Barriers to the successful implementation of school health services in the Mpumalanga and Gauteng provinces

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Abstract

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Background: The level of development of a country is measured by the health status of its children. The higher the mortality and morbidity rates in children, the more the country is challenged to improve its health care system. Although South Africa accepted the Convention on the Rights of the Child (CRC) in 1996 thereby committing itself to prioritisation of children, the implementation of school health services in South Africa has deteriorated to levels that contravene these rights.

The promotion of health in schools requires a strong political commitment that will influence all levels of policy making, in other words national, provincial and local, towards an integrated and coordinated school health programme.

Methods: A qualitative, explorative and descriptive study was conducted to identify barriers that led to poor implementation and a decline of school health services in the Mpumalanga and Gauteng provinces. The data-collection method of choice for this study was focus group discussions, which were conducted with all intersectoral role-players involved in school health programmes. To ensure broad representation of the various stakeholders, 10 participants were selected from five districts in each of the two provinces. This resulted in 50 participants per province.

Results: The study findings reveal the following as barriers that hamper successful implementation of comprehensive school health programmes:

- Barriers related to governance, for example lack of national policy guidelines for school health services and failure of government to prioritise school health services
- Programme-related issues, such as lack of intersectoral collaboration and unrealistic nurse–learner ratios
- Management-related issues, such as lack of support by management and managers' limited knowledge of the Health-promoting Schools Initiative
- Community-related issues, such as health professionals not including the communities in school health programmes

Conclusions: The need for political commitment in consistently placing the health and education of learners as a priority on the national agenda cannot be over-emphasised. Having adopted the CRC, South Africa took a giant step towards the prioritisation of child protection and care issues. This commitment can only be achieved through conscious intersectoral efforts that will promote a spirit of working together and sharing scarce resources towards one common goal.

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Background

The Health-promoting Schools Initiative[2] is a fairly new concept in South Africa. Lack of clear understanding of this initiative and its interrelatedness to school health services led to implementation problems, which in turn resulted in reduced quality standards and a total collapse of school health services in most areas.

According to the Population Census,[3] 17 150 434 children were enrolled in educational institutions in 1998 – a figure that has increased in the new millennium. These high enrolment figures underline the need for 'health-promoting schools'. A health-promoting school is defined as one that "aims at achieving healthy life styles for the total population, by developing supportive environments conducive to the promotion of health. It offers opportunities for and requires commitment to the provision of a safe and health-enhancing social and physical environment".[4]

In addition to the Convention on Rights of the Child (CRC), the Constitution of South Africa[5] enshrines rights that have

a direct bearing on health promotion in schools, such as the following:

- Section 24(a): "Everyone has the right to an environment that is not harmful to their health and well-being"
- Section 27(1)(a): "Everyone has the right to access to health care services"

The Alma-Ata declaration[6] defines health as a "state of complete physical, social and mental wellbeing and not only the absence of disease or infirmity". This definition supports a shift from a curative to a comprehensive model, inclusive of the psycho-social aspects of care. Comprehensive school health-promotion programmes require the recognition of the links between health, education and social services as the key role-players, while taking cognisance of the need to maintain partnerships with other sectors (including non-governmental organisations [NGOs]).

Within the new dispensation, the South African health system's reform initiative introduced the Comprehensive Primary Health Care Model[2] within which school health services would be incorporated. Due to the absence of clear policy guidelines, however, the implementation of school health services was hampered countrywide, with a total collapse in some of the provinces. This is contrary to government's commitment to prioritise the welfare of children. Hence, in order to facilitate policy formulation, wide consultation with the relevant stakeholders was regarded as imperative.

Before 1994, school health services operated as a vertical programme, resulting in a lack of collaboration with support services within and outside the Department of Health. Resources were inequitably distributed, with scanty resources allocated to render services in the black and coloured communities. The Department of Health was perceived as the only fraternity responsible for delivering school health services, and nurses employed by the Department of Education operated completely dissociated from the Department of Health's school teams.

Based on the National Education Policy Investigation Support Services Report,[11] the ratio between health personnel and students before 1994 had been unequal and inadequate, with ratios ranging from relatively satisfactory in white and Indian education systems, to minimal or non-existent in coloured and African systems. The quality of services rendered was also determined by geographical location. The poor infrastructure in rural areas aggravated the problems of access to health services. Poor roads, lack of transport and lack of manpower made it impossible for rural schools to be visited. Lack of clear national policy guidelines for school health services resulted in provinces and even districts within the same province operating differently. There were no formal mechanisms established for monitoring, evaluating or researching the effectiveness of the implementation of these services.

Since 1994, a number of programmes aimed at improving children's health, knowledge and practices target schools from different sectors. These include the Primary School Nutrition Programme, Environmental Safety Programme, the Child Protection Unit, Crime Stop, Road Safety Programme, HIV/AIDS Life Skills Education, Mental Health and Substance Abuse programme and several others. With adequate planning these services could have been coordinated into a comprehensive and coordinated school health programme, preventing the fragmentation and duplication of services in schools.

The White Paper on the Transformation of Health Services in South Africa outlines the development of a unified national health system based on the Reconstruction and Development Programme.[12] This restructuring, however, requires sound planning and commitment by all relevant stakeholders to promote intersectoral collaboration. Application of the principle of integration has since proved to be difficult to accomplish, especially with reference to services such as school health care, which previously operated as vertical programmes. This has contributed to implementation problems and virtual disintegration in most of the provinces.

The road towards intersectoral collaboration is not an easy one, but with the cooperation of all stakeholders efficient and fair use of resources can be achieved. Ambitious goals set by each sector, including NGOs, for improvement of the quality of life of children can only be achieved through the establishment of a common understanding that only through joint efforts will stakeholders succeed in implementing comprehensive school health programmes in an efficient and cost-effective manner.

The purpose of this study was to identify and describe the barriers that may hamper successful implementation of school health services at all levels of governance and to recommend strategies to overcome such barriers.

Methods

The research design used for this study was qualitative, explorative and descriptive in nature. The design was seen as appropriate for this study in view of the limited available information on issues that led to the collapse of school health services in the various provinces, including strategies through which these barriers could be overcome. Information obtained through focus group discussions with the various stakeholders enriched the data-collection process and facilitated ownership of resulting policies.

Population and sampling method

The population for this study included all intersectoral role-players involved in school health programmes in Gauteng and Mpumalanga. The selection of these two provinces for inclusion in the study was based on the fact that Gauteng, though limited geographically, is over-populated and Mpumalanga is geographically broad, rural and needy.

A purposive sampling method was used to select participants for inclusion in the study. The researcher liaised with the provincial Maternal, Child and Women's Health (MCWH) coordinators to consciously select intersectoral role-players in the five districts of each province. Selection was based on the participants' previous and present experience in the implementation of school health programmes.

This deliberate selection of various role-players from health, education and social development organisations as well as NGOs dealing with children enhanced cross-referencing for the sharing of ideas, thereby broadening the data collected. Participants were selected on the merit of being involved with the rendering of school health services in the various districts of the two provinces. This selection included participants from areas in which school health services had collapsed and therefore needed re-establishment.

To ensure broad representation of the various stakeholders, 10 participants were selected from the five districts of the two provinces. This resulted in 50 participants per province, in other words a total of 100 participants.

Point of entry

The researcher, as chairperson of the National School Health Task Team (South Africa),

- utilised her existing working relationship with the MCHW coordinators of each province in planning towards the focus group discussions, which took place during workshops in the two provinces; and
- obtained permission to conduct the focus group discussions from the Director General of Health. As a result, both focus group workshops were funded by the National Department of Health.

Ethical considerations

- The researcher ensured that the study falls within the national and provincial MCWH joint operational plans. As a result, the focus group discussions were perceived as a foundation for reorganising school health services.
- Verbal consent from the participants was obtained during the pre-focus group discussions. Permission to capture the focus group discussions on tape was obtained prior to the workshop. Participants were informed of the intention to utilise parts of the collected data for a dissertation.
- To ensure uniformity and consistency during the subgroup discussions, the facilitators were orientated to their role expectations and provided with facilitators' guidelines.
- The study proposal was submitted for critique and approval to the Research, Ethics and Publication Committee of the Medunsa Campus, University of Limpopo.

Data collection, analysis and communication of findings

In both the Mpumalanga and Gauteng provinces, the focus group discussions were conducted during workshops funded by the National Department of Health. The participants in the two provinces were divided into 10 subgroups. The following three broad topics or questions were addressed during the focus group discussions:

- What are the barriers hampering the successful implementation of comprehensive school health services in your province?
- How can these barriers be overcome?
- How can the present systems of operation be improved to accommodate the implementation of comprehensive school health programmes in your province?

All topics were given 45 minutes for discussion, inclusive of the time allocated for feedback from the subgroup rapporteur. At the end of the session, the facilitators summarised and verified their perceptions by allowing participants to correct and/or clarify information. After each focus group discussion session the researcher carefully listened to the tape recordings and made narrative descriptions of the content, taking into account the facilitators' personal notes and reports.

The researcher carried out the following activities throughout the data-analysis process:

- The recorded data from the 10 subgroups from the two provinces were collected and
- Intently listened to in order to gain a whole picture of the deliberations.
- Transcriptions of each subgroup session were made and validated with the facilitators (for the specific session) in order to seek clarification and gain understanding of the aspects that were unclear to the researcher. The stages below were followed:

Data reduction

To consolidate the data, the researcher carefully grouped the data from the transcripts, facilitators' notes, flipcharts and audio-tape recordings. Data reduction to coded information was accomplished by using the cut and paste technique.[19]

Data from both the Mpumalanga and Gauteng focus group discussions were combined and different colours marker pens were used to highlight aspects belonging to the same category. As a result, several themes emerged that embodied ideas or concepts..

Data display

The reduced data were displayed in columns and matrices, allowing the researcher to recognise connections of related data and aspects related to a theme.

Drawing conclusions

Conclusion drawing started when the researcher noted patterns and regularities. Verification of conclusions was made by returning to the tape recordings of the focus group discussions to determine whether the conclusions are rooted in the data. The data display was discussed with the provincial coordinators for school health services on an individual basis. The analysis and interpretation of data were based on the research purpose.

Validation

The researcher engaged an independent reviewer to cross-check the data display to ensure objectivity, reliability and validity of the results.

Limitation of the study

The findings of this study are limited to the Gauteng and Mpumalanga provinces and could therefore not be generalised to all provinces in South Africa.

Results

For the purpose of this article, the main themes and their subcategories are discussed as findings of this study, using narrative descriptions drawn from the participants' expressions. The main themes are the following:

- Governance issues
- Programme-related issues
- Management-related issues
- Community-related issues

Governance issues

These issues were centred around the need for active political support.

Participants expressed the need for all levels of governance, in other words parliament, national departments, provincial departments, local government departments and the District Health System to prioritise school health services as a service that will push forward the agenda for children as enshrined in the country's legal framework. The participants were concerned that all children's rights are attractively written on paper, and that government has ratified the Convention on the Rights of the Child, yet government portrays very little political support to school health services.

The following subcategories were identified:

Lack of national policy guidelines for school health services and lack of commitment by the national departments of Health and Education regarding the health and education of children were perceived by participants as a serious implementation barrier. This has led to lack of direction at provincial and local levels, with a resultant decline in quality care standards and a total collapse of school health services in some of the districts. Lack of national policy guidelines for school health services was expressed as the main barrier that hampered the implementation of quality, co-coordinated and comprehensive school health services in the various provinces. This is confirmed by the World Health Organization (WHO),[4] which stated that national policy and resources, in support of a comprehensive approach, facilitate and guide local efforts. With absence of a policy for such an important service for children, other barriers came to the fore that further aggravated the problems. For example, even in areas where the service is implemented, enrolled nurses are allocated to be in charge of health services – a delegation above their scope of practice as stipulated by the South African Nursing Council.[13]

Participants expressed that the *lack of clear policy guidelines* from national level contributed to the disarray in programme implementation at local level. An example cited by participants was that policy makers from the different sectors, for example health education and social development, "did not have a shared vision regarding the role that should be played by their respective departments regarding the health of the school children". Hamer and Collison[13] view health care policy as a framework for guiding decisions made by individuals, groups or organisations responsible for commissioning or providing health care services. The lack of national policy guidelines was therefore crucial in this respect.

One of the participants, a school nurse practitioner, said the following: "I think the main problem is that the policy makers from health and education do not see school health as a priority. If they did, we should be having clear policy guidelines. Teachers would then support nurses because their policy would also reflect their role in ensuring that the learners are healthy".

Programme-related issues

Several issues raised by participants relate to the implementation of school health programmes. Of great concern to the participants was that within the same

province, some districts implemented services in schools, while others did not. The District Health System, which directly oversees the implementation of the primary health care services, apparently *does not perceive the implementation of school health services as a priority*. In areas where school health services are operating, school nurses are used as the 'fillers-of-gaps' whenever there is a shortage of manpower in the primary health care facilities. This non-committal attitude by district health managers contribute to poor quality services, resulting in the gradual and ultimate collapse of school health services in most areas.

Nurses that visit schools do so once a year or once in two to three years. This is because of the vastness of the areas, especially those that are remote and rural; the allocation of inexperienced, enrolled nurses to provide the services; and unrealistic nurse–learner ratios.

One participant expressed the following: "I am a registered nurse, and at the moment I am doing school health services all by myself. It is a vertical programme so nobody assists me. When I am sick, the work 'stops' in schools. I am in charge of 90 schools, with a distance of more than 120 kilometres in between each school. The area is rural, the roads are bad; so during rainy seasons I cannot reach the schools. I visit a school once every five years".

The following additional barriers emerged:

- There was apparently no intersectoral collaboration, meaning that the vertical approach was being perpetuated. The Health-promoting Schools Initiative had not yet been introduced in most areas.
- Poor roads, especially in rural communities, made it difficult for outreach programmes.
- School nurses could not do proper follow-up and home visits for learners with problems.
- Collaboration with other support services, such as oral health, environmental health, primary school nutrition programmes and immunisation did not take place in all schools in the various districts of the provinces.
- There was inequitable distribution of resources, resulting in non-uniformity of service implementation in the different districts of the same province.
- Primary health care services in some districts incorporated school health, while in other areas the two operated as separate programmes within the same catchments area.
- In most areas, communities were not involved in school health programmes.
- School health nurses' activities were centred around 'screening' for health problems, thereby neglecting health-promotion activities that contribute to the total health of the learners and the entire school community.

Management-related issues

Lack of support from management was perceived by participants as having negative implications on their functioning. Participants expressed the following concerns:

- Some of the managers displayed a negative attitude because they apparently had a poor understanding of what school health services entail. One of the participants stated as follows: "The Health-promoting Schools Initiative is a new concept and unknown to most of the managers, both in the health and education fraternity. This lack of knowledge makes it difficult for us to plan and implement school health services in a comprehensive and integrated fashion."
- Whenever a shortage of personnel was experienced in the primary health care facilities, managers withdrew school health nurses to replace the missing staff members. This crippled continuity and the quality of services offered to the school children.
- Managers did not do 'spot checks' or pay supervisory visits to be conversant with what school nurses were doing. Monthly and annual reports compiled by school nurses apparently were not attended to. Problematic areas highlighted in these reports were ignored.
- Some school principals refused to allow school nurses entry to the school premises, stating that school health services belonged to the Department of Health and not to the Department of Education and that the nurses are therefore employed to the Department of Health and should not enter schools.
- Introduction of the Health-promoting Schools Initiative, within which school health must function, is a new concept and unknown to most of the managers, both in the health and education fraternity. This made the planning and implementation of school health programmes in a comprehensive and integrated fashion problematic

These barriers frustrated the nurses at implementation level, who, due to lack of managerial support, became despondent, with resultant low staff morale. This resulted in committed and experienced school health nurses resigning from the public sector.

Community-related issues

According to the focus group data, families and communities can support and contribute to the success of co-coordinated school health programmes. Presently, most of the activities and awareness campaigns are planned by health professionals, excluding the community. Marx

and Northrop, cited in Marx and Woody,[15] state that when parents are comfortable with the school and communicated with regularly, they are more likely to understand and support school health programmes.

The participants generally embraced the idea of involvement of communities. Working together with communities also benefits education and health in that when learners are healthy, educational achievements become high. Families, other community members and community organisations can support and in turn be supported by all the other components of a co-coordinated school health programme.[15]

Recommendations and conclusion

Cabinet should rededicate itself to the impact that school health services has on the improvement of the health of children, thereby enabling them to learn and elevate the country's literacy level. This means that political commitment and health-supportive policies should safeguard school health as an economic and political asset. There needs to be intersectoral commitment from the various national departments to guide and support provinces in the implementation of comprehensive school health programmes. While provinces will take responsibility for operational issues, guidance and direction are needed on national level, particularly with actualisation of the Health-promoting Schools Initiative, which requires collaborative efforts by all relevant partners. Within the minimum standards set by national policy guidelines, provinces should design operational policies that will influence quality care for learners in school. There is an urgent need for role clarification between the district health system and local government. A dedicated team should be allocated within the Primary Health Care System for the rendering of school health services.

The National Department of Health should adopt the Stages Model[16] of policy development, and the Health Promoting Schools and the School Health Services policy guidelines, which are presently separate documents, should be merged and launched as one compact document. This will clarify the fact that school health is a vital component within the Health-promoting Schools Initiative.

Health care providers in schools need to establish and maintain culture-sensitive programmes that are overtly linked to the needs of the particular community they serve. The tendency of planning 'for' and not planning 'with' the people should be eliminated if successful implementation of comprehensive school health programmes is to be achieved. Reluctance by health care providers to relinquish the power of control will not only defeat intersectoral collaboration, but will lead to conflict between the services and the community.

References

1. Unicef. First call for children. New York; 1990.
2. Department of Health. Green paper on health promoting schools guidelines. Pretoria, RSA; 2001.
3. Statistics South Africa. Census in brief. Pretoria; 1998.
4. World Health Organization. Improving school health programmes. Geneva; 1996.
5. Government of South Africa. The Constitution of South Africa (Act No. 108 of 1996). Pretoria, Government Printer; 1996.
6. World Health Organization. Alma-Ata primary health care. Geneva; 1978.
7. Barker C. The health care policy process. New Delhi: Sage; 1996.
8. Walt G. Health policy: An introduction to process and power. London & New Jersey: Zed Books; 1994.
9. World Health Organization. The Ottawa Charter for Health Promotion. Geneva; 1986.
10. Smith CF, Maurer FA. Health nursing theory and practice. Philadelphia: Saunders; 2000.
11. Department of Education. National Education Policy: Investigation support services report. Pretoria: RSA; 1992.
12. Government of South Africa. The Reconstruction and Development Programme. Pretoria: Government Printer; 1994.
13. South African Nursing Council. Regulations relating to the scope of practice of persons who are registered or enrolled under the Nursing Act, 1978. Regulation 2598 as amended. Pretoria; 1984.
14. Hamer S, Collison G. Achieving evidence-based practice. Edinburg: London; Baillière Tindall; 1999.
15. South African Nursing Council. Regulations regarding the conduct of enrolled nurses which shall constitute improper or graceful conduct. Regulation 1649 as amended. Pretoria; 1973.
16. Marx E, Woody SF. Health is academic. New York: Teachers College Press; 1998.
17. Porter RW. Knowledge utilization and the process of policy formulation. Place of publication: Academy for educational Development, USAID; 1995.
18. Dennill K, King L, Lock M, Swanepoel T. Aspects of primary health care. Halfway House: Southern Books; 1995.
19. Stewart DW, Shamdansani PN. Focus group theory and practice. London: Sage; 1990.