysis methods and findings. This chapter discusses the main integrated findings from the qualitative and quantitative strands of the exploratory sequential mixed method study. The discussions of the findings identified the basic concepts and central statements that guided the conceptual framework's development.

The purpose of this study was to evaluate the implementation of the national policy for school health in Namibia with the view of proposing a framework to strengthen the NSHP.

5.2 STAKEHOLDERS' EXPERIENCES WITH THE IMPLEMENTATION OF THE NSHP IN NAMIBIA

A school health programme is defined as "school processes that promote children and school staffs understanding, maintenance, and improvement of school health policy implementation in different strategies" (WHO 2020:30).

The majority of respondents in this study were women between the ages of 40 and 50+. Since most of the working population in the research regions falls within this age bracket, it explains why most of this study's respondents did as well. Moreover, most respondents held at least a tertiary degree, implying a well-educated teaching and nursing staff. This is likely why a higher number (55.9%) of respondents understood the NSHP's implementation. Bankole and Mabekoje (2008) found that 72.8% of teachers were graduates from university, contrasting with this study's findings since 100% of respondents were university graduates. According to Ofovwe and Ofili (2007:11), a probable explanation for such a discrepancy is that their study interviewed largely secondary school instructors, whereas this study questioned primarily primary school teachers.

Even within regions with more advanced district health systems, such as region A, each area has its own set of data collection forms that have been established in a manner most appropriate for the area in question. A question that came up virtually every time the researcher spoke to nurses was whether she could supply them with a form on which to record the school health data because they were unaware of where to get appropriate forms.

Many school health nurses were unsure of the overall number of schools for which they were responsible and the number of pre-primary Grade 1 learners who needed to be screened. Consequently, it is hard to compute genuine coverage and track the implementation progress. While nurses tended to be aware of which schools they wanted to visit throughout the year on an individual level, this information was primarily used to shape their work plans for the remainder of the school year.

According to the WHO (2020:10), restrictions in health services such as water, sanitation and hygiene (WASH) infrastructure could have a negative impact on school health policy implementation. The report further stated that health messaging, could continue to obstruct the NSHP's implementation, unless government parastatals demonstrate increased political commitment and "take the bull by the horns". In assessing overall service provision and monitoring progress to achieving equity in service provision, the district, provincial, and national offices are unable to use current data to their advantage (WHO, 2020:10).

5.2.1 Namibia's School Health Policy 2008

As reported by nurses and managers, a few policy-content concerns require revision. The following points should be reconsidered:

- Eliminating the phases of the health examination among Grade 1 learners, as this creates confusion and invariably results in nurses delivering phase one and phase two concurrently.

- Reassessing the viability of mental health evaluations, as nurses frequently discover examination rooms are unavailable in schools for private examinations, and referral providers are seldom available. Additionally, nurses are unable to do follow-up visits.

- The exact standards for pre-primary physical examinations must be defined, as they dictate the minimal certification required of the nurse who leads the school health team.

- Health assessments should be restricted to Grade 1 learners because nurses have discovered that pre-primary learners struggle to follow instructions. Also, not all learners enter Grade 0, and not all schools offer Grade 0, yet all students are assessed in Grade 1, resulting in duplication and a waste of scarce nursing time.

5.2.2 Monitoring, evaluation and surveillance

In terms of monitoring and evaluation, the currently employed indicator ("Percentage of districts with fully operating school health services") is not sensitive enough to identify school health service delivery failures at the sub-district, area, school, and learner levels. Suggestions are:

- A variety of more detailed and sensitive measures are suggested in the policy, under the heading "district-level indicators". These will more accurately represent the school health policy's performance.

- These indicators require the appropriate denominators, namely the number of schools and the number of students. Most nurses lack this information and report on numerator data solely in their monthly and annual reports.

- A uniform national form for recording, compiling, and reporting school health service outputs is required. The current state of affairs, where nearly every school health team uses a unique set of forms, is inefficient and hampers the accurate monitoring of school health service coverage.

- Although school health nurses shared numerous anecdotes of effective service delivery, mere instances of effective service delivery are not sufficient justification for the commencement, retention, and growth of any health intervention. Consequently, this component of the school health policy needs to be addressed as soon as possible.

5.2.2.1 Evaluation of the school health policy

The managers stated that their primary responsibility is to implement the policy, but they also acknowledged that their roles go beyond this. Again, the managers emphasised that the effectiveness of the school health programme is dependent on their performance in a variety of roles that are not necessarily related to their core function. Among these functions is policy evaluation, which is useful in determining whether managers completed their assigned tasks in accordance with established objectives.

Managers refer to themselves as policy evaluators because of their decisions during policy implementation. In this case, the managers' primary focus is on what has been accomplished rather than what has not been accomplished in terms of policy evaluation. Again, such decisions determine whether to continue implementing a policy in its current form or modify or expand it (Ramma, 2010:12). This is demonstrated by the following comment from a primary healthcare supervisor:

> *"The facility manager must know the policy, must adhere to the policy in its concepts, and must then verify that whatever was delegated was completed" (Primary healthcare supervisor 2)*

According to the research findings, managers are aware that they are required by the Departments of Health and Basic Education to guide and supervise the policy's effective implementation.

> *"Evaluation should be conducted regularly to identify and resolve issues as they arise" (Primary healthcare supervisor 3)*

Additionally, managers feel obligated to seek answers to resolve potential programmatic problems, since evaluations during the implementation process often reflect early warning signs.

Lastly, district health services have previously absorbed vertical school health services. It is provided in conjunction with other primary healthcare services by nurses who report to the management of PHC facilities and structures at the district level. The way nurses provide school health services, the school health team, and the level of qualification of the nurses who lead the team have all been tailored to the unique circumstances of each area. This has both positive and negative consequences.

5.3 THE STATUS OF THE NSHP's IMPLEMENTATION IN THE KHOMAS, OSHANA AND KAVANGO REGIONS

Despite documented benefits and connections between an effective school policy and student health, the view that teachers' awareness of the NSHP is suboptimal in Nigeria (Ademokun, Osungbade & Obembe, 2014:5; Ramma, 2010:30) was supported by this study. Findings revealed that 36.8% of teachers had knowledge of the NSHP, and only 15.9% had not seen the policy document.

The study's analysis and findings reveal that the NSHP challenges considerably outweigh its accomplishments thus far. Despite great efforts on the part of regions and certain districts, the programme's objectives remain unattainable. The core objectives of eliminating unfairness in service provision and creating a uniform, standardised, high-quality service have remained consistent with those of the pre-policy period.

These findings imply that until the school health policy's implementation becomes a non-negotiable component of the district-level PHC package, it will fail to be implemented successfully. To accomplish this objective, district administrators and school health service providers require substantial support, both in principle and in terms of ensuring effective management and delivery structures and the necessary resources are in place. This obligation ultimately rests with those in charge of child health care at the national and regional levels.

Compared to conventional PHC services, a community-based preventive service (like school health services) presents a unique set of obstacles. At times, even with an integrated system of PHC delivery, additional support for struggling services may be necessary. If this does not occur, the school health services will continue to be, in the words of several nurses, “the stepchild of PHC”.

Finally, as evidenced by the “policy to implementation gap” in school health service provision, future policy processes should contain proper “policy effect” assessments. This requires a detailed examination of the implementation environment and the potential impact of implementing a new policy or service in that context. This will help districts anticipate obstacles, make more informed decisions about the viability of implementing new policies or services, and ensure that districts are better prepared and able to provide high-quality services.

Despite commitments to school health improvement through the implementation of Universal Basic Education in 1999, according to Arnold, Mamicka-Tyndale, Tenkorang, Holland, Gaspard and Luginaah (2012:3), Austin, Fung, Cohen-Bearak, Wardle and Cheung (2006:4), and Barnes, Bauza and Treiber (2003), the low level of awareness of the policy remains concerning. Weak information and communication technology, communication breakdowns (between principals and the Ministry of Education), and a lack of technology adoption in schools all foster limited access to the policy document and may be the unanticipated underlying factors causing this lack of awareness (Aduwa-Ogiegbaen, Okhion & Iyamu, 2005:6).

5.4 FACTORS AFFECTING THE NSHP’s IMPLEMENTATION PROCESS IN NAMIBIA

The findings indicate that most schools and health facilities have no records of school health activities that occurred during the past year. In addition, a lack of awareness and comprehension of the school health policy among educators was identified as a major source of concern during the policy implementation process in this study. The roles of educators are critical to the programme’s effectiveness and the adoption of healthy lifestyles among school students.

Bedford, Enria, Giesecke, Heymann, Ihekweazu, Kobinger et al. (2020:2) claim it is critical to prepare educators with the necessary abilities, awareness and understanding of the policy, before implementing a school health programme. According to Aduwa et al. (2005:6), who conducted similar research, many class instructors and most principals were aware of school health programmes in their schools. The finding from UNICEF (2016:10) also highlighted that the majority of teachers were aware of the implementation of a healthy school policy, which is a necessary condition for protecting, promoting learners' health and achieving Millennium Development Goal 2.

Furthermore, the finding that over half (55.9%) of respondents demonstrated adequate knowledge could be explained by the fact that majority of the teachers had a university education, as knowledge is often linked with an individual's education categories (Alex-Hart & Akani, 2011:12). This conclusion supports Akani, Nkanginieme and Oruamado's (2001:3) findings in Port Harcourt, and Darlington et al. (2018:7) findings in Australia. In this study, knowledge was assessed using the contents of the school health programme as specified in the NSHP. Conversely, Akani et al. (2001:13) conducted their study in 2000, before the NSHP's implementation. Their study discovered a statistically significant relationship between age and understanding of school policies; thus, respondents aged 50 years and older were twice as likely as their younger counterparts with fewer years of experience to have a good understanding of the school health policy. Finally, a study conducted in Dharwad, India, discovered that knowledge about dental decay and oral cancer prevention was significantly higher in older age groups than in younger age groups.

The study findings indicate that respondents with advanced degrees were twice as likely to have a strong understanding of the school health policy than those with diplomas in education. This is credible, since advanced age and higher education are associated with a broader experience in various disciplines, including policy management.

More than half of the teachers reported constraints related to a lack of adequate environmental facilities (means of waste disposal, source of water supply, and toilet facilities) in support of studies emphasising the importance of water and sanitation

(Stocks, Ogden, Haddad, Addiss, McGuire & Freeman, 2014:10), food and hygiene (Tessema, Gelaye & Chercos, 2014:6).

The study's findings illustrated that teachers' recommendation to promote the school health programme's implementation was similarly revealed in the principals' interviews. Ademokun et al. (2014:9) also mentioned the need for adequate health programme training for teachers, a dedicated budget for school health service implementation by the government, community involvement in school health policy promotion, and drawing parents' attention (Ademokun et al., 2014:9). However, poorly constructed interactions among key policy actors were observed. A lack of a policy translation process also led to a lack of understanding and prioritisation of school health among district and facility administrators, as well as insufficient support and training for nurses.

Finally, it is strongly advised that experienced government representatives (from the Federal and State Ministries of Education) conduct on-the-spot checks on a regular and periodic basis to ensure compliance with the NSHP's rules (Ramma, 2010:40).

5.4.1 Services for school-based health that stakeholders can support

School health services, according to Ramma (2010:45), promote health and well-being by monitoring, preventing, reducing, treating, and referring students and staff with health problems or conditions to appropriate treatment facilities. A teacher may be assigned to monitor students' diets and physical activity, or a trained school nurse or a school health team comprised of a nutritionist or a diet and nutrition specialist. Although not all governments can provide health services in schools, when resources are available, the following services should be considered (Ramma, 2010:44):

- Measurement of learners' body weight and height on a regular basis, with feedback to parents. Schools that implement BMI measurement programmes should take precautions to avoid endangering students, create a safe and supportive environment for students of all body sizes, and promote physical activity and healthy eating.

- Nutritional screening and data collection for physical activity participation.

- Additional school and community health services referrals based on screening results.

- Recommendations for physical activity for all students, including those with disabilities and their parents.

- Counselling learners and parents on healthy eating habits and physical activity levels.

Health professionals may conduct research, monitoring and evaluation, education, and advocacy in addition to providing routine health care.

5.4.2 School health services

The following general principles serve as a guide for policymakers as they develop and implement national policies:

- A nutrition and physical activity policy in the school should be consistent with and supplement existing policies and action plans, such as those on health promotion and disease prevention.

- Policy formulation and implementation should be interdisciplinary, integrated, and holistic.

- Policy formulation and implementation should consider the cultural context, gender issues, ethnic minorities, and the jurisdictional and legal structure of the country.

- A school nutrition and physical activity policy should be inclusive of all students, participatory, and prioritise the health needs of the most disadvantaged students.
- With a dedicated budget, a long-term school policy on diet and physical activity should be developed and implemented.

- Whenever possible, the implementation of a nutrition and physical activity policy should make use of existing structures and resources (technical staff, civil society, information, ongoing initiatives, and policies).

- Policy development and implementation should be monitored and evaluated at all stages. To make this process easier, resources (both technical and financial) for monitoring and evaluating activities must be set aside from the start.

5.5 SUMMARY AND INTERPRETATION OF RESEARCH FINDINGS (Qualitative)

5.5.1 The status of the implementation process for the school health national policy in Namibia

School administrators' and primary healthcare facility administrators' managerial roles refer to the various responsibilities administrators must fulfil in their institutions to ensure that individual and departments needs and goals are met (Mazibuko, 2007:11). In contrast to teaching and nursing, the administrator's function in schools and basic healthcare facilities is to act as the institution's "glue". Managers need to direct the subordinates well as well as to provide direction and guidance for the units.

5.5.1.1 Policy formulation and execution

When possible, existing structures and resources should be used to implement a nutrition and physical activity policy (technical staff, civil society, information, ongoing initiatives, and policies). All stages of policy development and implementation should be monitored and evaluated. To make this process easier, resources for monitoring and evaluating activities (both technical and financial) must be set aside from the start.

5.5.1.2 Factors at the systemic level

In the Namibian health context, systemic factors are well established and are not unique to school health services. According to this research, the following factors are particularly significant.

At the district level:

> *"Because the district health system is still in the process of being promoted in most districts, it's difficult, if not impossible, to set up school health service at most of the rural clinics" (PHC supervisor).*

Inadequate managerial capacity was also reported at the district level and precluded the following:

- Properly conceptualising a district-wide school health service.
- Adequate support, training, and supervision for school health personnel.
- Guaranteeing appropriate financing for the service.
- Regular monitoring of school health policy outputs.

Additionally, confusion regarding organograms and line management responsibilities creates uncertainty among nurses regarding their accountability and ultimate responsibility for school health services at the provincial or district level.

5.5.1.3 Inadequate staffing levels across the board

Inadequate staffing is the primary impediment to delivering school health services, let alone one of sufficient quality. This is especially true for NSHP as a community-based service, as nurses are required to leave clinics for a few hours and are thus unavailable to perform other clinic duties during that time. Typically, in the words of almost all school health nurses, this means that the school health services are "put on hold in favour of clinic duties" when staff shortages occur. However, this advantage was negated by the distances between clinics and schools. In rural areas of the research, the highest reported nurse-to-learner ratio was 1:135. This means that even if the nurse visits two schools per week, it will take at least two years to cover all schools' phase one activities.

Similarly, even in the wealthier metropolitan district of Khomas, nurse-to-school ratios vary. Three school health nurses in one facility cover nine, 17, and 23 schools per

year, respectively. They had all been appointed relatively recently and had not yet covered all their schools at the time of the interviews. In another area, the nurse-to-school ratio was approximately 12 or 13. The ratio can reach 1:30 in a contiguous rural district, where there are numerous additional pre-schools with pre-primary grade children.

Nurse-to-learner ratios were frequently exacerbated by nurses being required to travel great distances. While distances between clinics and schools were occasionally as little as two kilometres in urban areas, they could reach up to 200 kilometres round-trip in rural areas. Surprisingly, in one area where the ratio was 1:8, and the schools were within walking distance of the clinic, the clinic manager stated they were unable to reach all the schools each year. In another part of the region, only 40 kilometres away, the nurse covered and followed up on all 26 schools in the same year. Some suggest that supervisors should take a closer look at clinic and staff allocation, but the researcher acknowledges that a variety of other variables could account for these differences.

Staff shortages in urban areas are exacerbated by the large number of children enrolled in each school. In urban areas where school health services are delivered in teams rather than individually, pressure is relieved by nursing assistants and community health workers assisting with tasks that do not require the expertise of a professional nurse.

These disparities in staffing ratios illustrate the extent to which inequity persists between regions, particularly between rural and urban areas. As with other aspects of equity, central oversight and leadership are required to assist struggling areas and attempt to close the gap between service requirements and available staffing resources.

5.5.1.4 Inadequate support systems for the school health programme

Transportation, referral services, and the health information system all fall under this category. Unless all of these systems operate smoothly, a breakdown in one, such as a lack of transport availability, can jeopardise the entire service. For instance, school

health nurses reported that transportation is often prioritised over other services, while the school health policy, as a preventive service with less immediate urgency, is "pushed to the back burner" (Mazibuko, 2007:11).

Among the many positive findings of this research is that all interviewees had a reasonable understanding of what equity in health service provision means, and they showed a desire to assist in achieving this policy objective.

When the researcher asked what they understood by equity, the interviewees provided a range of responses. The vast majority agreed that "equity" is a complicated concept with many diverse facets. Equitable service supply was one way of looking at equity, while equitable access to services was another. Equitable resource distribution was also mentioned, as was the equitable distribution of resources to different places. One interviewee mistook the phrase for "employability equity". However, even though they had different views, all interviewees agreed that it is critical to consider equality in the delivery of health services provision.

The distinction between vertical and horizontal fairness is established in the context of health system development and the supply of health services, as well as in the context of healthcare delivery. Horizontal equity implies that resources are allocated fairly, and that everyone receives an equal share of the "healthcare cake". "In practice, most interviewees thus acknowledged the importance of prioritising disadvantaged areas based on their geographic location and poor socioeconomic conditions.

A group of nurses at the "coal face" spoke about their efforts to achieve greater justice in the school health services provision. Among the many examples nurses gave were:

- School-based health services should be prioritised for schools located in the most socio-economically deprived communities.
- Transport needs to be provided so school health nurses can access remote schools.
- Schools that were not accessed the previous year should be prioritised at the beginning of each new school year.

There is insufficient training for teachers and principals on the school health policy, thereby negatively affecting the policy's implementation. Interviewed principals similarly supported these findings by emphasising that teachers were not well trained to implement the school health policy.

One of the policy's objectives, according to Chapter 3, Section 3.4 (on the policy framework), is to ensure that health workers are trained to provide school health services. According to UNICEF (2016:15), school health programmes in Namibia face a shortage of trained school health nurses, a lack of health education materials, a lack of equipment for health check-ups, and underdeveloped information systems. Furthermore, rural public schools face a lack of water, electricity, sanitary facilities, and teaching and learning materials, which makes it difficult to implement school health policy requirements (UNICEF, 2016:14). Darlington et al. (2018:7) also demonstrated that a lack of skilled professionals hindered the adoption of national health education standards in the United States.

The timeframe for implementing the school health policy interventions in different regions, districts, and facilities also fluctuated significantly. Some locations began providing services immediately following the NSHP's implementation, while others continued to provide services that were previously in place but modified these to comply with the new school health programme guidelines. Others began providing the service only a short time before the start of this study, while some places had not yet begun implementing the programme. In certain cases, schools had begun offering school health services, but the programme was subsequently discontinued, mostly due to personnel issues, and the programme had not been reinstated.

In this research, provincial school health coordinators stated that school health services are not in operation in all districts. Unfortunately, some statistics are misleading, as it does not reflect the numerous gaps in coverage that exist at the sub-district, school, and learner levels, among other places.

Coordinators admitted that there were numerous obstacles to service supply that frequently put a stop to their good intentions. The findings thus revealed that there is

no coverage of the school health services (defined as the proportion of schools in districts that implemented the services in any given year since 2008, as well as the proportion of pre-primary/Grade 1 learners who were screened in any given year) is unclear. According to the interviews, not a single district in the studied regions (Khomas, Oshana and Kavango) had achieved 100% coverage, meaning that school health policy interventions had not been delivered to every eligible learner in every school. Interviewees at the district and facility levels stated that there were several sub-districts, or schools within sub-districts, where no health services were available at the school during the time of the study. Few places in the studied regions, and certainly not entire districts (Khomas), provided the service annually to all schools in the area.

Despite these challenges, policy implementers were generally pleased with the policy's implementation and recognised its potentially beneficial effect on learner health and, ultimately, the learning process.

- **What can be done to strengthen Namibia's processes for implementing national school health policies?**

1. A definition of screening, as well as the reason for screening school-going children, should be clear.

2. A plan should be developed to evaluate the facility's screening needs based on adopted best practice guidelines, referral resources, and previous screening programme outcomes (Darlington et al., 2018:7).

3. A calendar aligned with the overall school health schedule should be designed, showing the estimated dates for screenings and follow-ups.

4. Nurses involved in the screening process should be identified. Screening may be performed or assisted by appropriately trained lay individuals (volunteers) to save professionals' time (Darlington et al., 2018:7).

5. Guarantees should be provided that parents/guardians will be notified of any scheduled health screenings, and they should have the option to opt out. They will also be informed of the test results.

6. As part of pre-screening school health education, the district plan to describe the objective of the screening and the ways it will be delivered to pupils should be clear.

7. A description of the screening's follow-up activities, such as notifying parents of positive and negative results, recommending additional evaluations, and providing any assistance that may be available, should be provided. The screening methods should specify how the staff will communicate with parents/guardians once a health concern has been identified in order to determine what, if any, action should be taken, as well as how referral follow-up will be recorded in the student's health record (Darlington et al., 2018:7).

8. Procedures should be available for parents seeking advice from health facility staff about the results of any school health procedure done to the children.

9. According to Darlington et al. (2018:7), if screening indicates the potential need for classroom modifications, the appropriate district officials should be notified of modifications, special education services, or other adjustments should be made, and there should be a clear method for sharing the information.

10. If a school health screening shows that a learner may require special education care, the special education director must be notified.

5.6 CONCLUDING REMARKS

School managers and PHC facility managers, who act as planners, implementers, decision-makers, problem solvers, and policy evaluators, make significant contributions to school health policy implementation. These managers understand the importance of their roles, but they are unable to fulfil them due to their inability to coordinate and collaborate, as mentioned previously. Managers should be given the

authority they need to carry out their responsibilities. To ensure compliance, timely delivery of relevant and up-to-date information on policy implementation is required. It is also critical to use specific performance measures to track the progress of school health policy indicators and guidelines.

CHAPTER 6
A CONCEPTUAL FRAMEWORK TO STRENGTHEN THE NSHP's IMPLEMENTATION IN NAMIBIA

6.1 INTRODUCTION

The results of the study were summarised in Chapter 5. The goal of this chapter is to identify, define, and conceptualise the primary concepts. A conceptual framework, according to Chinn and Kramer (2018:40), is a "laborious method of constructing ideas while viewing phenomena purposefully and analytically". The conceptual framework presented here outlines all the components required to create a health policy. They all have an impact on one another and must be carefully considered. The framework is likely to be ineffective if any are omitted; however, a school may begin at any point in the framework and address the components in any order. Nonetheless, a "theme" or "challenge" is a great place to start.

This framework should be used dynamically, with each component being evaluated in relation to the others. This enables continuous assessment of the alignment and coherence of the components, making the justifications for the health policy's 'who, what, how, and when' explicit and clear. Key concept definitions were critical in developing a conceptual framework for NSHP implementation in Namibia.

Dickoff et al. (1968), as cited in Chinn and Kramer (2018:50), defined a conceptual framework as an organised collection of ideas and theories that assist investigators in accurately identifying research problems. A model was developed in this study using both the theory generation design and practice-oriented theory. The conceptual framework served as the foundation for creating a model to help schools in the Khomas, Oshana and Kavango regions to implement school health policy accordingly.

6.2 DEVELOPMENT OF THE CONCEPTUAL FRAMEWORK

This chapter describes how the framework was developed to optimise the quality and strengthen the school health policy's implementation in Namibia. The framework was

developed using Dickoff's practice-oriented theory, Chinn and Jacobs' systematic approach to theory, and findings from the earlier phases of this study (Chapters 3 to 5). The framework is oriented around Dickoff's prescriptive or situation-creating theory and the components of a theory proposed by Chinn and Jacobs.

The situation-producing theory was used in this study to demonstrate factors and their interconnections that reinforce school health policy interventions in schools and health facilities. Three components of Dickoff's theory were incorporated into this study's framework. The ingredients include the goal or purpose of the framework's activities; a description of the activities required to accomplish the goal; and guidelines to assist in their implementation. This framework aims to optimise the use of information to support the quality of the health policy interventions in schools. The steps for developing the framework correspond to Chinn and Jacobs' components of defining the goal and concepts, developing interconnections between the concepts, and evaluating the framework. The framework's relationships are based on the findings described in Chapters 3–5 of this dissertation.

6.2.1 Naming the concepts

This entailed identifying the concepts necessary for the model's development. Chinn and Jacobs (1987) defined concepts as "words or groups of words that denote objects, properties, or events in a theory".

The data analysis findings evaluating the implementation of Namibia's school health policy revealed the following factors: national strategic leadership, supportive environments, supportive policies, supportive programmes, monitoring, surveillance, and evaluation. The term "situation-producing theory" may also refer to prescriptive theory, goal-incorporating theory, normative theory, value theory, or practice theory, as it goes beyond detailing factors to describe how desired outcomes can be achieved.

6.2.2 Isolating factors/concepts and sub-concepts

This step involved categorising the concepts and sub-concepts based on the evaluation, implementation, and eventual intervention of school health policies. The conceptual framework's factors and sub-factors are listed in Table 6.1.

Table 6.1: Concepts and sub-concepts for the conceptual framework

Concepts	Sub-concepts
National strategic leadership	• Policies, strategies and action plan at national level • Dietary guidelines • Budget • National coordination mechanism • Advisory boards
Supportive environment	• Civil society and NGOs • Physical activity and transportation • Workplaces • Private industries • Schools
Supportive policies	• Promotion food and non-alcoholic beverages to children • Nutrition classification • Food and agricultural policies
Supportive programmes	• Education, communication and public awareness • Health services-based programmes
Monitoring, surveillance and evaluation	• Core outcome indicators (short and intermediate terms) • All stakeholders, including teachers, parents, students, and community members, must be empowered. Respondents should be involved at every stage, consulted before the study's commencement, involved in data collection and interpretation, and the implementation of any outcome. It can be used in conjunction with teaching and learning.

6.2.2.1 Definition of the concepts

National strategic leadership refers to government structures that engage in activities such as developing national plans and securing funding to demonstrate leadership and coordinate action.

Activities aimed at influencing the creation of environments that make healthy choices easier are defined as **supportive environments.**

Supportive policies are defined as national or local policies developed by member states or institutions that, when implemented, foster and promote healthy diets and physical activity. It is a formal statement or procedure adopted by institutions in response to health needs, available resources, and other political pressures that establishes priorities and guidelines for action.

Policies that are implemented at all levels through activities carried out by one or more stakeholders are referred to as **supportive programmes**.

Monitoring, surveillance, and evaluation are mechanisms that have been put in place to process and comprehend the consequences of actions and to guide future actions.

6.2.3 Ingredients for the conceptual framework

This section goes over the concepts and sub-concepts listed in Table 6.1 in greater detail. The guidelines described in the schematic model are meant to be used within a single country. The goal is to show how policies and programmes, as well as how they are implemented, influence populations, resulting in behavioural changes and long-term social, health, and economic benefits. The model demonstrates how to incorporate appropriate monitoring and evaluation indicators into the behaviour change process (WHO, 2020:10).

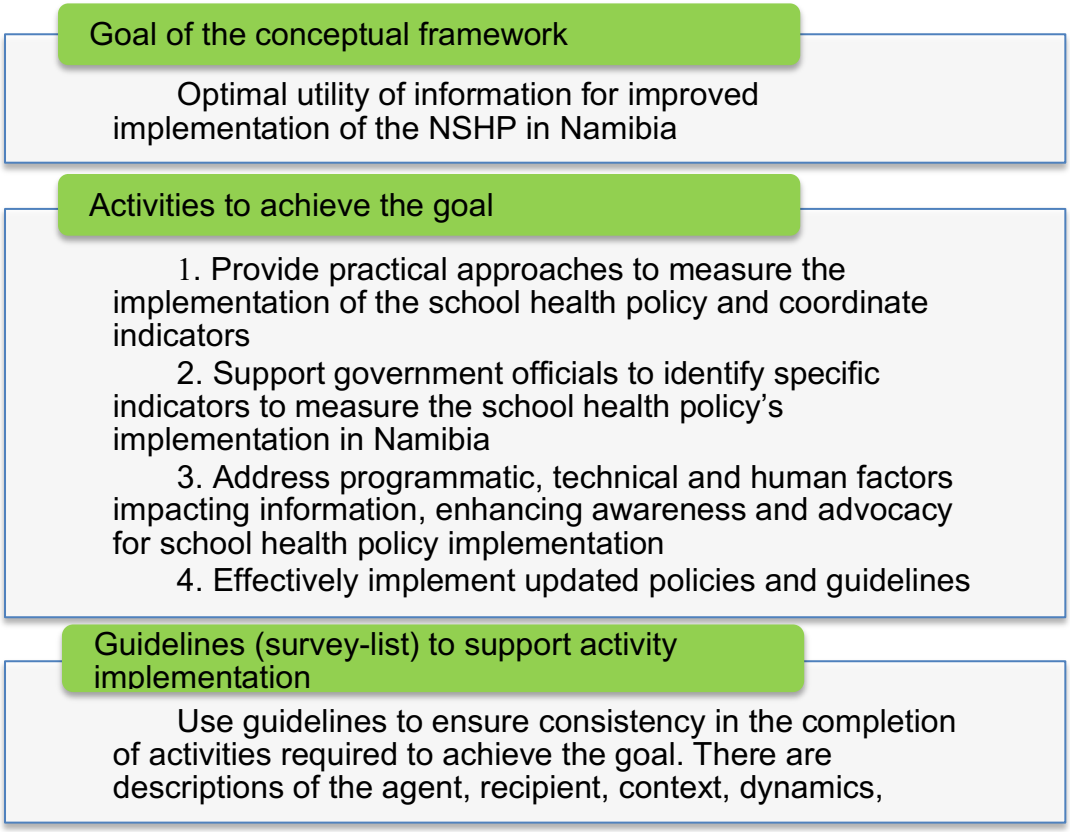

Figure 6.1: Illustration of the three key ingredients for the conceptual framework

6.3 DESCRIPTION OF THREE KEY INGREDIENTS AND INTER-LINKAGES OF THE FRAMEWORK

6.3.1 Goal of the conceptual framework

Chinn et al. (2018:40) recommend that conceptual frameworks' objectives should be defined. Chinn and Jacobs defined a goal as "the theory's overarching objective, which serves as a guide for identifying the spectrum of events to which the theory applies". Thus, the term "goal" refers to the desired outcome. This study intended to maximise the use of available school health programme forms and data collection tools in public health facilities as well as in schools. Over 80% of MoHSS managers considered optimal use factors when making decisions and intervening to improve the quality of the school health policy's implementation.

6.3.1.1 Optimal information for improved school health policy implementation in Namibia

The monitoring indicator tool proposes a framework and indicators for assessing Namibia's school health policy's implementation at the country level. The indicators in this document should be regarded as guidelines to be applied appropriately after considering country-specific conditions. The proposed framework and indicators are intended to provide member states with clear and consistent guidance.

Furthermore, the indicators are intended to be adaptable and flexible to national circumstances, considering both existing and planned surveillance and monitoring activities. Using the guide during planning and decision-making will improve the quality of interventions provided by the two ministries responsible for implementing school health services in the country, namely the MoHSS and the Ministry of Education, Sport, and Culture.

In Chapter 3, it was determined that in the Namibian implementation system, the MoHSS requires regional management teams (regional health programme officers) to plan, implement, provide training, supervise, evaluate and monitor district-level activities. As a result, regional programme officers are frequently preoccupied with specific NSHP components, such as health education. As a result, government officers may lack a thorough understanding of the actual NSHP implementation at schools, and schools may not receive feedback from government officers.

In terms of training and updating staff with new developments, this study found insufficient personnel and financial resources significantly contributed to the lack of data being gathered on policy execution in the Khomas, Oshana and Kavango regions. Furthermore, in some regions, such as Kavango West, training outcomes were not effectively disseminated or sustained among government officials. One respondent from a district health office in Kavango West, for example, had never seen the policy document. During interviews and document reviews, two main explanations were given. First, junior government officers who attended the training felt that most of the discussions were beyond their scope, and that their seniors should have attended such training.

Second, there were frequent transfers between departments without proper roles force handovers to the next member. This finding illustrated the need to utilise available data on the school health policy's implementation in Khomas, Oshana and Kavango regions.

6.3.2 Activities to achieve the goal of data-enhanced quality and use of data

Chinn et al. (2018:43) refer to these as "prescriptions for activity". The interconnections between these activities point to the framework's objective. According to the study's findings regarding predictors in utilising school health statistics (Chapter 3), there are no indicators in the MoHSS monthly summary reports capturing data on school health services. There is also a lack of monitoring and evaluation officers to collect and analyse this data, as well as a lack of accountability and ownership of school health services in the country. In addition, the introduction of an integrated model of health services in the facilities makes it challenging to implement school health services and monitor their implementation in the country. The following key activities were identified in Chapters 3 to 5.

a) Provide a practical approach to measure the implementation of school health policy and coordination of indicators

The two ministries should establish a coordinating team that is accountable and transparent in its work. The team's leadership may be shared or rotated across ministries, for example, education and health, but should ultimately be determined by the two ministries. The following procedures are encouraged:

- Establish a coordinating team to guide the development, implementation, monitoring, and evaluation of school policies
- Analyse the situation
- Create a work schedule and monitoring system
- Define the objectives and goals
- Publicise the policy

This study's (Chapter 3) findings revealed there are scant statistics, collaboration and communication between the two ministry officials who spearhead school policy implementation, and this need to be enhanced. This affects school health data collection and the analysis of school health policy implementation indicators.

b) To support government officials in identifying specific indicators to measure the implementation of school health policy in Namibia

The team is encouraged to develop a work plan to implement appropriate school policies after establishing a national coordination team, defining its specific role, and conducting a situational analysis.

The following items should be included in this work plan:

- Establishing goals and objectives
- Choosing policy options
- Putting policy options into action with the help of stakeholders
- Monitoring and assessing national school policy

Monitoring and evaluations are critical components in determining the effectiveness of school-based policies. Monitoring and evaluation must be integrated into the planning process from the start, and responsibility and appropriate funding must be assigned. Monitoring and evaluation should be done on a regular basis, using appropriate indicators (see Chapter 5).

c) Address programmatic, technical and human factors impacting the utility of information, enhancing awareness and advocacy for school health policy

In the desktop review, some updated memoranda of understanding were found between different stakeholders regarding the implementation of a school health policy (see Annexure J). However, at the time of this study, some respondents still believed

there was a lack of advocacy, and no clear national strategies for promoting, supporting or coordinating any aspect of the school policy in the study area.

As a result, the researcher proposed conducting a situation analysis before encouraging the full implementation of school health policy in schools. This can be done to provide a baseline assessment of school-based reality. A situation analysis will assist the national coordinating team in better understanding the needs, resources, and conditions pertinent to intervention planning.

The following quantitative and qualitative information can illuminate schools' needs and promote appropriate interventions:

- Current health status of learners Governments are encouraged to collect data on physical activity levels, fruit and vegetable consumption, school attendance, the prevalence of overweight students, obesity, and diabetes.

- Learners' knowledge, attitudes, beliefs, values, behaviours, and conditions related to healthy eating and physical activity.

- An examination of existing government programmes, as well as those organised by other stakeholders, that promote school health intervention in schools.

- Examine the available information on school health policy intervention in school curriculum, for example, routine review of life skills content.

- The country's current capacity and available resources for promoting healthy eating and school health policy in schools. This includes both financial and human resources, as well as healthcare infrastructure for implementation.

Standardised surveys can be used to assess learners' health status in schools, regions, and countries. The Global School-based Student Health Survey (www.who.int/chp/gshs) is an example of a student survey supported by the WHO. Surveys, multi-stakeholder meetings and consultations, interviews, and focus group

discussions with various stakeholders and relevant parties can be used to collect information on existing programmes, policies, and stakeholder preparation levels.

It is critical to act on the results of the situation analysis. For example, the government may recognise that school health policy requires more attention, that primary schools should be prioritised over secondary schools, or that policies implemented must take gender differences into account and be more gender-sensitive.

d) Effective implementation of updated policies and guidelines

To reach its intended audience and promote data collection in school health programme in schools, the NSHP must be widely distributed. The policy document can be distributed through both formal and informal channels to all relevant stakeholders. For example, an official memo informing all schools of the policy can be distributed. Key policy messages can also be disseminated through a variety of channels, such as print media, electronic media, regional/local events, influential individuals, role models, well-known individuals, and advocates. However, school health policy training must be conducted before a policy can be disseminated widely to everyone.

6.4 GUIDELINES (SURVEY LIST) TO SUPPORT ACTIVITY IMPLEMENTATION

The purpose of the guidelines is to ensure clarity and to aid in the implementation of activities aimed at achieving a goal. The findings and recommendations detailed in Chapters 3–5, as well as the conceptual framework (Figure 6.2), form the basis for developing guidelines for implementing the provisions of the conceptual framework. The guidelines are designed for use within a single country and are described using a schematic model. Its goal is to demonstrate how policies and programmes influence populations, resulting in behavioural changes and long-term social, health, and economic benefits. The model shows how to include appropriate monitoring and evaluation indicators in the behaviour change process (WHO, 2020).

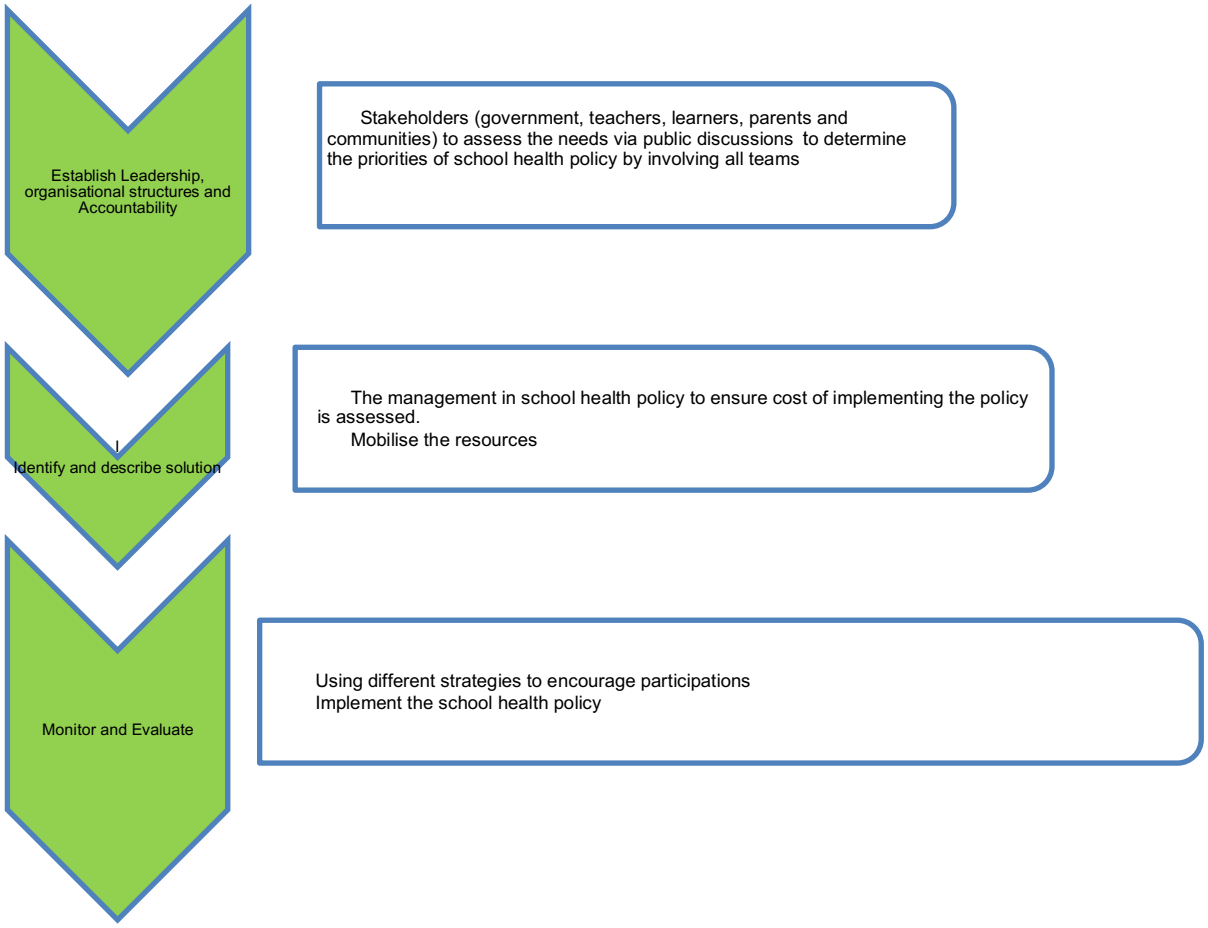

Figure 6.2: Illustrates relationships among the factors and activities of the framework

The framework is geared toward principals, teachers, and community leaders who are involved in school health programmes. It provides school leaders with organising ideas and activities for collecting data about school health intervention in their school and community, so they can take steps to improve health and learning through the school. Additionally, monitoring and evaluation concepts provide guidance and tools for data collection, dissemination and developing action plans to remedial of issues arise in school health policy implementation. These tools can be used by school teams to:

- Assess their resources, local health issues, and opportunities.
- Involve members of the community, including learners, managers, and staff, in generating ideas and laying out a plan of action.
- Establish goals and objectives and create action plans to accomplish them.
- Keep track of progress and make additional plans.

The features are depicted in Figure 6.3 and discussed in greater detail below the figure.

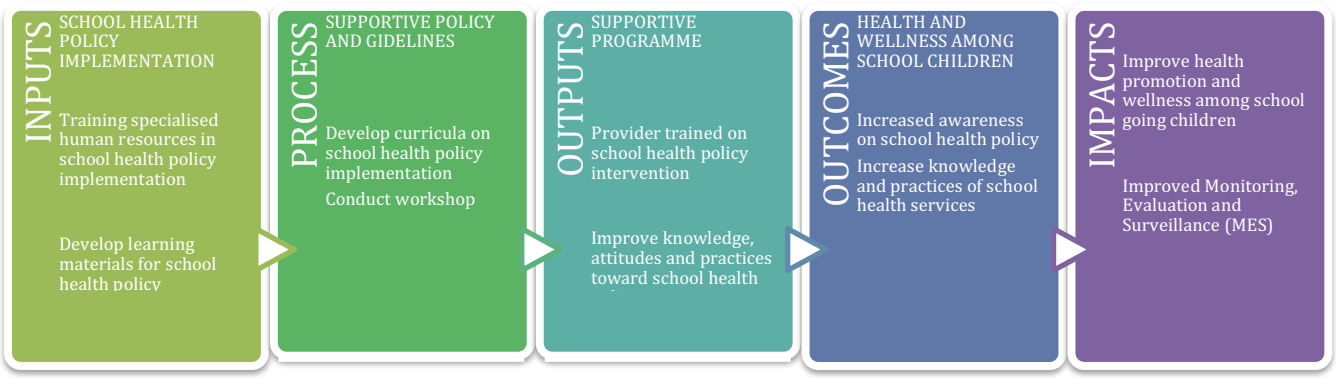

Figure 6.3: Illustration of the survey list's characteristics

Source: conceptualisation and reasoning of the researcher

6.5 THE PROPOSED FRAMEWORK'S INTERPRETATION

MOHSS, according to this model, should provide national strategic leadership on school health policies by developing and implementing supportive policies, programmes, and environments. All interested parties should be included in this process (e.g., other ministries and other interested governmental agencies, non-governmental organisations, and private sector organisations).

The policies put in place will encourage and facilitate the necessary behavioural changes in data management and reporting system. The consequences of this change can be tracked and evaluated in terms of population health as well as a variety of social and school health activities. Research, monitoring, evaluation, and surveillance should be carried out throughout the process to provide feedback to the institutions involved in order for potential changes to be made on progress made in school health policy implementation.

6.5.1 National strategic leadership

Namibia's Ministry of Education must prioritise children of school age's education, and school-going children's health should be prioritised by the Ministry of Health. Learners matter, and if the goal of "improved learning and education achievement through improved health and nutrition" is adopted, the health of children enrolled in a country's schools must also become a priority for the education sector. Schools, in fact, are an ideal setting for providing basic health education and services. While schooling is rarely universal in most developing countries, it is generally superior to healthcare coverage. School administrators and teachers represent a sizable skilled workforce with unparalleled access to children and the ability to enlist the support of parents and other local community partners.

The MES guideline encourages broad representation and participation in all stages of developing, implementing, and evaluating school-based health programmes. While statistics from government and intergovernmental agencies are a good place to start, planners should also seek information from local sources such as hospitals, doctors, and schools, as well as traditional community needs assessment methods such as surveys, focus groups, and key informant interviews. While representatives from the Ministries of Education and Health may lead this effort, input from healthcare providers, school administrators and teachers, parents, students, and community leaders will help improve data quality and raise awareness about the link between health and education among school learners.

Nonetheless, adequate and effective leadership at all levels (central and peripheral) is required to ensure that agreed-upon health programmes and services are not rendered obsolete. Establishing bodies responsible for monitoring the implementation of health activities at all levels of government, including decision-makers, stakeholders, and beneficiaries, is highly desirable.

Thus, identifying the highest-priority health needs of a specific population is the first activities promotion. In a proposed framework, these groups would serve as valuable contact points for the community (traditional authorities), national (ministers and

programme officers), and international partners (UNESCO, UNICEF, WHO and PEPFAR). They could be an efficient medium for developing and sharing all types of resources if linked in national networks, and even globally through their participation in guiding the implementation of a monitoring and evaluation system. Furthermore, an expert advisory mechanism should be established that includes representation from all critical sectors and disciplines, as well as an expert advisory mechanism with a clear mandate, clear lines of accountability, and the ability to influence policy. The team defines financial and human resources, as well as the presence of renowned academic centres dedicated to the school health policy agenda.

6.5.2 Supportive environment workplace conditions conducive to render school health policy for all learners in schools.

The strategies should aim to alter social norms and increase community awareness of the importance of incorporating physical activity into daily life. Physical activity-promoting environments should be encouraged, and supportive infrastructure should be built to improve access to and use of appropriate facilities.

Civil society and non-governmental organisations (NGOs) have a significant impact on both individual behaviour and the organisations and institutions responsible for implementing elementary school health policies. They can play a role in ensuring that consumers demand that governments support healthy lifestyles and that the food industry provides healthy products. Non-governmental organisations (NGOs), for example, can effectively support a government strategy if they collaborate with both domestic and international partners in the development and implementation of national policies and programmes to promote healthy eating habits and physical activity.

Additionally, the country should consider regulating the food industry, retailers, caterers, sporting goods manufacturers, advertising and recreation businesses, insurance and banking institutions, pharmaceutical companies, and the media. All of these have important roles to play as responsible employers and advocates for healthy lifestyles. All of these organisations could collaborate with governments and non-governmental organisations to put policies in place that send positive and consistent

messages, facilitating and enabling integrated efforts to promote healthy eating and physical activity.

Initiatives by the food industry to reduce the fat, sugar, and salt content of processed foods and portion sizes, introduce new, healthy, and nutritious foods, and review current marketing practices have the potential to accelerate national and global health gains.

6.5.3 Supporting policies

Governments should collaborate with consumer groups and the private sector (including advertising) to develop cross-sectoral solutions to problems such as data collection, analysis of data and feedback on school health policy implementation at all government levels.

Furthermore, the framework encourages national food and agricultural policies to be aligned with public health protection and promotion. Governments should consider policies that make it easier to adopt a healthy diet when necessary. Food safety and long-term food security must be incorporated into food and nutrition policies.

Governments should be encouraged to consider the potential health implications of food and agricultural policies. The government can implement and monitor the following practical interventions:

- Food regulation legislation to protect consumers' health.
- A system for reviewing and revising food and nutrition policies.
- Mechanisms for monitoring food safety.
- Agriculture policy that is nutritionally sound.
- Food subsidies and pricing in accordance with national dietary guidelines.

The proposed framework directs the government (particularly the MoHSS and MoEAC) to impose the key role of monitoring school health activities and evaluate the progress made. As a result, health claims may not mislead the public about a product's

nutritional value. An advisory body on nutrition labelling and health claims on foods and beverages is required. Legislation governing nutrition labelling and health claims should also be developed.

6.5.4 Supportive programmes

For the programme to succeed, education, communication, and public awareness are all required. Government experts, non-governmental and grassroots organisations, and relevant industries should develop and communicate messages that are consistent, coherent, simple, and clear. They should be communicated in a variety of ways that reflect the local culture, age, and gender.

Adult education programmes should incorporate health literacy. Furthermore, a well-defined national programme or campaign should be developed to educate and mobilise the public about nutrition and safe water and sanitation.

Institutional support for the promotion and implementation of NSHP activity guidelines must also be maintained. The framework, for example, recommends keeping track of the number of channels through which messages about healthy eating and physical activity are communicated, as well as the percentage of children in schools reached with campaign messages promoting school health interventions.

Routine interactions with healthcare personnel should include practical advice for patients and families about the benefits of HPT vaccination and increased physical activity, as well as assistance initiating and maintaining healthy behaviours using the school health programme.

School health activities are included in the national primary care plan; for example, 80% of the population of girls and boys in schools received advice on school health services from a primary care practitioner, and 60% received physical activity advice from a primary care practitioner.

6.5.5 Monitoring and surveillance

It is critical for governments to invest in surveillance, research, and evaluation. It is also vital to monitor major risk factors on a long-term and continuous basis.

Establishing effective mechanisms for assessing the efficacy and cost-effectiveness of national disease prevention and health promotion programmes, as well as the health impact of policies in other sectors, is critical. When appropriate, information about school health programmes that promote healthy diets and physical activity as part of larger development and poverty-reduction efforts should be included in the evaluation process.

The proposed framework stipulates that a separate budget line be set aside for monitoring and evaluating the MES's implementation. Monitoring and surveillance systems for process, output, and outcome indicators are also recommended. In addition, a national surveillance system has been established to monitor food, nutrient intake, dietary habits, physical activity patterns, and anthropometric data.

6.6 THE FRAMEWORK'S PRESUMPTIONS

Chinn and Jacobs recommend that assumptions should be addressed when developing frameworks. To accomplish the objective, the following assumptions are made:

- All school health interventions should be recorded, and evidence must be made available.

- Respect should be shown to learners, and equal treatment of all individuals regardless of their gender, religion, colour, mental handicap, religion, or HIV status.

- School environments are safe, healthy, and protective environments where physical and psychosocial environments promote learning.

- There is no tolerance for bullying on school grounds, and weapons are prohibited.

- There is protection from sexual harassment by other learners or school personnel, as well as disciplinary measures against those who commit such acts.

- Codes of Conduct for staff at schools are enforceable.

- Teachers must receive adequate preparation on contents of school health, support on data collection.

- Mechanisms for timely and effective emergency response are available.

- There is a sufficient supply of drinkable water.

- Separate restrooms are available for male and female teachers.

6.7 THE CONCEPTUAL FRAMEWORK IS EVALUATED

Interventions are evaluated to ensure they are not based on erroneous assumptions and to persuade those who are sceptical of the importance of this work. To do so, sound and objective evidence is required to reflect that the interventions were effective. Stakeholders at all levels, from classroom teachers and school principals to administrators and policymakers, require evidence(data) of the variety of benefits a school health intervention (WHO, 2020:15).

A framework must be evaluated to determine whether it facilitates goal achievement. This study's framework was evaluated using concepts adapted from Chinn et al.'s (2018:34) theory generation criteria, namely clarity, simplicity, generality, applicability, and consequences. Experts were consulted regarding the model's evaluation.

The **clarity** of the framework is determined by determining whether the following are present: major concepts are defined; the three key components of the framework as defined by Chinn et al. (2018:33) are described; relevant examples and diagrams are

provided and aligned with the text; concepts are used consistently with their definitions, and the framework demonstrates achievement of the goal (Table 6.2).

The **simplicity** criterion was adapted to determine the framework's readability. Table 6.3 details the aspects that were examined. The framework's scope and purpose were determined using the **generality** criterion (Table 6.4). Moreover, the framework's relevance was determined using the **applicability** criterion. Table 6.5 summarises the aspects that were examined.

Consequences of the framework: This criterion was adapted to determine whether the framework is capable of achieving the goal of improving information use to increase the quality of school health services, a critical component of school children's healthcare necessary for optimal school health outcomes. The checklist is shown in Table 6.6.

Table 6.2: Clarity

Verification aspect	Status	Reference note
• Definition of all major concepts	Done	Defined concepts like national strategic leadership, supportive environment, supportive policies, supportive programmes and monitoring, surveillance and evaluation
• Definitions are consistent	Yes	
• The three key ingredients, according to Dickoff et al.'s situation-producing theory, are described	Yes	The goal, activities and guidelines
• Words borrowed from pharmaceutical services and other disciplines are used in the framework	Yes	School health policy implementation and management are included in the framework, and explained
• Examples of diagrams are needed and present	Yes	Figure 6.1 illustrates the three key ingredients for the framework; Figure 6.2 diagrammatically shows the framework

Verification aspect	Status	Reference note
• The diagrams used are meaningful	Yes	
• Basic assumptions are consistent with the goal	Yes	
• Concepts are used in a manner consistent with their definitions	Yes	
• Diagrams are consistent with the text	Yes	
• The framework can be followed	Yes	
• All concepts fit in the framework	Yes	
• The framework demonstrates accomplishment	Yes	

Checklist adapted from Chinn and Jacobs (1987:70)

Table 6.3: Simplicity

Verification aspect	Status	Notes
• Number of concepts in the framework	5	Stated in labelled boxes
• Concepts are differentiated into sub-concepts	Yes	In Table 6.1
• The framework describes activities and how they are to be undertaken to achieve the goal	Yes	

Checklist adapted from Chinn and Jacobs (1987:70)

Table 6.4: Generality

Verification aspect	Status	Notes
• The goal of the framework is specific	Yes	
• MoHSS managers and MoEAC focal staff can utilise the framework	Yes	The guidelines guide target recipients to use the framework
• The goal is justifiably a school health policy goal	Yes	
• The concepts in the framework are broad	Yes	Concepts cover the scope of national strategic leadership, supportive environment, supportive policies,

		supportive programmes and monitoring, surveillance and evaluation

Checklist adapted from Chinn and Jacobs (1987:70)

Table 6.5: Applicability

Verification aspect	Status
• Concepts in the framework are broad	Yes
• Definitions are associative within the framework	Yes
• The concepts' indicators are identifiable in reality	Yes
• Concepts' indicators are within the realm of school health policy	Yes
• Definitions adequately reflect the meanings of the concepts	Yes

Checklist adapted from Chinn and Jacobs (1987:70)

Table 6.6: Consequences

Verification aspect	Status	Notes
• The framework can influence the delivery of school health services	Yes	The framework's components are based on the findings and suggestions in Chapters 3 to 5, namely: national strategic leadership, a supporting environment, supportive policies and programmes, as well as monitoring, surveillance and evaluation.
• The goal of the framework is specific	Yes	
• The framework provides guidelines within which to act to achieve the goal	Yes	
• The stated goal is important to school health services	Yes	
• The framework can resolve problems to facilitate the achievement of the goal	Yes	

CHAPTER 7
CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

7.1 INTRODUCTION

The goal of the study was to evaluate the NSHP's implementation in health facilities and schools in three regions of Namibia and develop a conceptual framework to improve the NSHP's implementation. This chapter summarises the study's findings and presents recommendations for implementing and evaluating school health policies in government schools and health facilities. The conclusions respond to the goals presented in Chapter 1. This chapter also discusses the study's potential strengths and limitations, as well as references for future research. The recommendations are founded on the findings presented in Chapter 4.

7.2 CONCLUSIONS OF THE STUDY

The purpose of this study was to assess the process of implementing the 2008 school health policy. There was no attempt to assess the policy's impact, so the study's conclusions are limited to the researcher's assessment of the implementation process. From the perspective of school health nurses, this policy has not been implemented largely in accordance with its implementation guidelines, and the minimum requirements for phase 1 service implementation have not been met. The research sought to discover and describe the extent to which Namibian school and primary healthcare facility supervisors are knowledgeable and aware of their roles in implementing Namibia's NSHP, unfortunately, there were no data (statistics or reports) to back up this statement. It has been demonstrated that school and primary healthcare facility administrators are well-versed in the potential barriers to implementing the NSHP in the regions.

Policy implementation was hampered by broader systemic issues, necessitating national intervention. Certain aspects, however, could be addressed at a more fundamental level. For example, teachers and school health nurses did not share the same level of policy knowledge and understanding; low levels of parental involvement

were reported in some contexts; there was a reported shortage of implementation personnel; and a lack of dedicated funding to provide these services and a lack of documented data on school health policy interventions conducted, all of which threatened to undermine policy implementation.

7.3 LIMITATIONS AND STRENGTHS OF THE RESEARCH

Each study has its own set of advantages and disadvantages. The limitations of this study are discussed in this section.

7.3.1 Limitations

This study had a few limitations, as is typical of studies on school health policy implementation:

- There is a significant lack of statistics on school health policies' evaluation and implementation in Namibia. This demonstrates the significance of this research in filling this void.

- The qualitative and quantitative research methodology was employed to acquire pertinent study data. Unfortunately, the researcher was unable to collect the perspectives of the majority of those affected by the NSHP's implementation in Namibia; thus, the sample did not represent the entire population. As a result, the study's findings are limited to schools and basic healthcare facilities in the Khomas, Kavango and Oshana areas. However, the study could still be used as a baseline for other regions in Namibia.

- Since the school health policy is still being implemented, a longitudinal study might have been a better methodology. However, this approach was not feasible within the normal duration of a PhD programme. Additionally, there was a dearth of data from schools and health facilities regarding school health services being implemented since the policy's inception in 2008.

- Methodological trade-offs occurred during the research, such as the decision to use thematic analysis as the data analytic strategy. Thematic analysis was chosen in anticipation of the emergence of various themes, given the breadth of the research questions. A different approach could have been to use narrative methodology, which would have revealed more about actors' policy implementation processes but provided fewer insights into other theoretical constructs.

7.3.2 Study's strengths

It is critical for researchers to recognise and report on their research inquiries' strengths and weaknesses. The exploratory nature of the research questions and the incorporation of multiple theoretical constructs into the conceptual framework constituted a significant strength of this inquiry. Some additional strengths of the study follow:

- The broad scope of the research questions promoted detailed descriptions of the individuals involved in implementing school health policies.

- By incorporating multiple theoretical constructs into the conceptual framework, theoretical contributions beyond sense-making theory became possible.

- The decision to address some of the shortcomings in existing sense-making studies through *a priori* research provided the impetus to make original contributions to the literature.

- The investigation of school health policy implementation, as mini-cases within the overarching case study, bolstered the findings' generalisability.

- This study also recommended a conceptual framework should be developed to guide the school health policy's monitoring and evaluation.

7.4 RECOMMENDATIONS

The study's findings have led to a number of recommendations. The findings were organised based on the items listed in the research questionnaire. These recommendations are directed at schools, healthcare facilities, policymakers, and researchers.

7.4.1 Recommendations for policymakers

The study's findings and a desktop review of the MoHSS and MoEAC memorandum are used to make recommendations to improve school health policy implementation, as respondents suggested.

- A nutrition and physical activity policy in the school should be consistent with and supplement existing policies and action plans, such as those focusing on health promotion and disease prevention.

- Policy formulation and implementation should be interdisciplinary, integrated, and holistic.

- When developing and implementing policies, consider the cultural context, gender issues, ethnic minorities, and the country's jurisdictional and legal structure.

- A monitoring and evaluation system must be constructed using lessons from prior systems and data from newly developed school health monitoring systems in some areas. School health service monitoring and assessment must be connected with current district health information systems. Additionally, school principals and teachers implementing school health policy activities should communicate with the educational information system. Monitoring and assessment must prioritise the following aspects:

    - enhancing existing programmes,
    - expanding service coverage to all students, and

    - developing infrastructure for school health promotion.

- The level of coordination within the health sector and between the health and education sectors, as well as the service's impact on learners' progress, should be evaluated.

- School administration and health facility managers lack a thorough understanding of the steps required to implement the school health policy. The managers are aware that implementing the policy will be difficult at times, but the two ministries are responsible for ensuring managers are skilled and knowledgeable about the policy's objectives.

- Existing structures, such as the school board, should be used to promote school health. There is a need for regular meetings among key stakeholders, including educators, parents, and the school nurse, to discuss school health issues. Open communication is also required between these various stakeholders to address and educate one another about the policy's relevance to them, and discuss and explain each party's respective roles. Currently, there is no formal forum that brings all of these critical stakeholders together. If used effectively, the school board can serve as an excellent forum for that purpose.

- A review of the NSHP guidelines is required. Life skills teachers and school health nurses both expressed a desire for frequent contact in order to address school health issues effectively. Current student-to-team ratios in schools may need to be reconsidered in order for nurses to spend more time at their designated schools and focus on health promotion activities, which may include incorporating some or all of these activities into the existing school curriculum. Alternatively, the recommended number of school health visits should be increased. The revised guidelines should also include parents of learners.

- The MoHSS should set aside funds for school health services. Schools must currently fund school health-related expenses from their central budgets, which is especially difficult for disadvantaged schools. This could have the unintended

consequence of exacerbating disparities between schools in different geographic regions with varying socioeconomic profiles. A portion of the district health budget should be set aside by the MoHSS for school health services. The size of this dedicated budget should correspond to the costs estimated during policy development. This will improve service planning, organisation, and monitoring.

- A district-based school health task force should be formed. Rather than relying on managers, the task force should establish a committee to monitor and evaluate the school health policy. Managers should initiate and oversee quarterly monitoring and evaluation. Again, the provincial Departments of Health and Education should keep a publicly accessible provincial database of monitoring and evaluation findings from policy implementation that can be used to refine indicators and provide benchmark data. Managers will be able to compare their performance to that of comparable districts.

7.4.2 Recommendations for schools and health facilities

- Senior school managers and health programme administrators should be educated on the significance of the school health policy. School health nurses encountered a lack of buy-in and, at times, opposition from some senior programme managers who believed that money spent on school health services was squandered because it was spent on healthy children rather than sick people. Furthermore, there have been reports of managers believing that school health should be the responsibility of the Ministry of Education rather than the MoHSS. Managers should therefore be guided by a broader public health philosophy that emphasises the importance of prevention and health promotion, as well as an understanding of the value of these services. Furthermore, school health nurses should use their statistical records to demonstrate the importance of school health services.

- Teachers understanding and awareness of the 2008 school health policy should be improved. The study's findings indicate that teachers and nurses do not share a common understanding of the requirements for implementing school health policies. Life skills teachers must become acquainted with this policy because they

will play an important role in its implementation. Furthermore, life skills teachers should be helped to understand how this policy relates to data collection of implemented activities. The current guidelines should be updated in consultation with the MoHSS to reflect the role of the MoEAC, as well as the roles of school health nurses and life skills teachers in particular. Workshops should be organised to provide managers with the necessary managerial skills.

For instance, communication channels should be established through which stakeholders can express their opinions and concerns about the school health policy and its implementation. This enables the establishment of a clear chain of events for the NSHP's implementation, including the development of plans and timeframes, as well as collaboration with managers to meet the policy's deadlines.

- The school health nurse has to ensure that:

    - Learners' body weight and height should be measured on a regular basis, with feedback given to parents. Schools that implement BMI measurement programmes should take precautions to avoid endangering students, provide a safe and supportive environment for students of all body sizes, and encourage physical activity and healthy eating.
    - It is recommended to conduct nutritional screenings and collect data on physical activity participation.
    - Based on screening results, additional school and community health services should be offered. Although vaccination against the human papillomavirus (HPV) is officially allowed for everyone up to the age of 45, it has been advised for adults up to the age of 26. Some studies recommend investigating the differences in HPV vaccination rates by age, with subgroup analysis by groups of sexual orientation and gender identity, as well as sociodemographic characteristics that might act as inhibitors or enablers of vaccination.
    - Physical activity guidelines should be developed for all students, including those with disabilities and their parents.
    - In addition to routine health care, health professionals may conduct research, monitor and evaluate, educate, and advocate.

The general principles outlined below serve as a guide for policymakers as they develop and implement national policies:

- A school nutrition and physical activity policy should be inclusive of all students, participatory, and prioritise the health needs of the most disadvantaged students.
- With a dedicated budget, a long-term school policy on diet and physical activity should be developed and implemented.
- When possible, the implementation of a school nutrition and physical activity policy should make use of existing structures and resources (technical staff, civil society, information, ongoing initiatives, and policies).
- Monitoring and evaluation should take place at all stages of policy development and implementation. To make this possible, resources (both technical and financial) for monitoring and evaluation activities must be set aside from the beginning.

7.4.3 Recommendations for researchers

- The researcher suggests that a like study be conducted in other private and public schools in Namibia and other countries to validate the current study's findings.
- The researcher also recommends, intervention studies be conducted on the subject.

7.5 CONTRIBUTION OF THE STUDY

7.5.1 Development of the conceptual framework

The conceptual framework for the NSHP's implementation will revisit its vision, mission, and original aspirations, compare the original aspirations with current reality, and make recommendations on how to improve school health service management and provision (see Chapter 6).

7.5.2 Giving implementers a voice

The other contribution of this study is to empower service providers with advocacy tools to enable them to render adequate health services to school learners. If the policy

is insufficiently implemented, this will deprive school-going children of their right to health and has an impact on their health outcomes.

7.6 CONCLUSION

The final chapter restated the research questions and the study's purpose. The study's contribution was explained, and future research opportunities were identified. Finally, the study's limitations and strengths were discussed.

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ANNEXURE A: Application letter for permission to conduct research

Ndasilohenda Nakashwa
PO Box 26324
Windhoek
Namibia
09 Apr. 18

Ministry of Education, Art and Culture
Permanent Secretary
Government office Park, Windhoek
Namibia

Dear Ms. Sanet Steenkamp

RE: Request for study Permission

Mrs Nakashwa Ndasilohenda, a Doctoral of Philosophy student in Health studies and literature (Student Number: 61322911), at the University of South Africa (UNISA) intends to research selected regional office on Evaluation of the implementation of the National Policy for school health, in Namibia by the Government.

The purpose of this study will be to evaluate the implementation of the national policy for school health in Namibia with the view of proposing a framework to strengthen the school health national policy.

The research will take place in 3 regions, namely Oshana, Kavango and Khomas region, in Namibia. These three sites identified will be suitable enough for the researcher to be able to evaluate the implementation of the national policy for school health in Namibia. In this study, units of interest will be the Ministry of health and social services and Ministry of education national level representatives, school health services and schools in the three regions. In this study, the target population will comprise of policymakers at the National level from the two ministries (health and education) which comprise of programme officers; and all stakeholders involved in the

implementation of the school health national policy which include programme administrators at the district level and school health care professionals (nurses and allied health) in the primary health care settings; school principals and school governing bodies.

All the data collected from this study will be safely stored to ensure that no other person has access to them. The research is primarily academic but the results of the study will be submitted to the Ministry of Education, Art and Culture at national and regional levels.

I am therefore kindly requesting permission to carry out this study in the regions. The study should run from 2018 until 2019. Feel free to contact me if you have any further questions.

+2642169513 or jndinelago@yahoo.com

Kindly find the Ethical Approval from UNISA Research Ethical Committee: Department of Health studies and research proposal.

Kind Regards,
Ndasilohenda Nakashwa

ANNEXURE B: Approval letters for permission to conduct a research

UNISA university of south africa

RESEARCH ETHICS COMMITTEE: DEPARTMENT OF HEALTH STUDIES
REC-012714-039 (NHERC)

6 December 2017

HSHDC/808/2017
Nakashwa Ndasilohenda

Student No.:6132-291-1
Supervisor: Dr FH Mfidi
Qualifications: D Litt et Phil
Joint Supervisor: Prof GB Thupayagale-Tshweneagae

Dear Nakashwa Ndasilohenda

Decision: Ethics Approval

Name: Nakashwa Ndasilohenda

Proposal: Evaluation of the implementation of the National Policy for school health in Namibia

Qualification: **DPCHS04**

Thank you for the application for research ethics approval from the Research Ethics Committee: Department of Health Studies, for the above mentioned research. Final approval is granted from 6 December 2017 to 6 December 2022

The application was reviewed in compliance with the Unisa Policy on Research Ethics by the Research Ethics Committee: Department of Health Studies on. 6 December 2017

The proposed research may now commence with the proviso that:

1) *The researcher/s 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 the Research Ethics Review Committee, Department of Health Studies. 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.*

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

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.*

4) *[Stipulate any reporting requirements if applicable].*

Note:

The reference numbers [top middle and right corner of this communiqué] should be clearly indicated on all forms of communication [e.g. Webmail, E-mail messages, letters] with the intended research participants, as well as with the Research Ethics Committee: Department of Health Studies.

Kind regards,

Prof JE Maritz
CHAIRPERSON
maritje@unisa.ac.za

Prof MM Moleki
ACADEMIC CHAIRPERSON
molekmm@unisa.ac.za

Prof A Phillips
DEAN COLLEGE OF HUMAN SCIENCES

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
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REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag 13198
Windhoek
Namibia

Ministerial Building
Harvey Street
Windhoek

Tel: 061 – 203 2537
Fax: 061 – 222558
E-mail: btjivambi@mhss.gov.na

OFFICE OF THE PERMANENT SECRETARY

Ref: 17/3/3 NN
Enquiries: Mr. B. Tjivambi

Date: 26 July 2018

Ms. Ndasilohenda Nakashwa
P.O. Box 26324
Windhoek

Dear Ms. Nakashwa

Re: Evaluation of the implementation of the national policy for school health in Namibia.

1. Reference is made to your application to conduct the above-mentioned study.

2. The proposal has been evaluated and found to have merit.

3. **Kindly be informed that permission to conduct the study has been granted under the following conditions:**

3.1 The data to be collected must only be used for academic purposes;
3.2 No other data should be collected other than the data stated in the proposal;
3.3 Stipulated ethical considerations in the protocol related to the protection of Human Subjects' should be observed and adhered to, any violation thereof will lead to termination of the study at any stage;
3.4 A quarterly report to be submitted to the Ministry's Research Unit;
3.5 Preliminary findings to be submitted upon completion of the study;

REPUBLIC OF NAMIBIA

MINISTRY OF EDUCATION, ARTS AND CULTURE

Tel: +264 61 -2933200
Fax: +264 61- 2933922
Enquiries: C. Muchila/ G. Munene
Email: Cavin.Muchila@moe.gov.na/gm12munene@yahoo.co.uk

Luther Street, Govt. Office Park
Private Bag 13186
Windhoek
Namibia

File no: 11/1/1

Ms. Nakashwa Ndasilohenda
Po Box 26324
Windhoek
Cell: 0812169513

Dear Ms. Nakashwa

SUBJECT: PERMISSION TO CONDUCT RESEARCH IN OSHANA, KAVANGO AND KHOMAS REGION.

Kindly be informed that permission to conduct an academic research for your Doctorate of Philosophy degree Studies on *"The evaluation of the implementation of the National Policy for school health in the Oshana, Kavango and Khomas Region,* is here with granted. You are further requested to present the letter of approval to each of the Regional Director to ensure that research ethics are adhered to and disruption of curriculum delivery is avoided.

Furthermore, we humbly request you to share your research findings with the ministry. You may contact Mr C. Muchila/ Mr. G. Munene at the Directorate: Programmes and Quality Assurance (PQA) for provision of summary of your research findings.

I wish you the best in conducting your research and I look forward to hearing from you soon.

Sincerely yours

SANET L. STEENKAMP
PERMANENT SECRETARY

Education, Arts and Culture
Office of the Permanent Secretary
2018 -04- 26
Private Bag 13186
Windhoek, Namibia

Date

All official correspondences must be addressed to the Permanent Secretary

REPUBLIC OF NAMIBIA
KAVANGO EAST REGIONAL COUNCIL

DIRECTORATE OF EDUCATION, ARTS AND CULTURE

OFFICE OF THE DIRECTOR

Tel. (066) 258,9000/258,9001.....
Fax (066) 267 707.....
Enquiries: Maria I. Ribebe
Ref. No.: 12/3/10/1

Private Bag 2134
RUNDU
Namibia

TO: Ms. Ndasilohenda Nakashwa
P.O. Box 26124
WINDHOEK

Dear Ms. Nakashwa

SUBJECT: PERMISSION TO CONDUCT RESEARCH IN KAVANGO EAST REGION

1. The communiqué on the above bears reference.
2. Kindly be informed that approval has been granted to you to conduct research at schools in Kavango East Region.
3. The normal teaching and learning activities should **NOT** be disrupted in the process.

Yours sincerely,

.....
Panuel Kapapero
REGIONAL DIRECTOR
KAVANGO EAST REGIONAL COUNCIL

KAVANGO EAST REGIONAL COUNCIL
Directorate of Education, Arts & Culture
2018 -09- 19
DIRECTOR
PRIVATE BAG 2134, RUNDU

19.09.2018
.....
Date

All official correspondence must be addressed to the Chief Regional Officer

REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag 5538
Oshakati
Namibia

Oshana Health Directorate

Tel: 09 264 65 223 3119
Fax: 09 264 65 220 303
jhaimene@mhss.gov.na

Enquiries: Ms Johanna Haimene

17 September 2018

TO: Ms N. Nakashwa
P.O.BOX 26324
Windhoek

RE: PERMSION TO CONDUCT RESEARCH IN HEALTH FACILITIES IN OSHANA REGION

Kindly be informed that permission to make use of the health facilities in Oshana region has been granted for your study purpose

I wish you all the best in your studies.

Yours Sincerely

MINISTRY OF HEALTH AND SOCIAL SERVICES
17 SEP 2018
REGIONAL DIRECTOR
OSHANA HEALTH DIRECTORATE

Ms. J. A. Haimene
Regional Director
Oshana Health Directorate

"Health for All"

REPUBLIC OF NAMIBIA

KHOMAS REGIONAL COUNCIL

DIRECTORATE OF EDUCATION

Tel: [09 264 61] 293 4356
Fax: [09 264 61] 231 367/248 251

Private Bag 13236
WINDHOEK

12 September 2018

University of South Africa
P.O. Box 26324
Windhoek
Contact: 0812169513

For Attention: Ms Nakashwa Ndasilohenda

REQUEST FOR PERMISSION TO CONDUCT RESEARCH INTERVIEWS FROM SCHOOLS IN KHOMAS REGION

Your letter dated 11 September 2018 on the above topic is hereby acknowledged.

Permission is hereby given to you to collect data on "Evaluation of the implementation of the national school health policy in Namibia" for academic research development at Frans Aupa Primary School, Martti Ahtisaari Primary School, Groot Aub Junior School, Jan Jonker Afrikaner High School and A. Shipena Secondary School in Khomas Region under the following conditions:

- The Principal of the selected school to be visited must be contacted in advance and agreement should be reached between you and the principal.
- The school programme should not be interrupted.
- The teachers who will take part in this exercise will do so voluntarily.
- The Directorate of Education, Arts and Culture should be provided with a copy of your thesis/ findings.

We wish you success in your research.

Yours sincerely

12/09/2018

Gerard N. Vries
Director of Education, Arts and Culture

MINISTRY OF EDUCATION
ARTS AND CULTURE
PRIVATE BAG 13236 WINDHOEK
12 -09- 2018
DIRECTOR
KHOMAS REGION

ANNEXURE C: Introduction to Respondents

I am Ndasilohenda Katangolo-Nakashwa, a doctoral student with the Department of Health Studies at the University of South Africa. I am carrying out a study to ***evaluate the implementation process of the National Policy for school health in Namibia with a view of proposing a framework to strengthen the school health national policy***.

Your participation

Permission is sought to participate in a single interview or focus group discussion regarding your experiences as a stakeholder involved in the implementation of Namibia's national school health policy. If you agree, I've asked you to participate in a one-hour interview. Permit me to tape-record the interview. I have been taping the interviews to accurately document what is said, and this information has not been utilized in any way that would identify you individually. Please keep in mind that participation is optional and that you have the right to withdraw without penalty. You have the option of participating or not, and you may wish to consult with other critical individuals in your lives. If you choose not to participate, you will not be harmed in any way. If you agree to participate, you may withdraw at any moment without fear of negative consequences and you will not be harmed in any way.

Confidentiality

Any study records that identify you have been kept confidential to the extent possible by law. The records from your participation may be reviewed by people responsible for making sure that research is done properly, including members of the research ethics committee at UNISA. (All of these people are required to keep your identity confidential.) Otherwise, records that identify you have been available only to people working on the study.

Ethics

The information you provide has not been published in any way that specifically identifies your involvement with the study. All identifying information has been kept in a locked file cabinet and has not been available to others. We refer to you by a code number in any of the records that have been retained within the study. Your

information has not been published in a manner that explicitly identifies your participation in the study. All personally identifiable information was housed in a locked file cabinet and was not accessible to anyone. We refer to you by a code number in any of the study's stored records.

Risks/discomforts

This study did not entail any invasive procedures, and we anticipate no reportable discomforts. If you require access to a therapist to debrief, this has been made available to you.

Benefits

This study did not entail any invasive procedures, and we anticipate no reportable discomforts. If you require access to a therapist to debrief, this has been made available to you.

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

This study has been approved by the Department of Health Studies' Ethics Committees, University of South Africa. For further questions about the study you may contact:

The principal researcher: Ndasilohenda Nakashwa, on telephone no:0812169513 email: jndinelago@yahoo.com

or

Prof FH Mfidi, the Research Supervisor on Tel number: 012 429 6731 or email: mfidifh@unisa.ac.za

or

Prof J Maritz, the Head of the Department of Health Studies' Ethics Committees on Tel number: +27-827888703 or E-mail: maritje@unisa.ac.za

ANNEXURE D: Consent form for respondents

Title: EVALUATION OF THE IMPLEMENTATION OF THE NATIONAL POLICY FOR SCHOOL HEALTH IN NAMIBIA

Lead Investigator: *Ndasilohenda Nakashwa*
Contact Information: +264812169513

The goal of this study is to assess the execution of Namibia's national school health policy to present a framework for strengthening the national school health policy.

I Have Agreed to the Following Terms:
The terms to which I have agreed include voluntarily responding to questions about school health policy implementation with the right to withdraw from the survey at any time without explanation, the confidentiality of both my identity and responses regardless of survey completion, assurance that my responses have not resulted in any risk or cost, and the knowledge that once my survey has been completed,

Respondent's Signature/Thumbprint:
.....
Date of Survey Completion: .....

ANNEXURE E: Individual interview schedule for key informant

Interview Schedule for Key Informants

Name of School

Position/Designation

Date of interview

a. Could you please tell me about your involvement in the implementation of your school's health policy (inquire about roles and responsibilities; duration of involvement)?

b. Is there a budget allocated for implementing the school health policy?

c. Do you have someone in charge of the school's health services?

d. Does this school have a forum for coordinating school health services?

e. How are services organized in this school (probes: the relationship between school personnel and school health nurses, frequency of Pre-primary grade/I assessments, referrals, and follow-up)?

f. What specific services are currently being provided following this policy? (ENQUIRE WHO PROVIDES WHICH SERVICES; HOW ARE THESE SERVICES PROVIDED IN THIS SCHOOL?)

g. Do you keep track of the total number of learners who received Pre-primary grade routine assessments? (If the answer is affirmative), Permit me to examine the records (Note: The researcher is not interested in the identifying information of the learners).

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

i. What do you consider to be some of the policy's successes (or failures) in your school?

j. What, in your opinion, explains those successes (es)?

k. What limitations/obstacles or challenges (if any) do you see in implementing this policy in your school?

l. What were the rationales for these decisions?

m. How have you addressed the issues you've mentioned thus far?

n. If you could change or improve anything about the way this policy has been implemented, what would it be?

o. Do you have any additional information/comments to add to what you have said thus far?

Additional Information: The following information was gleaned from the learners' statistical records:

i.e. The percentage of learners who received Pre-primary grade/I assessments

ii. Percentage of learners with health problems referred

iii. Percentage of learners with identified difficulties who were successfully treated

iv. The percent of learners who have been followed up on at least one occasion due to health problems.

[Inspect the first aid kit's contents]

We appreciate your willingness to speak with me.

ANNEXURE F: Focus group interview schedule for school health care professionals

KEY QUESTIONS:

- What are your experiences as a stakeholder in Namibia's national school health policy implementation?
- What challenges did you have in implementing Namibia's national school health policy?
- What can be done to strengthen Namibia's processes for implementing national school health policies?

Probing and clarification-seeking queries have been employed intermittently.

ANNEXURE G: Introduction and questionnaire for national, regional and district school health programme administrators and school health care professionals

What are stakeholders' perceptions of Namibia's national school health policy implementation?

What is the status of Namibia's national school health policy?

What elements contribute to the execution of the national school health policy?

What can be done to strengthen Namibia's systems for implementing national school health policies?

ANNEXURE H: Checklist for factors concerning resources on the implementation of school health policy

Recommended facilities for SHS	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Total
Ablution facilities						
Water availability						
Recreational facilities						
Proper garbage disposal System						
Clinical facilities including first aid						
Availability of fire extinguishers						
Proper staff houses						

ANNEXURE I: Turnitin digital receipt

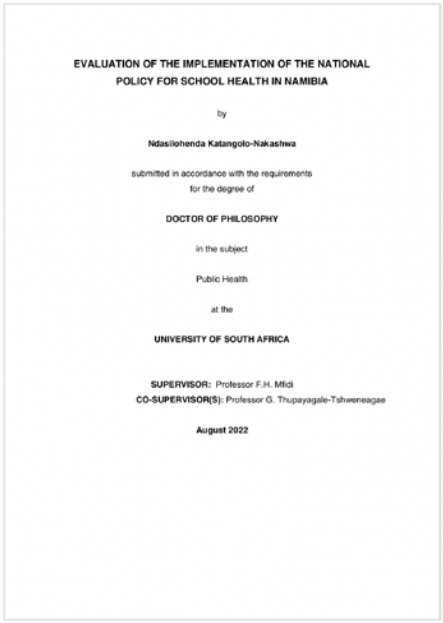
turnitin

Digital Receipt

This receipt acknowledges that Turnitin received your paper. Below you will find the receipt information regarding your submission.

The first page of your submissions is displayed below.

Submission author:	Ndasilohenda Katangolo-nakashwa
Assignment title:	Research
Submission title:	PHD THESIS
File name:	KATANGOLO-NAKASHWA-THESIS_FINAL.docx
File size:	43.99M
Page count:	242
Word count:	47,850
Character count:	283,418
Submission date:	05-Aug-2022 03:09PM (UTC+0200)
Submission ID:	1879132913



EVALUATION OF THE IMPLEMENTATION OF THE NATIONAL POLICY FOR SCHOOL HEALTH IN NAMIBIA

by

Ndasilohenda Katangolo-Nakashwa

submitted in accordance with the requirements for the degree of

DOCTOR OF PHILOSOPHY

in the subject

Public Health

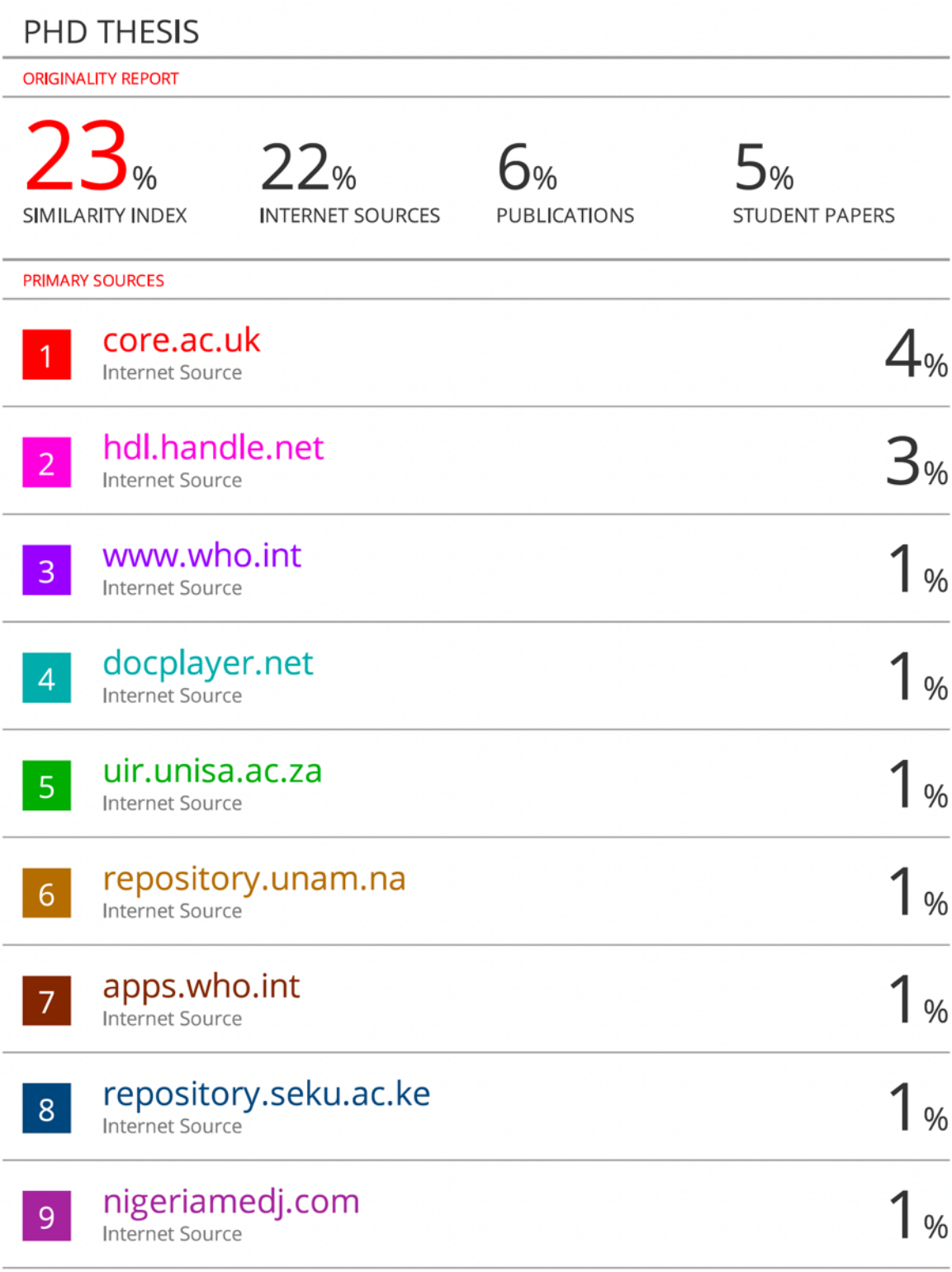
at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: Professor F.H. Mfidi
CO-SUPERVISOR(S): Professor G. Thupayagale-Tshweneagae

August 2022

ANNEXURE J: Turnitin originality report



PHD THESIS

ORIGINALITY REPORT

23%	22%	6%	5%
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9	nigeriamedj.com Internet Source	1%

ANNEXURE K: Editing certificate

Between the lines editing

Leatitia Romero
Professional Copy Editor and Proofreader
(BA HONS)

Cell: 083 236 4536
leatitiaromero@gmail.com
www.betweenthelinesediting.co.za

1 June 2022

To whom it may concern:

I hereby confirm that I edited the thesis entitled: "EVALUATION OF THE IMPLEMENTATION OF THE NATIONAL POLICY FOR SCHOOL HEALTH IN NAMIBIA". Any amendments introduced by the author hereafter are not covered by this confirmation. The author ultimately decided whether to accept or decline any recommendations I made, and it remains the author's responsibility at all times to confirm the accuracy and originality of the completed work. Research participants' verbatim quotes were not grammatically altered or checked for contextual accuracy. The author is responsible for ensuring the accuracy of the references and its consistency based on the department's style guidelines. I am not accountable for any changes made to this document by the author or any other party subsequent to my edit.

Leatitia Romero

Affiliations

PEG: Professional Editors Group (ROM001) – Accredited Text Editor
SATI: South African Translators' Institute (1003002)
REASA: Research Ethics Committee Association of Southern Africa (104)