Why child health policies in post-apartheid South Africa have not performed as intended: The case of the School Health Policy

Maylene Shung King

Wolfson College

Hilary Term, 2012.

Thesis submitted in fulfilment of the requirements for the degree of DPhil in the Department of Social Policy and Intervention at the University of Oxford.

Abstract

Why child health policies in post-apartheid South Africa have not performed as intended: the case of the School Health Policy

Maylene Shung King
Wolfson College, University of Oxford
Department of Social Policy and Intervention
Submitted for Degree of DPhil
Hilary Term, 2012

The unprecedented scale of health sector reform in the course of radical political transformation in post-apartheid South Africa is well-documented. This thesis examines child health policy reform as a crucial part of this process. The goals of broader health sector reform were to improve the overall health status of citizens, in particular those most vulnerable, and eliminate inequities in health service provision and health status outcomes. Although children were accorded explicit prioritisation during this time, child health indicators remain poor and some have worsened. Amidst the documented explanations for the poor progress with child health indicators, the specific role and contribution of child health policies had not been interrogated.

The thesis examines the development, design and implementation of national child health policies, with particular focus on equity.

The National School Health Policy serves as a case-study for the analysis. Three complementary policy analysis frameworks guide the enquiry. Findings are based on a documentary analysis of key policies and 81 qualitative interviews with national policy makers and managers, provincial and district managers, and service providers in three socioeconomically different provinces of South Africa.

The common assertion by South African health system analysts, that "policies are good, but implementation is poor", is refuted by this research. The findings show that child health policies have many deficiencies in their design and development. These "poor policies" contribute to inadequate child health service provision, which in turn have a bearing on poor child health outcomes. In particular the failure in clearly defining and conceptualising equity in policy development and design contributed to the absence of equity considerations in the implementation phase. The explanations for these policy failures include: lack of strategic direction for child health services; poor policy making capacity; a lack of clear policy translation; and the diverse politics, power and passion of policy actors. Broader health system factors, such as an immature and poorly functioning district health system, compound these policy failures.

The thesis deepens the understanding of child health policy reform through a retrospective policy analysis and so contributes to the body of knowledge on policy reform in South Africa and in low- and middle-income countries more generally.

Acknowledgements

All glory and honour to God, by whose Grace and Mercy I was able to complete this thesis.

To Rebecca, my supervisor, who has had incredible patience and tolerance with me, and who also undertook the seemingly insurmountable task of teaching me better writing skills. I will always be grateful to you for this, as well as for your unique ability to balance professionalism with friendship – a rare skill, and one that is of immense value in a supervisor. Thank you!

The Oxford Nuffield Medical Fellowship has provided me with more than funding for an education opportunity: it has given me a life experience that has shaped me in unexpected and unimaginable ways.

The Oppenheimer Trust assisted me to complete my last few months at Oxford.

To the 81 interviewees and many colleagues along the way, for giving generously of your time, I offer you my deepest gratitude. If this can change something for you, even in the smallest way, then it would be truly worth it.

My thanks also go to the Department of Social Policy and Intervention and Wolfson College for helping to fund my fieldwork. Thank you, too, to Bryony Groves, Sharon Long, Mary Smith and Anja Jeczalik for your invaluable administrative support throughout this process.

I also owe a huge debt of gratitude to many family members and friends who helped me through my doctoral journey.

To my mother, Gimela, who gave me every possible opportunity to learn and develop, sometimes at great personal cost to herself. Thank you for braving the English winter to look after my boys during my fieldwork period. You are a truly remarkable woman. Your unconditional love gives me more than anyone could ever hope for. For this, and the many blessings you have given me, I thank you with all my heart.

To my husband, Reno: I could not have asked for more love, kindness, care, and consideration during the last two years of completing my thesis. You have been an incredible father to our boys and an invaluable friend to me. Many parts of this thesis have improved enormously as the result of your hours of proofreading, analytical and constructive criticism (albeit with trepidation at times), and the application of your astute mind. I hope that the completion of this thesis repays you in some small measure.

To my darling sons, Rowan and Nathan: you showed incredible strength of character and maturity when I uprooted you to go and pursue my studies at Oxford and then uprooted you again to come back home. I have learnt so much from you about what it means to be true to yourself and to face your challenges with courage and determination. I love and admire you more than you will ever know. I can only hope that, when you look back, your Oxford journey will be amongst those experiences that you consider worthwhile.

Thank you too to my very special family members and many friends, whom I cannot list by name, for praying for me, encouraging me through your visits, calls and emails – I don't regret any of the times that I took a break from thesis work to spend time with you instead.

I have to make special mention of my most special Oxford friends, who carried me through my darkest days when I was ready to give up on everything: Jaco and Amanda, you are my rocks and the depth of what our friendship means to me is *onpylbaar*; Phakama, you taught me so much about myself; Kareni, for the many special dinners, visits and laughs – bottoms-up dear friend!; Marian, we shared so many tears and laughs, pleasures and pains, *muchas gracias mi amiga.*

My heartfelt thanks also to the members of the fellowship meetings in Oxford where I received so much love, care and encouragement.

Emile and Michelle, thank you for always being there for the boys during their English sojourn. Dean, Willow and the girls, thank you for the many visits and "boy-sitting" stints.

To the transcribers Charles, and especially Michelle, for your endless hours of listening, rewinding and meticulous transcriptions.

To Rory Tanner, Lucy Gilson, Gill Walt and Yolande Harley, who provided comments on my work at various stages, proofread and edited and helped with layout, my sincere thanks for your time and assistance.

My sincere thanks also goes to David Newmarch for the final proofreading and editing of this thesis and for going far beyond the 'call of duty'.

Table of Contents

Abstract ii

Acknowledgements iii

Table of Contents v

List of Tables vii

List of Figures vii

List of abbreviations viii

Chapter 1: Introduction 1
- The determinants of child health 4
- The role of public policies 7
- Brief overview of apartheid health system challenges 8
- Transforming the health sector post-apartheid 9
- The specific situation of children 10
- Post-apartheid child health policy reform 21
- Thesis Aim 26
- Research questions 27
- The analytic frameworks 29
- Definition of key terms 32
- Outline of the thesis 35

Chapter 2: Policy analysis and policy implementation theories and frameworks 37
- Introduction 37
- Overview of policy analysis frameworks 38
- Alternate policy analysis frameworks 43
- Analysis of policy actors through theories and frameworks 47
- Interrogating governance through policy analysis frameworks 50
- The application of equity in policy analysis frameworks 54
- Policy analysis frameworks and implementation 56
- Conclusion 58

Chapter 3: Methodology 60
- Introduction 60
- Brief overview of retrospective policy analysis 60
- Why choose qualitative methodology for primary data collection and analysis? 61
- The documentary analysis 63
- The case study 68
- Analysis of results 78
- The role of the researcher in the School Health Policy process 79
- Ethics and feedback 80

Chapter 4: Child health policy development in South Africa: context, process and policy positions 82
- Introduction 82
- Background to child health policy reform 86
- The place of children in health care reform 88
- The development of child health policies: 1994–2009 91

Characteristics of child health policy development 103
Child health policy features and content implications for child health service provision 109
Discussion 113

Chapter 5: Implementation of the National School Health Policy 120
Introduction 120
The content and requirements of the SHS package of care 122
Coverage of the SHS 124
The health problems identified through the SHS 132
Quality of the SHS 133
The transition from a vertical to an integrated SHS 136
Progress with collaborative relationships: Education and the Health Promoting Schools programme 141
Brief comment on equity in SHS provision 144
Discussion 145

Chapter 6: Poor performance of the SHP: institutional and other factors 153
Introduction 153
Institutional arrangements of the Department of Health 153
Rules for governance in the Department of Health 155
Impact of management capacity on the SHP implementation 163
Organisational structures influencing child health 168
Impact of systemic policies on districts: Example of the Occupation Specific Dispensation policy 172
The “soft elements” of individual passions, perceptions, and practices 173
How some characteristics of the SHS influenced its implementation 175
Discussion 177

Chapter 7: How equity manifested in child health policy development and implementation 184
Introduction 184
The concept of equity 185
Health officials’ perspectives on equity 197
Impact of federalism on the equity agenda 199
Discussion 200

Chapter 8: Conclusion..... 207
Introduction 207
Overall performance of South African child health policy reform 209
Implications of policy development gaps and deficiencies 214
Health system explanations for child health policy failures 218
What are the analytical and methodological lessons from this research? 221
Do new developments with the national SHP have a better chance at success? 224

REFERENCES 230
APPENDIX A: Topic Guide Nat. Dept of Health officials 249
APPENDIX B: Topic Guide Prov. Dept of Health officials 254
APPENDIX C: Topic Guide District Level officials 259
APPENDIX D: Topic Guide: Prov. Managers and Co-ordinators 263

List of Tables

Table 1: Infant mortality rates by province 16

Table 2: Structure of health care services for children pre- & post-1994 19

Table 3: Modifications to the stages framework 40

Table 4: National and Provincial interviewees 72

Table 5: District interviewees 72

Table 6: Overarching policy documents shaping health sector reform 84

Table 7: Key child health policy documents, 1994-2009 85

Table 8: Child Health Policy supporting documents 86

Table 9: Nurses' accounts of SHS coverage across research sites 129

Table 10: National Health Act provisions for each level of the health system 156

List of Figures

Figure 1: Ecological framework for the determinants of child health 5

Figure 2: Organisational structure – National Department of Health 11

Figure 3: Trend in deaths from death notifications, 1997–2004 14

Figure 4: Top three cause-specific deaths of infants nationally for 2000 14

Figure 5: Leading causes of death for children under-5 years 15

Figure 6: Child mortality rates by province 16

Figure 7: South African National Health System structure 18

Figure 8: Immunisation coverage in provinces 21

Figure 9: The Policy Triangle 29

Figure 10: Eight steps in developing an equity-orientated policy 31

Figure 11: The Policy Cycle 41

List of abbreviations

AIDS	-	Acquired Immune Deficiency Syndrome
ANC	-	African National Congress
HIV	-	Human Immunodeficiency Virus
HPS	-	Health Promoting Schools
MCWH	-	Maternal, Child and Women's health
MDG(s)	-	Millennium Development Goals
NHC	-	National Health Council
PHC	-	Primary Health Care
PMTCT	-	Prevention of mother-to-child transmission (of HIV)
RMR	-	Routine Monthly Report
SADHS	-	South African Demographic and Health Survey
SHP	-	School Health Policy
SHS	-	School Health Service
UNICEF	-	United Nations Children's Education Fund
WHO	-	World Health Organisation

Chapter 1: Introduction

In 1994 South Africa underwent a major political transition which propelled the country into a period of unprecedented political, social and economic reform. During this time, a prolific number of cross-sectoral policies were developed. The research for this thesis took place against this backdrop.

The political changes in 1994 involved a transition from 50 years of oppressive minority rule by the National Party in the apartheid period[1] to a new era of constitutional democracy led by the African National Congress (ANC), which had been the major liberation movement during the struggle against apartheid. The apartheid era was characterised by systematic oppression of the majority black[2] population, leading to significant political and socioeconomic inequities between white and black South Africans.

An important aspect of the reform that occurred when the ANC came into power was a massive overhaul of the health sector, whereby underlying health philosophies, policy emphases, governance, and organisational structures and functions were altered significantly from those of the apartheid health system. Child[3] health reform, which addresses the health challenges of close to 40% (18 million) of the population formed part of this process. Aspirations of the National Department of Health, as expressed in the 1999–2004 Health Sector Strategic Framework, were as

[1] Apartheid, derived from the Afrikaans word for "apartness," is a term that came into usage in the 1930s and signified the political policy under which the races in South Africa were subject to "separate development." Apartheid was a system of racial segregation enforced by the National Party governments of South Africa between 1948 and 1994, under which the rights of the majority non-white inhabitants of South Africa were curtailed and white supremacy and Afrikaner minority rule was maintained. For the purpose of implementing these policies, apartheid recognized four races: Bantu (or black African), Coloured (or mixed race), white, and Asian. Apartheid met with international condemnation and spurred a resistance movement among black South Africans. (Source for definitions: www.worldnews.about.com; www.wikipaedia.com)

[2] See note 1. Many anti-apartheid activists combined the Black, Coloured and Indian groups into one, and referred collectively to these racial groups as either White or Black.

[3] A child is defined in the United Nations Convention on the Rights of the Child as “every human being below the age of eighteen years”. Available at: <http://www2.ohchr.org/english/law/crc.htm> [Accessed 31 March 2012].

follows for child health: reduction of infant and child mortality, reduction of child malnutrition, amelioration of adolescent health issues such as teenage pregnancy and substance abuse, and improving the management of common serious childhood illnesses (Department of Health, 1999b). Yet 15 years into the reform period (the period covered in this research) child health indicators, which are sensitive and robust markers of a country's socioeconomic and health system performances, can be regarded as shockingly poor for a country of middle-income status such as South Africa (Every Death Counts Writing Group, 2008; Sanders and Schaay, 2008; Nkonki, et al, 2011). Set against the 2015 target for meeting the Millennium Development Goals[4] (MDGs), South Africa's progress with the MDG child health components in the past decade ranks as one of the poorest. This performance compares unfavourably against countries of similar middle-income status such as Mexico and Brazil, or indeed some low-income countries such as Malawi (Every Death Counts Writing Group, 2008; Chopra et al., 2009; Lozano et al., 2011). This is despite the unquestionable political prioritisation given to children by the new government, especially in the immediate post-apartheid period.

Such was the priority accorded to children that a specific section in the Bill of Rights of the Constitution is dedicated to them, a feature that is globally unique in constitutional democracies. An Office on the Rights of the Child is located in the Presidency. Further prioritisation is inscribed in all of the initial overarching health policy reform documents, which specifically identify children as a vulnerable group deserving of special attention. Why, in such a favourable climate for the advancement of child health, child health indicators should show such poor progress, and even in some instances regression, is a question which demands serious investigation. With

[4] In 2000, 189 nations made a promise to free people from extreme poverty and multiple deprivations. This pledge became the eight Millennium Development Goals to be achieved by 2015. In September 2010, the world recommitted itself to accelerate progress towards these goals Goal 4 specifically relates to child health and requires the reduction of infant- and under-5 mortality by two thirds in 2015.(Source: www.UNDP.org)

only three years left to meet the 2015 MDG targets, the central question of this thesis – "Why did child health policy in post-apartheid South Africa not perform as intended?" – is hence both apt and timely.

A legacy of unequal development for white and black citizens under the apartheid system is that South Africa is one of the most unequal societies in the world, with a Gini[5] coefficient of 0.7 (Bosch et al., 2010). Even if a slightly lower Gini coefficient would be more accurate, as some local economic researchers suggest, this measure of income inequality puts the South African ranking as one of the highest in the world (ibid). A key goal of post-apartheid reform was to improve the lives of citizens overall, but also to decrease the significant inequities between subgroups of citizens (Republic of South Africa, 1994a). The elimination of inequities in health status, health service provision and access, and resource distribution featured strongly on the health sector reform agenda. Based on this, the examination of the role and contribution of child health policies in the reduction of inequity is a key focus in this thesis.

The weak performance of South Africa's health care system in relation to international comparative indicators has been examined frequently over the past 15 years (Development Bank of South Africa, 2008; Coovadia et al., 2009; Harrison, 2009; Nkonki et al., 2011). Analysts particularly examined the function and structure of the health system, including the district health system, in search of explanations for this poor performance. Dating from 1995, the annual *South African Health Review*[6] publishes detailed analyses and commentary on various facets of the South African health system. Dating from 2005, the *South African Child Gauge*[7] provides similar

[5] The Gini coefficient is a measure of income inequality of a country. It has a scale of 0 (least unequal) to 1 (most unequal).

[6] The *South African Health Review* (SAHR) is an annual publication of a non-governmental organization, the Health Systems Trust, with support from the South Africa Department of Health since 1995. It provides current and longer term review of health policy developments and their implementation in the democratic South Africa. It is regarded as the most comprehensive and authoritative publication available on monitoring changes and challenges in provision of equitable and accessible health care in the country.

[7] The *South African Child Gauge* is an annual publication produced by the Children's Institute at the University of Cape Town. It comments on all facets of the lives of children. The 2010 volume focused

annual commentary on inter-sectoral progress on children's issues, including child health. The common explanations for the poor child health outcomes such as child mortality rates are nested in social determinants of health, broader health system factors such as funding distribution and staffing, and the HIV epidemic.

In these analyses of the South African health care system there is often overt or implied comment that "policies are generally good but implementation is poor" (Coovadia et al., 2009; Sanders & Chopra, 2006). The researcher contests this assessment and postulates that inadequacies in the policy development phase have translated into inadequacies in the policy implementation phase, and that this has in part contributed to the current situation of poor child health services and poor child health outcomes.

The determinants of child health

It is well-documented that the determinants of child health are complex and multi-factorial. Some of the many and varied interventions to address these determinants fall directly within the ambit of the health sector (e.g. delivery of health services), while others fall within the ambit of sectors other than health (e.g. road safety measures or provision of clean safe water to avert childhood diarrhoeal disease). An ecological framework, as illustrated in Figure 1, depicts the complexity of these determinants.

Figure 1 indicates a hierarchy of child health determinants, from factors that operate at a global level, through various intermediary layers, down to factors that operate at the community, family and individual levels. At the global level, child health advances in recent decades have led international agencies such as the United Nations Children's Fund (UNICEF) and the World Health Organisation (WHO) to

---

on child health. It is accompanied by a database which synthesizes available data and generates new data on various child statistics, including child health statistics.

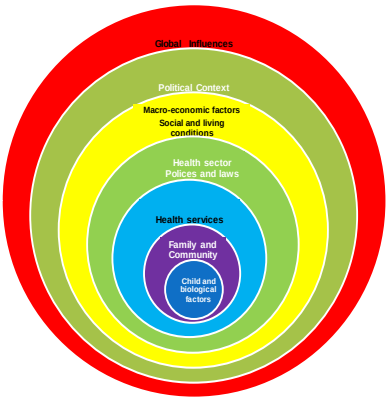


Figure 1: Ecological framework for the determinants of child health

Source: Adapted from original UNICEF framework on determinants of child malnutrition: UNICEF, 1990.

advocate for countries to address serious health conditions among children. Most familiar of these, dating back to the 1950s, would be immunisation programmes for vaccination of children against potentially fatal but preventable infections (WHO, 2011). The Expanded Immunisation Programme launched in 1974 made vaccines more accessible to children in developing countries and poorer contexts. Currently, many countries have almost eradicated polio and measles (WHO, 2011). UNICEF's GOBI-FFF initiative[8] promoted oral rehydration for children with diarrhoea, growth monitoring and breastfeeding, and factors such as female education, fertility levels and family planning practices known to impact on children's overall well-being.

At individual country level, macro-economics and politics are well-documented determinants of health and well-being (Sanders & Werner, 1997). In South Africa particularly, the political economy of child health was shaped by the oppressive politics and unequal economic development of the apartheid era. In the post-apartheid period the ills of child health are still closely linked to poverty and poor living

[8] "United Nations GOBI FFF strategy of 1982 . . . . At its foundation were four child health interventions which met the above criteria and which were considered to be synergistic – growth monitoring (G), oral rehydration therapy for diarrhoea (O), the promotion of breastfeeding (B) and childhood immunizations (I). Birth spacing/family planning (F), food supplementation (F) and the promotion of female literacy (F) were added subsequently (GOBI-FFF)" (Source: http://www.who.int/whr/2002/chapter5/en/index5.html)

conditions. Some have argued that these issues have been exacerbated by the adoption of the neo-liberal macro-economic agenda known as GEAR[9], which has been criticised as less pro-poor in its objectives and more about economic advancement (van Niekerk, 2007, p.242; Sanders & Chopra, 2006). Further social determinants of health, such as poor education or lack of adequate housing, safe water and good sanitation, all fall under the jurisdiction of government sectors other than health. This makes inter-sectoral collaboration between health and other relevant sectors particularly important. While these inter-sectoral factors are fundamentally important to child health, the examination of interventions within these sectors lies beyond the scope of this thesis. Beyond these specifics, the health literature contains an abundance of research and publications on the social determinants of health.

In the ecological framework, determinants pertaining to individuals, families and communities form the inner core. These are factors that speak to psychosocial elements operating within families and communities, coupled with individual biomedical issues, and are not addressed in this thesis.

Much analysis has already been done in the post-apartheid years on the impact of social determinants, broader health system issues and international factors on child health (Sanders & Chopra, 2006; Shung-King et al., 2000; Mhlanga, 2008; Chopra et al., 2009; Coovadia et al., 2009; Nkonki et al., 2011). What is missing is a critical review of the specific role of policy in shaping child health service provision, and in determining child health outcomes. No substantive research has been documented in South Africa that examines child health policy development processes. Nor is this gap in the literature on child health policy analysis peculiar to South Africa. It is equally

[9] Acronym for Growth, Employment and Redistribution. GEAR is a medium-term macro-economic strategy adopted by the South African government in 1996. Core elements include:· a renewed focus on budget reform to strengthen the redistributive thrust of expenditure;· expedited fiscal deficit reduction and a programme to contain debt service obligations, counter inflation and free resources for investment; an exchange rate policy to keep the real effective rate stable at a competitive level; and consistent monetary policy to prevent a resurgence of inflation. Critics of GEAR believed that it favoured economic growth, and hence the business and profit-making sector, and that whilst it aimed in principle to increase resource distribution to social services, it failed to do so in practice (http://www.info.gov.za/view/).

manifest in a comprehensive review of policy in middle- and low-income countries where none of the 164 reviewed articles focused on child health (Gilson & Raphaely, 2008). The focus of this thesis is accordingly on layers four and five of the ecological framework, namely, child health services and the policies and laws that determine their strategic direction, structure and functions. These two layers also fall under the direct jurisdiction of the health sector, and are less dependent on input from other sectors.

The role of public policies

Public policies are key instruments of government in shaping interventions for its citizens (Goodin et al., 2008, p3). "Public policies", according to Walt (1994, p41), "are those policies developed by governmental bodies and officials, and thus focus on purposive action by or for governments". A health reform process on the scale that South Africa has undertaken merits a closer look at the public health policies that shaped the reform process. In addition to being an important activity of government, policy development also consumes considerable resources – such as money, energy, and expenditure of time by numbers of high-level officials. Simply put, public policy is "concerned with what governments do, why they do it and what difference it makes" (Dye, 2008, p1). It is therefore important to understand the intentions of government policies. This includes their development and implementation and an assessment of how policy intentions matched against health service outputs and health outcomes.

By inference and as shown in Figure 1, child health policies are important instruments that shape child health services and these in turn contribute to the improvement of child health outcomes. It is important to point out that the intention of this thesis is not to demonstrate causality or examine the pathway from policies to services to child health outcomes in a causal light. The ecological framework illustrates that the determinants are too many and varied to demonstrate a direct relationship between policies and eventual health outcomes. Policies in this research are viewed as important instruments that shape the direction, structure and functions

of child health services, which themselves only partly contribute to child health outcomes.

The next sections provide more detail on the post-apartheid health system challenges and the situation of children.

Brief overview of apartheid health system challenges

The health challenges created by apartheid were formidable (Price, 1986; Savage 1990). The country had 14 uncoordinated health departments – one for each of the previous four provinces and ten homelands.[10] Health resources were unequally distributed. Per capita health expenditure across the country and homelands differed by as much as three- to four-fold between whites and blacks (ibid). Large hospitals absorbed most of the public health sector budget, despite the majority of health needs requiring primary-level and community-based care (ibid). A lucrative and poorly regulated private health sector covering less than 20% of the population (the majority of the health insured were white) accounted for 60% of total health care expenditure (ibid). A high prevalence of serious preventable health conditions directly linked to poverty, such as tuberculosis and malnutrition, afflicted the majority black population. In addition, huge inequities existed in health status and access to health care facilities between race groups, rural and urban dwellers, and rich and poor. Children were especially vulnerable under these conditions of deprivation and oppression and this was reflected in poor child health status indicators.

[10] One of the major legacies of apartheid was that the country was subdivided into mainland South Africa with four provinces, and 10 homelands (or "self-governing" territories), to which large numbers of blacks were moved, according to their tribal origins (Price, 1986; Pillay and Bond, 1995). Homelands were poorly governed by leaders who were generally not recognised by black South Africans. Homelands were chronically under-resourced, compounded by wide-spread corruption in their governments. Homelands lagged behind in all social services as compared to the mainland.

Transforming the health sector post-apartheid

Following the negotiated settlement of a Government of National Unity, with President Nelson Mandela from the majority ANC party as its first democratically elected president, the focus of health sector transformation was to build a single national health system. Dominant goals of the proposed health system were the reduction of inequities in health status and health service access and provision, and the increase in availability, affordability and the quality of health care across the country (Republic of South Africa, 1994a). Part of health system transformation involved a change from a curative, hospital-centred system to one underpinned by the primary health care (PHC) philosophy. In addition it involved the redistribution of resources from tertiary to primary level care, as well as between provinces. This transformation therefore required major policy, legislative, structural and budgetary changes (ibid). Consequently the post-1994 period involved the development of numerous health policies, plans, programmes and laws. Many of these undertakings occurred simultaneously.

Structurally, the country was reunified by incorporating all the designated "homelands" back into South Africa. The unified country was then subdivided into nine provinces. The new South Africa consequently had a single National Department of Health, with nine provincial Departments of Health under its jurisdiction. The nine provinces were further subdivided into health districts, of which there are now 52. Each province has between three and eight districts, depending on their geographical size and population density. This enabled the introduction of a district health system[11] in which districts were intended to be self-sufficient administrative units that managed

[11] "A district health system is a more or less self-contained segment of the national health system. It comprises first and foremost a well-defined population living within a clearly delineated administrative and geographic area, whether urban or rural. It includes all institutions and individuals providing health care in the district, whether governmental, social security, nongovernmental, private, or traditional. A district health system, therefore, consists of a large variety of interrelated elements that contribute to health… Its component elements need to be well co-ordinated by an officer assigned to this function in order to draw together all these elements and institutions into a fully comprehensive range of promotive, preventive, curative, and rehabilitative health activities" (WHO, 1988).

their own staff, resources and activities. For child health this meant the introduction of district-level Maternal, Child and Women's Health (MCWH) teams that would oversee child health activities in each district. A new National Health Act was to provide the legislative framework for the structure, roles, responsibilities and functions of the new health system. As the Act took more than ten years before completion and only came into effect in 2004, many provinces and sections within the National Department of Health developed their own of policies and plans in the interim to guide their activities.

Part of the transformation involved the setting up of new organisational structures for the management of key programmes. Management structures for child health were grouped with those for maternal and women's health, in view of the integral relationship between these three areas. The current organisational structures within the National Department of Health are as follows: There are six "branches," each managed by a Deputy Director-General. Each branch is divided into several clusters. Areas that are perceived to naturally belong together are grouped into one cluster. MCWH issues fall under the MCWH cluster in Branch 2, while health promotion issues fall under the cluster "Occupational health, Health Promotion and Nutrition" in Branch 5 (Figure 2). Child health is primarily managed in the MCWH cluster, but child health issues are also addressed in at least three branches and several clusters, therefore requiring good co-ordination and planning. The mandate of the child health unit within the MCWH cluster is to develop policy, and provide oversight and support to provinces in the execution of the policy.

The specific situation of children

Overview

Children are defined as persons between the ages of 0 and 18 (Republic of South Africa, 1996) and constitute almost 40% (18 million) of South Africa's population (Statistics South Africa, 2005; Statistics South Africa, 2006). Information about children's general situation and their health status, especially of black children,

was not readily available during the apartheid period. National surveys and panel studies shedding light on the health status of all South African children first became available in the post-apartheid period.

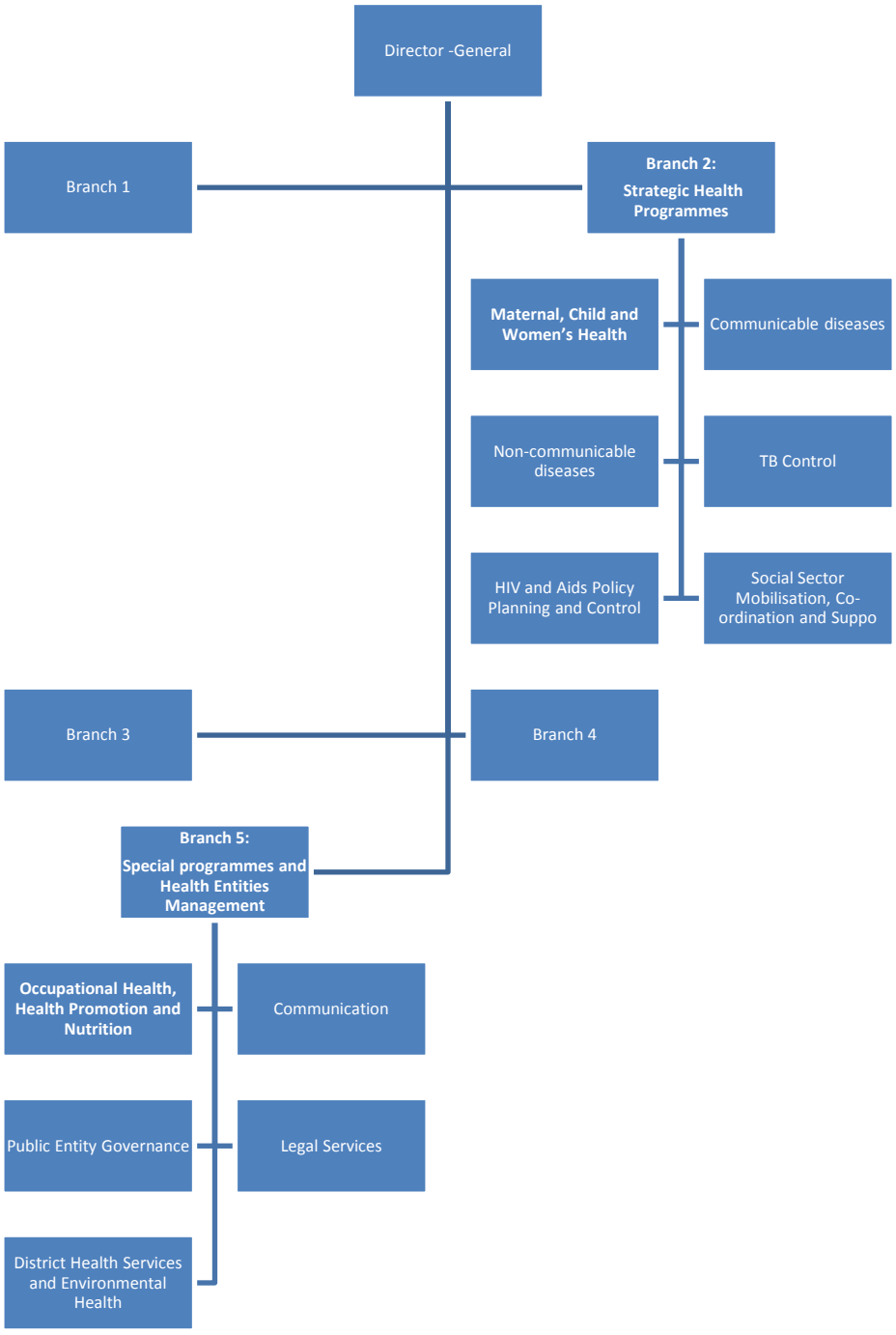


Figure 2: Organisational structure – National Department of Health

Source: Department of Health at www.health.gov.za, sourced on 26 July, 2011

The South African Child Gauge 2009/2010 (Children's Institute, 2006) contains a comprehensive synthesis of information on children derived from different sources that became available after 1994, among which are the following indicators: about 10 million children (55%) live below the ultra-poverty line, with a monthly household income below R800 per month (equivalent of two British pounds per day); 42% live in a household with no employed adult; 7.5 million children under the age of 14 receive the Child Support Grant (a means-tested poverty-alleviation grant). Overall more children, when compared to adults, live under suboptimal conditions. For example, just over half (54%) of all children live in under-resourced rural areas – where 22% live in traditional rural dwellings with poor or non-existent basic municipal services as compared to only 14% of adults. This might be indicative of adult migration to cities for purposes of employment. Those in urban areas mostly live in informal housing in peri-urban areas or low-income suburbs (Monson et al., 2006). A quarter of all children live in over-crowded dwellings. In 2005, close to 60% of children were reported to have access to clean, safe water. Those without access live primarily in rural or peri-urban areas. Approximately 54% have access to basic sanitation, the remainder having suboptimal sanitation facilities (ibid). Primary school enrolment figures are close to 100% in all provinces, but school completion rates are low (ibid). These statistics on children's living conditions depict the social determinants that contribute to children's poor health status.

The health status of children

Child mortality indicators are the best available measures of children's health status, as data on child morbidity are not readily available. Child mortality indicators reflect socioeconomic conditions and health service access and are used globally to monitor progress and compare performance within and between countries. The absence of national mortality data during apartheid forced a reliance on modelled estimates in the pre- and post-apartheid period. The first empirical child mortality data became available through the 1998 South African Demographic and Health Survey (SADHS) (Department of Health, 1998a).

Unsurprisingly, South African children have suboptimal mortality indices for a middle-income country. In comparison in 2000 Brazil and Mexico had infant mortality rates (IMRs) of 30 and 33 respectively, compared to 51 for South Africa (World Health Organisation, 2000). Both Brazil and Mexico have since further reduced their IMRs, whilst South Africa's remains unchanged (Every Death Counts Writing Group, 2008). South Africa's IMR also reflects significant inequities by classified race groups and geographies, and the margin of these inequities has remained steady across several decades. The inequity in mortality between black and white children was recorded in 1944 as "50 for white children and 'somewhere between 150 and 600' for black children" (National Health Services Commission, 1944). Currently the national IMR shows a 7-fold difference between white and black babies: 8 and 59 respectively (Department of Health, 1998a). Whilst the IMR for each group dropped significantly over time, the inequity gap remains. In the period preceding 1994, the national IMR showed an encouraging decline from 50 in 1986 to below 40 in 1991. However, from 1992 it steadily increased, with no sign of the rates levelling off, reportedly due to the rising HIV epidemic (see Figure 3) (Bradshaw & Nannan, 2006; Department of Health, 1998a; Bradshaw et al., 2003). The under-5 mortality rates show a similar picture. HIV and AIDS currently account for 40% of under-5 child deaths (Bradshaw et al., 2003; Grandin et al., 2005; South African Government, 2005). All sources of data concur that the remaining 60% of child deaths are due to factors such as low birth weight and diarrhoeal disease. These are mostly preventable and can be ascribed to upstream factors such as inadequate clean water, poor sanitation and malnutrition (see Figure 3) (ibid).

…/Figures 3 and 4

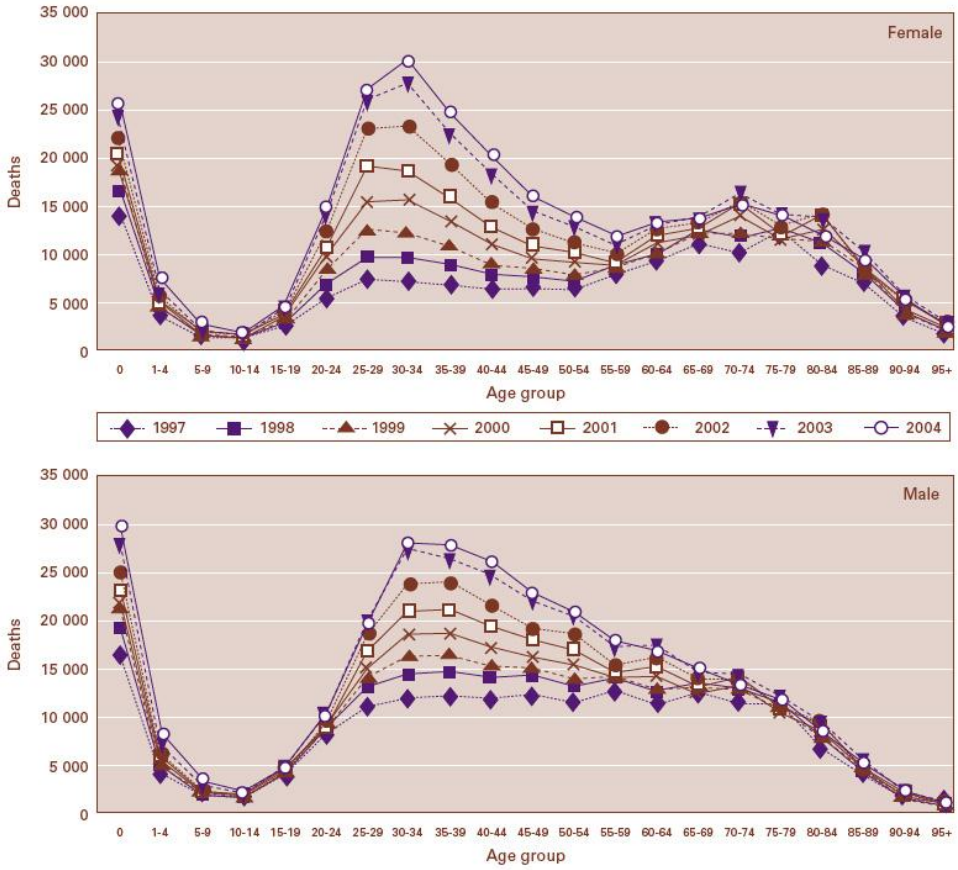


Figure 3: Trend in deaths from death notifications, 1997–2004

Source: Bradshaw and Nannan (2006) In: South African Health Review 2006

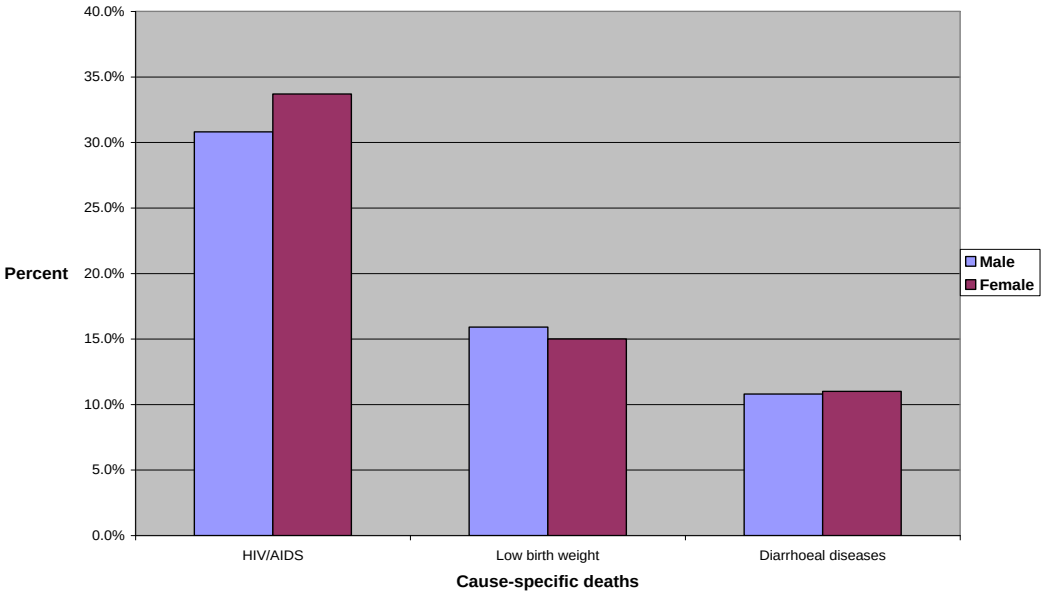


Figure 4: Top three cause-specific deaths of infants nationally for 2000

Source: Bradshaw and Nannan (2003)

The top three causes of death in the under-5 age group are similar to those for children under one, with trauma deaths increasing in the age groups one to four (see Figure 5).

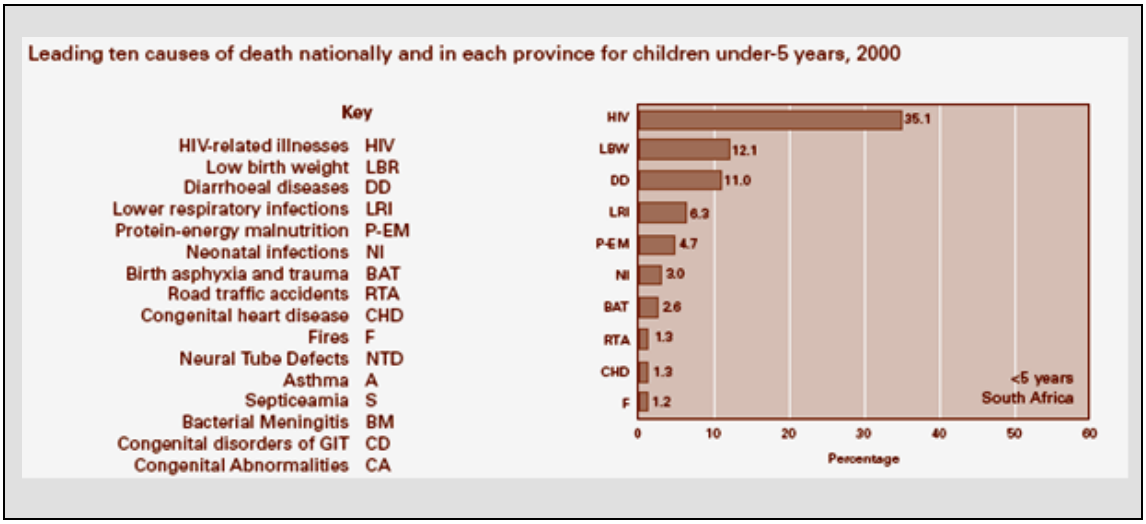


Figure 5: Leading causes of death for children under-5 years

Source: Bradshaw and Nannan (2006) In: South African Health Review 2006

Infant mortality rates display marked inter-provincial differences, ranging from 30 in the Western Cape to 61.2 in the Eastern Cape (Table 1), and reflect the inter-provincial socioeconomic differences. The provinces with the higher IMR are mostly rural, inherited the majority of the previous homeland territories[12], and have lower income levels with lower per capita expenditure on health. The Western Cape and Gauteng, with the lowest IMRs, are the two richest provinces and the Eastern Cape with the highest IMR is one of the poorest. Under-5 mortality rates in figure 6 show similar inter-provincial differences.

[12] In the last 25 years of apartheid, South Africa was divided into four provinces and ten homelands (or "self-governing" territories), to which a large proportion of black South Africans according to their tribal origins were forcibly moved (Price, 1986; Pillay and Bond, 1995). Homelands denied South African citizenship to the majority of black South Africans and further segregated the population. Though given "independence" by the apartheid regime, homelands were systematically underdeveloped and under-resourced.

Table 1: Infant mortality rates by province

Province	IMR
Eastern Cape	61.2
Free State	53.0
Gauteng	36.3
KwaZulu-Natal	52.1
Mpumalanga	47.3
Northern Cape	41.8
Northern Province	37.2
North West	42.0
Western Cape	30.0

Source: South African Demographic and Health Survey (1998)

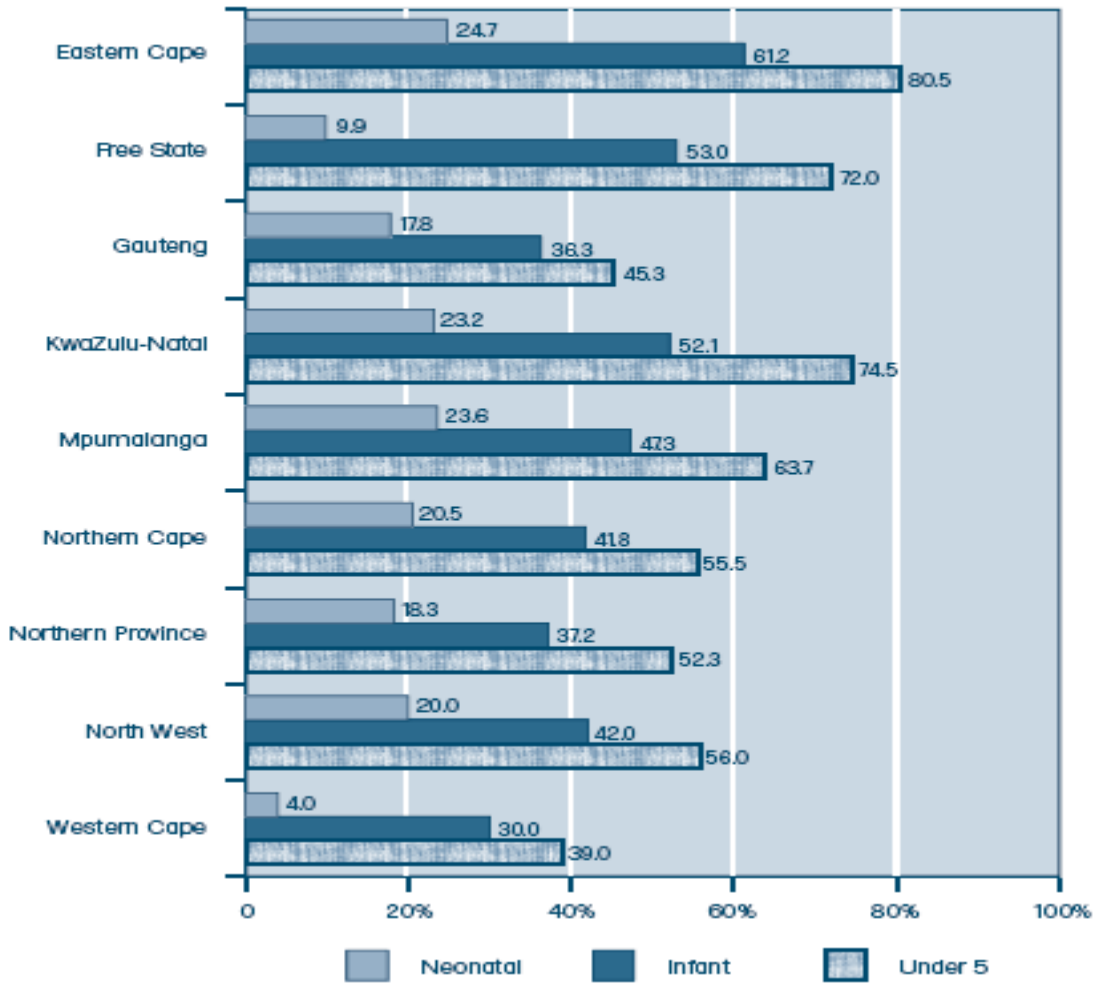


Figure 6: Child mortality rates by province

Source: South African Demographic and Health Survey (1998)

There are also marked intra-provincial differences, which are mainly linked to differential socioeconomic conditions in areas. The poorer areas are predominantly populated by black South Africans. In 2000, the city of Cape Town in the Western Cape had an overall IMR of 22.9. Khayelitsha, a poor peri-urban informal settlement ten kilometres beyond the city, had an IMR of 64.5, while white babies in wealthier suburbs had an IMR of 8 – similar to that of developed countries (Shung King et al., 2000). This eight-fold difference in IMR within a 10 kilometre radius typifies the national situation. The IMR is also higher in babies born to mothers with no formal education, in families with four or more children and in families where the birth interval between children is less than two years (Department of Health, 1998a). For the 5–19 year age group, deaths due to trauma and violence have increased in recent years. The main cause of death in younger children is motor vehicle accidents and in teenage boys the commonest cause of death is firearm injuries (Wigton, 1998). Child mortality data is not disaggregated by local area or socioeconomic groups and does not allow for the differentiation between varying degrees of poverty and deprivation. Some postulate that further disaggregated mortality data will show a proportionately greater increase in the poorest areas due to decreased resources, declining health access and the impact of the HIV epidemic (Burgard & Treiman, 2006).

Morbidity indicators for children are not routinely available, but they are reflected in the causes of death. Malnutrition, diarrhoeal disease, preventable infections such as HIV and TB, and trauma and violence in older children are the predominant health challenges (Hendricks et al., 2006; Meyers et al., 2006; Grandin et al., 2005; Labradarios et al., 2000). Little is known about other prevalent conditions such as acute respiratory infections, chronic health conditions and mental health. Studies have only recently emerged on the nature and extent of mental health problems in children affected by HIV (Cluver & Gardner, 2007).

Children's access to health care

Figure 7 presents a diagrammatic overview of the South African health care system within which child health services are located, showing the responsibilities of

the three levels of the health system: national, provincial and district, in which the district health system operates. The roles and responsibilities of these levels are legally determined and this is explained in greater detail in Chapter 6. Important here is that policies which shape health services are made at the national level, further interpreted and developed into implementation plans at a provincial level, and implemented through the district health system. All of these levels therefore have to come together to facilitate the primary function of a health system, namely the provision of health services.

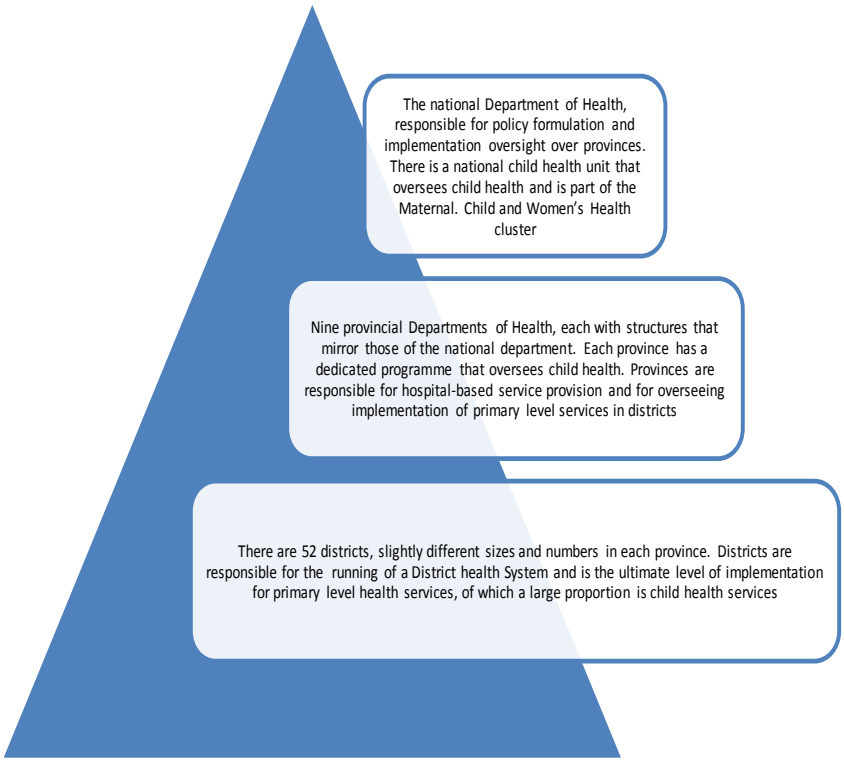


Figure 7: South African National Health System structure

Source: Generated by researcher

Health care provision, including that for children, occurs across three levels of care, as depicted in Table 2 (Zwarenstein & Barron, 1993). The primary level of health care, which addresses uncomplicated health problems, is located in facilities such as clinics, community health centres and small district hospitals. These primary

level services provide the predominant health services to poor and rural communities (ibid). For young children, the primary level is the most important level of health care.

Table 2: Structure of health care services for children pre- & post-1994

Level of care	Facility type	Managing authority	Staffing	Services provided
Primary	Clinics	Local authorities including such as municipalities and regional services councils	Clinics are staffed mainly by nurses, many who have additional training in primary health care	Preventative health programmes such as immunisation, family planning, and well-baby clinics where babies are assessed for developmental progress and nutritional status
	Stand-alone "vertical" programmes	National Department of Health		Delivery of vertical programmes such as school health services, mental health and orthopaedic care. These services were not part of clinic services
	Community health centres and outpatient departments of district hospitals. The former are more common in some provinces, whilst district hospitals predominate in others	Managed by provincial health authorities	Community health centres are staffed by nurses and general practitioners. District hospitals are staffed by general practitioners and nurses	Curative care for simple uncomplicated conditions that do not require hospital or specialist care. No preventative activities take place in these centres Curative care for uncomplicated conditions. Inpatient admissions occur for uncomplicated conditions and simple surgical procedures. In areas where health centres don't exist, district hospital outpatient departments provide curative primary level services
Secondary	General hospitals Mainly located in large towns and cities	Funded and managed by provincial health departments	Staffed by general specialists and nurses	Manage patients with more complicated conditions that require specialist care
Tertiary	Highly specialised hospitals or general hospitals with highly specialised sections) Most provinces have only one hospital that provides tertiary care	Funded by the National Department of Health, but managed by provincial health departments	Staffed by nurses and doctors with additional specialisations such as cardiac specialists	Manage patients with rare and/or highly complex conditions

Source: Generated by researcher

This is the level where all preventative health care interventions that are essential to development in the first five years of life are provided. The secondary level of hospital care is concentrated in large cities and towns and provides more advanced curative care. These hospitals were formerly racially segregated, providing a lesser

quality of care in black sections of hospitals (Wren, 1990; Price, 1998). There are ten tertiary level hospitals providing highly specialised care, which are concentrated in large cities, making access to this level of care difficult for rural communities (ibid). Health services at the different levels of care in the apartheid era were characterised by fragmentation and poor co-ordination between the various health authorities.[13] (Van Rensburg & Harrison, 1995; Pillay & Bond, 1995). Health service availability was also typically mal-distributed, with predominantly poor access and quality of care for poor and especially rural communities.

All health services, with the exception of preventative health care at clinics, required a user fee prior to 1994. Clinics charged a small fee for adult medication. Charges were also levied at community health centres and hospitals for the care of children. A number of changes to the structure, distribution and funding of health care occurred through post-apartheid health care reform. The implications of these policy changes for the health sector as a whole, and for children specifically, are described and analysed in Chapter 4.

National data on child health service provision and access is unavailable for the apartheid era and still is of poor quality. Immunisation coverage[14] is the only routinely collected health service coverage indicator for children. Nonetheless, immunisation coverage is a good proxy for coverage of other preventative primary level child health services, as many of these interventions, such as vitamin A supplementation (Department of Health, 2000a), developmental screening and antibiotic prophylaxis for HIV-positive babies, are linked to the immunisation schedule. It is therefore reasonable to assume that children will not receive these other interventions if they do not receive immunisations. The first-ever SADHS, conducted in 1998, showed a

[13] Regional services councils were local structures serving localities that were too small to have their own municipalities and/or municipalities that were too small to deliver services.

[14] Immunisation coverage is an indicator of the extent to which children receive all their scheduled vaccines through the Expanded Programme for Immunisation. Several vaccines are administered from the time children are 14 weeks of age up to five years of age. Immunisation is regarded as complete when all the scheduled doses of the different vaccines are received. Coverage can be calculated for individual vaccines, or for the entire schedule.

national immunisation coverage of 63% for all vaccines. Coverage was marginally higher in urban (67%) than in rural (60%) areas. Provincial immunisation coverage ranged from 50% in KwaZulu-Natal[15] to 81% in the Northern Cape (Figure 6). A comparative study of two provinces, Mpumalanga (one of the poorer provinces) and the Western Cape, showed measles immunisation coverage in 1994 of 79% and 95% respectively – with a national average of 85% (Uzicanin et al., 2002). These coverage rates reflect the inequity in child health service provision and the differences contribute to the inter- and intra-provincial differences in mortality rates.

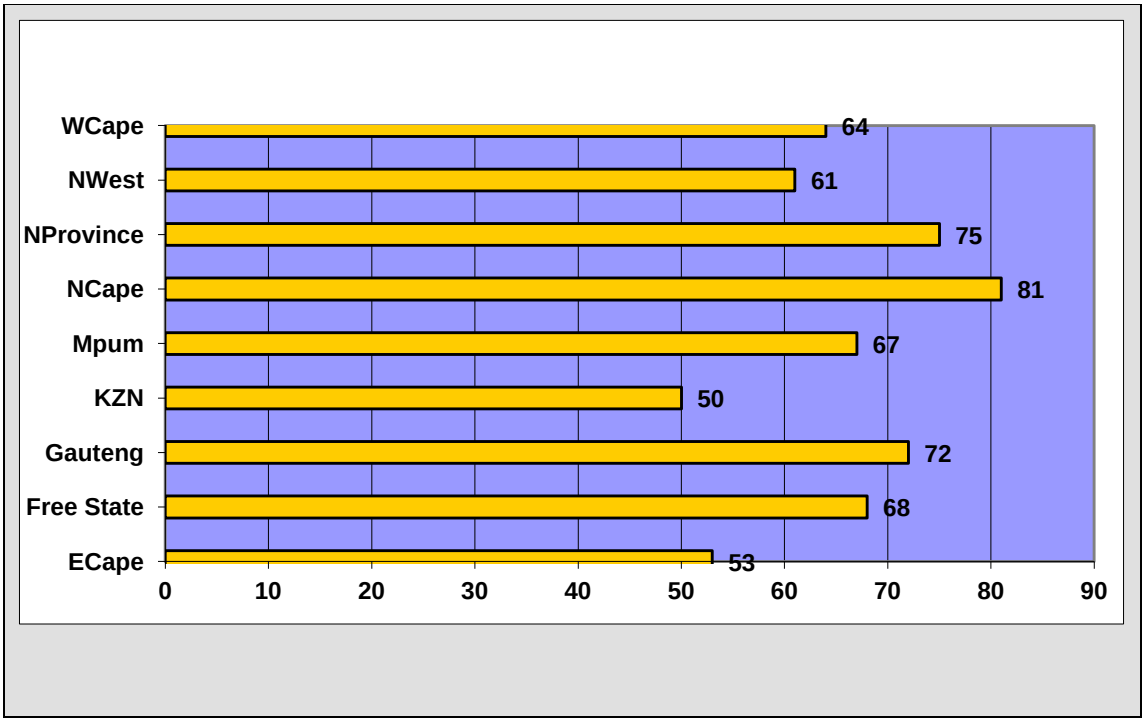


Figure 8: Immunisation coverage in provinces

Source: South African Demographic and Health Survey (1998)

Post-apartheid child health policy reform

A major change for children post-1994 was the explicit political priority granted to them in the new dispensation. The Constitution's Bill of Rights includes a special section (28) on socioeconomic rights. In section 28(1c) children are accorded the

[15] KwaZulu-Natal is the province with the highest number of children and the highest HIV prevalence.

"right to basic health care services" (Republic of South Africa, 1996, p13). In addition, they are accorded the right "to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health" through the United Nations Convention on the Rights of the Child (United Nations, 1989, article 24,1) to which South Africa is a signatory. All child health policies and interventions are meant to embody these child rights.

In the first hundred days of his presidency, Nelson Mandela launched two policies that set the stage for child health policy reform: the Free Health Care policy for children under six and pregnant mothers[16] and the Primary School Nutrition programme (Republic of South Africa, 1994a; 1994b). The first sought to improve access to health care services for young children and pregnant women previously excluded on the basis of their inability to pay, and the second sought to provide nutrition for school-going children who experienced hunger on a regular basis. An extensive clinic building programme accompanied the Free Health Care policy to expand health facilities in under-serviced areas. This policy was incrementally extended to: all citizens attending public sector primary level health care facilities, excluding hospital care in April 1996; and free hospital care for persons with moderate and severe disabilities in July 2003.

Currently only children older than six and adults with no or mild disabilities requiring hospital care have to pay for public sector health care. For these individuals, fees are calculated on an income-based sliding scale. Children who live with parents or caregivers who are either unemployed or in receipt of social assistance are exempt from paying hospital fees. The Free Health Care policy is further described and analysed in Chapter 4.

[16] The free health care policy for the children under six years of age applies to all public sector facilities, including hospitals, community health centres, clinics, state-aided hospitals that receive more than half of their expenditure in subsidies from the State, and district surgeons. The policy excludes members of medical aid schemes and non-South African citizens. Pregnant women (approximately one fifth being teenagers) are eligible for free health care up to 42 days after giving birth, and longer if pregnancy-related complications occur.

In response to policy and service gaps the Department of Health has since 1994 introduced several additional child health policies and programmes.[17] Programmes are more narrowly focused and generally address one specific aspect of child health and child health services. Examples of these programmes are vitamin A supplementation, specific nutrition interventions and the introduction of new vaccines. Policies, which are broader statements of intent, are aimed at shaping the structure and content of child health services on a broader scale. In addition to national policy goals, South Africa is also committed to the international Millennium Development Goals (MDGs) of 2000[18]. Goal 4, the one relating to child health, requires countries to reduce infant and under-5 mortality rates by two-thirds by 2015. In South Africa this means reducing the current rates from 45 to 15 for IMR and from 59 to 20 for under-5 mortality.

Of these new national policies, the National School Health Policy, aimed at providing preventative health care interventions and health promotion programmes for children in school, was one of the first to be initiated post-1994. This policy provides the case study for this thesis. Chapters 4 to 7 examine the development and implementation of this policy in detail. Analysis of all other child health policies' intentions, content and application is also undertaken in this thesis and detailed discussion is presented in Chapter 4.

The National School Health Policy

The School Health Policy (SHP) emphasises preventative health care and health promotion, and the School Health Service (SHS) is provided in schools, primarily by nurses (Department of Health, 2003a). Some components of the SHP include visual

[17] For purposes of this research a policy is defined as national guidelines that provide an overarching framework on how to structure and deliver various components of child health services. Several health conditions and interventions are covered in one policy.

Programmes are condensed expressions of policies and provide specific guidance on how to address a given condition, such as the transmission of HIV from mothers to babies, or the delivery of a specific intervention such as immunisation. Policies are therefore broader and provides guidelines for services to deal with a number of conditions and/or interventions

[18] Sourced at : http://www.un.org/millenniumgoals/bkgd.shtml

and hearing screening, dental and nutritional assessments, health promotion education and providing a referral conduit for children to other relevant health services. The policy currently focuses only on children who are in school and excludes school-aged children who are not attending school, which is an estimated 3.5% 0r 400 000 out of 11.6 million children (Children's Institute, 2010). Enrolment of children in Grade one is estimated at close to 100% (numbering about 1 million), with some attrition in later years (ibid). The SHS is provided from Grade 1 through to Grade 12, the last year of school. The screening and health care assessments for children mainly take place in the first year of school. Some schools have a reception year (Grade R) and these children are also covered by the SHS. Beyond Grade 1, the children mainly receive health promotion interventions.

The policy was officially launched by the Department of Health in 2003 for implementation by provinces. It was developed in response to concerns raised by provincial child health managers about the unacceptable state of school health services and the absence of national guidance on how to address this. There were a number of reasons for their concern:

- School health was one of the most fragmented and unequal child health services. During the apartheid era, school health services fell under different health departments. It functioned extremely well in white areas, had varying success in Indian and Coloured areas, and was implemented poorly, or not at all, for blacks, especially those who lived in the homelands.

- The health of school-going children took a back seat to that of younger children.

- Health problems at school-going age compromised children's ability to learn effectively.

Children in schools are a "captive group". Given the sharp decrease in attendance at health care facilities by children after the first two years of life, it is unlikely that non-urgent health problems, such as hearing and visual, problems would

be picked up prior to school entry. Screening children in year one of their schooling provides an opportunity to identify and correct such health problems early in their schooling.

During the early stages of the development of the school health policy in South Africa, a broader Health Promoting Schools (HPS) approach was launched internationally by UNICEF and adopted in South Africa. This initiative fell under the Health Promotion division of the Department of Health. The HPS initiative has four key components[19] (UNESCO, 2004), of which the provision of health services in schools is one. HPS concerns itself with the "whole" development of the school community of learners, parents, teachers and governing bodies, and surrounding communities. In 1996 and 1997 there was much debate in the National Department of Health on whether school health services required a separate policy or would be subsumed under a HPS policy (Abrahams & Wigton, 1997c). The final position was that school health services, as a discrete component of HPS, require a separate school health policy (SHP) to guide the delivery of health services in schools. The proviso was that the HPS policy as the "umbrella" policy would be developed first and guide policy development for its sub-components, including school health services.

[19] Source: UNESCO, 2004.

1. School health programmes should include actions to improve health education, health-related aspects of the environment, and health services. Health is promoted not only through instruction but also through the environment and health services.

2. Heads, teachers, students, parents, non-teaching staff and managers should be encouraged to work together to integrate and co-ordinate school health programme activities.

3. External support for school health programmes is important; however, the impetus for developing and maintaining a programme must come from within the school community.

4. School health programmes should be underpinned by a definition of health that incorporates mental, social and physical dimensions and is acceptable within local and national cultures.

Thesis Aim

Taking into account all the issues considered thus far, the following, in particular, helped to inform the aim of this thesis:

- Public policy development is a significant activity of government.
- A health reform process of the magnitude of the South African process merits rigorous examination of policy development.
- Among the factors to which the documented poor child health outcomes are ascribed, the specific role of child health policies had not yet been investigated as a potential contributory factor.
- As depicted in the ecological framework in Figure 1, policies are important instruments that shape child health services, which in turn contribute to the achievement of child health outcomes.
- The provision of good quality, equitable child health services was and still is an important health reform goal in South Africa. This merits the investigation of the role and contribution of child health policies in determining the structure, direction and functioning of child health services.
- In addition, the South African context of significant societal inequities calls for a more detailed focus on the role of child health policies in promoting equitable child health services.

The aim of this thesis is, accordingly, to assess the specific role and contribution of policies to the improvement of equity in child health service provision by examining the development and implementation of child health policy in South Africa.

This research focuses on two aspects: Firstly, an overview of child health policy transformation post-1994 by systematically reviewing key child health policies developed in this period. Secondly (and this is the more substantial part of the research) an in-depth analysis of the development and implementation of one key child health policy, namely, the National School Health policy, which the researcher

has adopted as a case study and lens through which to examine factors relating to child health policy more broadly. This choice was governed by several considerations:

- Time and resource constraints allowed for the in-depth examination of only one policy.
- Selecting one policy for an in-depth analysis allowed the exploration of various dimensions of overall child health policy. Among these are the integration of a previous vertical health programme into a comprehensive primary health care service; how a preventative health policy is prioritised in an environment with a growing curative health care load; how a new service for a previously neglected group of children – school-aged children in this instance – was perceived and developed; and whether the inequity in school health service provision had changed as a result of the policy.
- A detailed evaluation of this policy five years post-implementation is timely and necessary.

Research questions

The following specific research questions are addressed:

- Did child health policies address the key health challenges for children? This question looks at whether the policies that were developed, addressed the child health issues that national epidemiological studies identified as important child health priorities. This question also requires that the drivers of child health policies are explored to thus determine why these specific policies appeared on the national agenda.
- Did policies adequately consider equity dimensions in their design and implementation and thereby promote greater equity in child health service provision?

- Did policies promote the type of child health services that were envisaged in the overarching goals for the reform of South African health care, in particular the goals of the PHC approach?

  Based on some of these overarching reform goals, attention is given to universalism versus targeting, prevention versus cure, integration versus verticalisation and inter-sectoral collaboration. In addition, following recent analyses of the role of the federal system in South Africa (Development Bank of South Africa, 2008; Schneider & Barron, 2008; Harrison, 2009; van Niekerk, 2009), attention is also given to how child health policy reform and implementation was influenced by this system of governance.

- What were the key factors that influenced policy implementation and in particular how did context, process, actors and policy content contribute to implementation performance?

The researcher anticipates that this work will have utility for future child health policy reform, and will also contribute to the growing body of policy analysis literature from low- and middle-income countries. Systematic and rigorous analysis of child health policy will add to the growing body of literature on the South African transformation process, and to the literature on health sector reform in a developing country context in general. It also might assist in understanding the relationship between policy and equity in a developing country context more generally. Furthermore, child health policy development, along with the role of policy in addressing inequity, is a subject on which relatively little has been written in low- and middle-income countries, or indeed in developed countries such as the United States (Walt & Gilson, 2004; Gilson & Raphaely, 2008, Russ et al., 2010). This research will contribute towards filling this gap in the current policy literature. Understanding and documenting the development and implementation of child health policy against the original equity goals of the reform period is important, as it will contribute to an evidence-base to guide future policy development.

The analytic frameworks

This study is guided primarily by three policy analysis frameworks. The first of these is the *policy triangle* (See Figure 9) of Walt and Gilson, developed in 1994 (Walt & Gilson, 1994). The authors of the policy triangle see it as a particularly useful framework for the analysis of policy in developing country contexts. They propose four important components for consideration: *context*, *process*, *actors* and *content*. Their central tenet is that policy analyses tend to focus on technical content of policies, without considering the all-important political and socioeconomic context in which policies are developed, the important contributions and influences of the actors that participate in the policy development process, and the policy process itself.

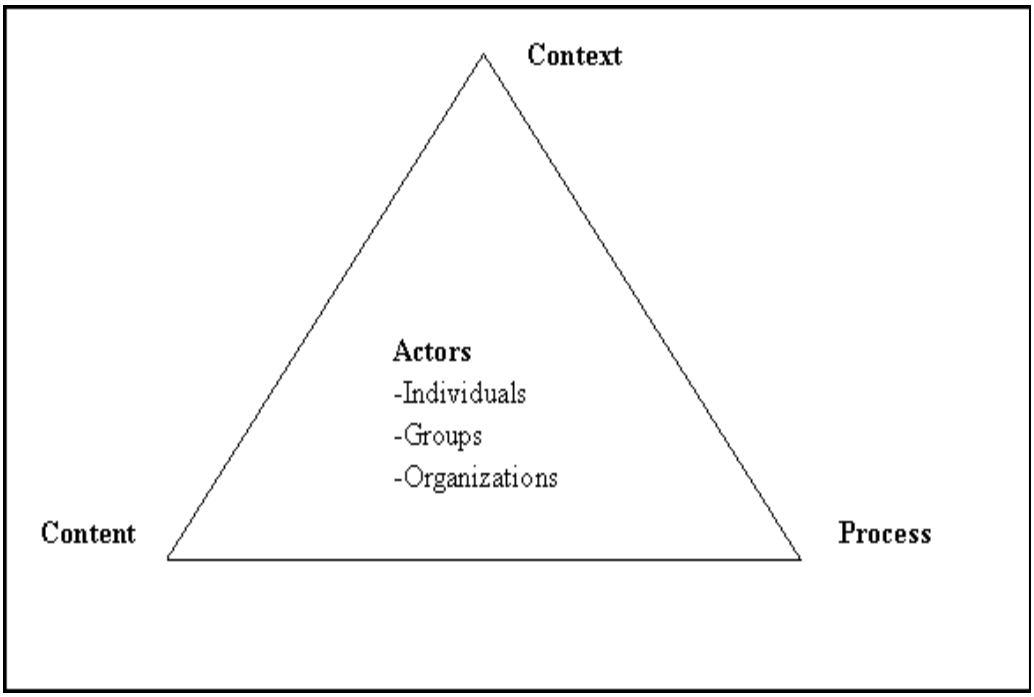


Figure 9: The Policy Triangle

Source: Walt and Gilson, 1994

The second analytical framework used here is the *stages* framework (Box 1), first proposed by Harold Lasswell in 1956, and adapted several times since. The stages framework identifies six distinct stages from the initiation to the final implementation and evaluation of policy. It thereby simplifies an otherwise very

complex and unwieldy process. Despite criticism of this approach (Kingdon, 2003; Hill & Hupe, 2006; Sabatier, 2007) that the policy process is seldom linear and that complex interactions occur within and between stages, the framework is still regarded as useful for prospective and retrospective policy analyses (Deleon, 2007; Jann & Wegrich, 2007; Dye, 2008).

- *Problem Identification.* The identification of policy problems through demands for government action.
- *Agenda Setting.* Focusing the attention of the mass media and public officials on specific public problems to decide what will be decided.
- *Policy Formulation.* The development of policy proposals by interest groups, White House staff, congressional committees, and think tanks.
- *Policy Legitimation.* The selection and enactment of policies through political actions by Congress, the president, and the courts.
- *Policy Implementation.* The implementation of policies through organized bureaucracies, public expenditures, and the activities of executive agencies.
- *Policy Evaluation.* The evaluation of policies by government agencies themselves, outside consultants, the press, and the public.

Box 1: The Stages or Process Model

Source: Understanding Public Policy. Dye, 2007

The third analytical framework used in this study is one developed for the WHO by Braveman (1998), which emphasises distinct considerations for the development of *equity-orientated* policies (Braveman, 1998). Braveman urges the need for policy makers to consider equity in the various stages of the policy process in order to address ultimate equity goals. She proposes eight steps in the policy process where equity must be considered. This policy analysis framework is fairly unique in its explicit attention to equity in the policy process.

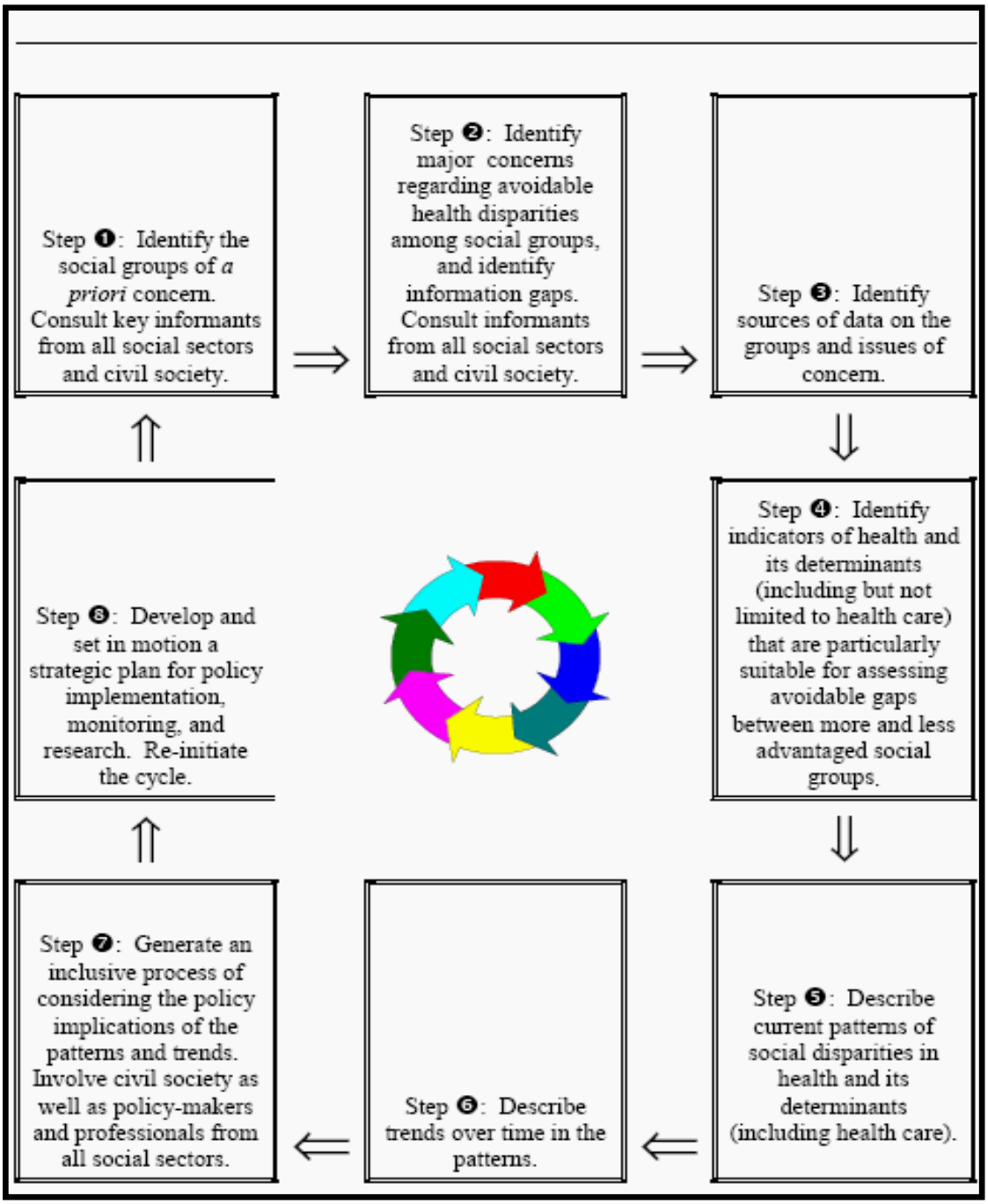


Figure 10: Eight steps in developing an equity-orientated policy

Source: Braveman (1998) WHO Division of Analysis, Research and Assessment.

The study utilises these three separate frameworks because no single policy analysis framework adequately addresses all the policy issues of interest, or sufficiently interrogates all the complexities of the policy process. Chapter 2 expands on this statement in detail. The policy triangle, by emphasising context, process,

actors and content, is a useful framework for policy analysis in developing countries in that it prompts the analyst to consider the complexity of context and wide range of actors that operate in developing countries. These factors are somewhat overlooked in other such analytical frameworks. The triangle also proposes analysis of the policy process, but without specifying how to interrogate this particular facet. This gap is neatly filled by the stages framework, which is useful for tracking key components of the policy process that merit inquiry. Lastly, the researcher specifically examines the contributions of child health policies in the development of equity-orientated child health services, where Braveman's is the only framework in the literature that specifically guides policy makers on how to consider equity in the policy process. The steps in the Braveman and the stages frameworks have many similarities and complement each other well. For example, the stages framework starts with problem identification, whilst steps one and two in the Braveman address the equity dimensions that require consideration during the problem identification phase of the policy process. Put together, these three frameworks provide a comprehensive approach for exploring all the dimensions of interest in this study.

Using these analytic frameworks as a guide, a retrospective policy analysis was employed to address the research questions. The application of the analytic frameworks, the detailed approach to data collection, the selection of research sites and participants, and the specific data collection instruments are described in Chapter 3 on Methodology.

Definition of key terms

This section defines the key concepts/terms as used in this research. These terms are explained in more detail in relevant chapters.

What policy means in this research

Policy is definable in many different ways, ranging from the broad to the specific. It may be described as "everything government chooses to do or not do" (Dye, 2007), or regarded as a set of principles and values intended to inform actions

(Walt, 1994). It may refer to public policy, essentially the domain of governments, or private policies, the domain of business and non-governmental organisations.

For the purposes of this research, the following definitions and characteristics of policy are used. Policy refers to public policy set by the South African government, in this instance through the Department of Health. It refers to the statements of intent by the Department of Health, as expressed in key national documents, developed by official bodies in the Department of Health. It includes documents that have been officially approved by the highest decision-making body in the Department of Health and that appear on the Department's Website as "the policy on . . . or for . . .". It also includes policy statements contained in documents that have not yet been officially endorsed as Department of Health policy, and reasons for this situation are explored in the research. The documents in question, as understood from Department of Health officials, set out the defining intentions of the Department of Health to guide the development and implementation of health services for children. Whereas government policy commonly consists of a plurality of documents and statements, the child health policies of the South African government consist in general of a single key national document, supplemented by provincial variations of the document, implementation guidelines, action plans and (where legal issues arise) regulations. In this thesis, a child health policy, for practical purposes, primarily refers to the single national officially accepted document that expresses the intention for the development and implementation of one or more aspect of child health services. This working definition does not extend to other forms that policy may take, such as oral instructions, implicit understandings or unwritten common beliefs. It includes the national implementation guidelines that accompany some of the policy documents.

Overarching policy documents

Overarching policy documents are policy documents that contain proposals for the reform of the broader health system reform process. These documents set the stage for overall health sector reform. They provide broad sets of guidelines and legal rules

for how the health system must be structured and function and which goals must be addressed through health system reform.

Micro-policy documents

Micro-policy documents are documents that refer to policies developed to address specific groups, diseases, sections of the health system and are meant to take their cue, conceptually and strategically, from the overarching policy documents.

What constitutes the policy process?

Many analysts separate policy development and design from policy implementation. Lasswell's framework identifies a series of steps that range from policy initiation and agenda setting, to policy development and design, to the final process of making policy legitimate state policy. Whilst analysts have contested the thinking behind Lasswell's framework and offered different policy analysis models, the framework is still regarded as a useful framework for analysis (further outlined in Chapter 2). Earlier policy analysts separate policy development from implementation. More commonly now, implementation is seen as an integral final step in the policy process, aside from evaluation, and implementation must be considered throughout the various stages of policy development.

This thesis regards policy as a continuum from policy initiation through to implementation, and examines implementation as an integral part of the policy process. It also includes the process of translating national policy into a commonly understood set of action plans at provincial, district and front-line level. The researcher refers to this part of the process as *policy translation*.

What is meant by child health service provision?

This research refers to school health service (SHS) provision in the sense of its being (a) one of several formally listed services that must be provided to children at large, and (b) a service that is meant to be specifically provided in every school and to children that fall within the parameters of the School Health Policy (SHP). The

research did not consider access, as this would have required visits to individual schools, as well as interviews with teachers, pupils and parents, and the researcher did not have the resources to extend the research to this level.

What is meant by equity?

Chapter 6 provides in-depth detail on equity in terms of definitions, concepts and application. The chapter explores the complexity of equity and how it manifests in the case of SHP implementation. There are very many dimensions of equity that one can examine. This research focuses solely on equity of service provision, meaning whether the SHS was available and delivered to all schools, regardless of the geographic location and socioeconomic circumstances of the districts in which the school was situated. "Equitable" as used in this thesis, means that the SHS was provided in "comparable" quantity and quality. Other measures of equity, such as equity of access or equity in budgetary allocation, etc., are not specifically considered.

What is meant by policy performance in this thesis?

Policy performance, as alluded to in the thesis title, ultimately refers to the health outcomes of children. However, many interim outputs occur along the pathway from policy to health outcomes. Establishing a causal link between policy and outcomes require a study of a scope and magnitude that was beyond the capacity of this research process. Therefore, within the scope of this thesis, "policy performance" refers to the intermediary measure of the provision of equitable child health services.

Outline of the thesis

This introductory chapter is followed by seven additional chapters.

Chapter 2 contains a synthesis of the literature on policy analysis frameworks. The literature addresses the theories of policy analysis and in particular the ones drawn upon by the researcher. It examines the pros and cons of the policy analysis frameworks used in this research and describes a range of alternative frameworks used in modern day policy analyses.

Chapter 3 sets out the detailed methodology used in this research.

Chapters 4 to 7 examine the empirical evidence on child health policy development and implementation yielded by the research. These chapters are complementary and at times might overlap, but each has a specific focus.

Chapter 4 focuses on the context, process and actors of child health policy development in South Africa.

Chapters 5 and 6 present the results from the evaluation of the National SHP implementation. Chapter 5 presents the part of the results that focus on implementation outputs of the SHS (the "what?" and "how?") – namely coverage, quality, and service integration. Chapter 6 focuses on the part of the results that offer explanations (the "why?") for the poor implementation performance of the SHP.

Chapter 7 focuses on whether and how child health policies addressed equity in child health service provision.

Chapter 8 draws together the key findings and conclusions from this research.

Chapter 2: Policy analysis and policy implementation theories and frameworks

Introduction

The aim of this thesis is to assess the specific role and contribution of child health policies in improving equity in child health service provision. A retrospective policy analysis was used. This method draws on the prevailing theories and concepts in the field of policy analysis, which is a recognized academic discipline of the policy sciences. As policy analysis is the dominant focus in the research, it is important to clarify the broader theoretical context for the three analytic frameworks which are used in this research and are outlined in Chapter 1.

This chapter provides an overview of the literature on the major policy analysis frameworks that are commonly used today. It specifically examines the concepts that underpin these policy analysis frameworks, the analytic approaches of each framework and their utility in the analysis of policy. The review spans theories that address all phases along the continuum of policy development, including theories on policy implementation. It also looks into whether there are any special considerations that impinge on health policy analysis in particular.

The articles and books for review were sourced from a search of electronic databases available on OLIS, in particular Medline and Pubmed, as well as Google Scholar and Google Books. Keywords used during the search included: policy analysis frameworks; policy analysis; policy models; policy and equity; policy and inequity; policy implementation and equity; policy implementation and inequity; equity orientated policy models; policy frameworks; and health equity

Analysis of public policy has been described as a concern with "what governments do, why they do it, and what difference it makes" (Dye, 2008, p1). Policy analysis for interrogating this action of government can be conducted prospectively or retrospectively (Buse et al.). Conducted retrospectively, as "analysis of policy" (ibid, p16), it helps in the understanding or clarification of a particular

policy; applied prospectively, as "analysis for policy", it can facilitate the planning or development of a new policy (ibid). Policy analysis draws from multiple disciplines for its concepts and methodologies and the ways in which it is conducted are therefore many and varied (Walt, 1994; Buse et al., 2007; Sabatier, 2007; Moran et al., 2008; Dye, 2008). A number of theoretical policy analysis frameworks that have an influence on current policy analysis discourses have been developed over the past six decades. Their contributions have facilitated understanding of the complex government process of policy making.

Overview of policy analysis frameworks

Lasswell's Stages Framework

One of the first policy analysis frameworks to be developed was the *stages* framework of Lasswell (1959), also commonly referred to now as the *process model* or *stages heuristic*. At the time, the role of the social sciences in policy making structures and society was still undeveloped and in response to this gap the discipline of policy analysis was established (ibid). Lasswell (1970, p3) described the field of policy sciences as "knowledge of the policy process and of the relevance of knowledge in the process". The former refers to the decision-making process when policy is made, and the latter refers to the knowledge, or "evidence", that helps to inform policy decisions (Brewer, 1974). These definitions of policy analysis imply that policy analysis frameworks should facilitate understanding of how and why policy decisions are made. At the same time, policy analysts must contemplate the kinds of information that inform policy decisions and also the kind of information that is required to interrogate the policy process.

The original stages framework proposed a set of seven distinct stages, and provided the first structured approach for interrogating the complex world of policy making (Lasswell, 1956; Jann & Wegrich, 2007). The utility of this model was that it broke down a very complex government process into discrete, discernible steps or stages. Each stage addresses a distinct part of the policy process, with a particular

focus of enquiry. This allows for a detailed analysis of each part of the policy process, and minimises the possibility of glossing over important parts of the process.

The first stage involves identification of the policy issue of concern. This is followed by six other stages, the last two concerning implementation and evaluation of the policy. The seven stages are: intelligence, promotion, prescription, invocation, application, termination and appraisal (Lasswell, 1956). Whilst the stages are presented as sequential and discrete, a later discussion of this framework emphasises "interdependence among the functional components of a policy process" (Lasswell, 1970, p9).

Though ground-breaking, the framework nevertheless met with intense scrutiny and criticism. The stages framework was subject to more analysis and critique than any other subsequent policy analysis model. Indeed, debates about the past and present utility of the stages framework span a period of almost fifty years (Lindblom, 1959; Brewer, 1974; Kingdon, 1984; Deleon, 1999; Jann & Wegrich, 2007; Sabatier, 2007; Torgerson, 2007). Debates on the stages framework still feature significantly in current policy analysis circles (Jann & Wegrich, 2007; Sabatier, 2007; Torgerson, 2007) and a diversity of discourses have developed in response to the original concept, with various proponents arguing for ways to improve and refine the model (Brewer, 1974; May & Wildavsky, 1978; Brewer & deLeon, 1983; Dye, 2007). Strong critics, who found the framework too simplistic and of limited utility, examined alternative frameworks to aid in the understanding and analysis of policy processes (Lindblom, 1959; Kingdon, 2003; Sabatier, 2007). Some policy analysts are critical of the fundamental characteristics of the stages framework but do not entirely refute the utility of the model (Walt, 1994; Walt and Gilson, 1994; Hill & Hupe, 2006; Buse et al., 2007: deLeon, 2007; Jann & Wegrich, 2007; Ostrom, 2007). Some of these analysts address elements of the stages framework in their alternate policy analysis frameworks (Walt & Gilson, 1994; Hill & Hupe, 2006; Ostrom, 2007). Examples of this appear later in the chapter.

Modifications to the original Stages Framework

There have been a number of subsequent modifications of the stages framework. Proponents reduced the number of stages, renamed some of them, and altered their sequence, but without introducing significant conceptual alterations to the intentions and utility of each stage or to the framework as a whole, as shown in Table 3 (Brewer 1974, deLeon, 2007; Dye, 2007).

Table 3: Modifications to the stages framework

Lasswell's original stages	**Brewer, 1974**	**Current use of stages Dye, 2007**
Intelligence	Invention or Initiation	Problem identification
Promotion	Estimation	Agenda setting
Prescription	Selection	Policy Formulation
Invocation		Policy Legitimation
Application	Implementation	Implementation
Termination	Evaluation	Evaluation
Appraisal	Termination	

Source: Generated by researcher, 2012

The terminology of some of the original stages makes it difficult to infer what that particular stage addresses ("invocation", for example). It uses a combination of legal and political science terms academically current in the 1950s but now less familiar. The renamed stages are more self-explanatory, even though the basic premise of each stage does not fundamentally depart from the analytical and conceptual intentions of the original stages. The enduring application of Lasswell's framework in policy analysis is ascribed to its prescriptive and normative approach, as the linear sequence of the stages closely resembles that of a problem-solving model. The synchrony of this approach, with that of other rational models of planning and decision-making, has wide appeal for those involved in decision-making processes (Jann & Wegrich, 2007; Torgerson, 2007).

A more fundamental change occurred with the re-conceptualisation of the stages framework as a *cycle*, rather than a linear set of steps (May & Wildavsky, 1978).

Many different versions of the policy cycle exist, of which one is depicted in Figure 11.

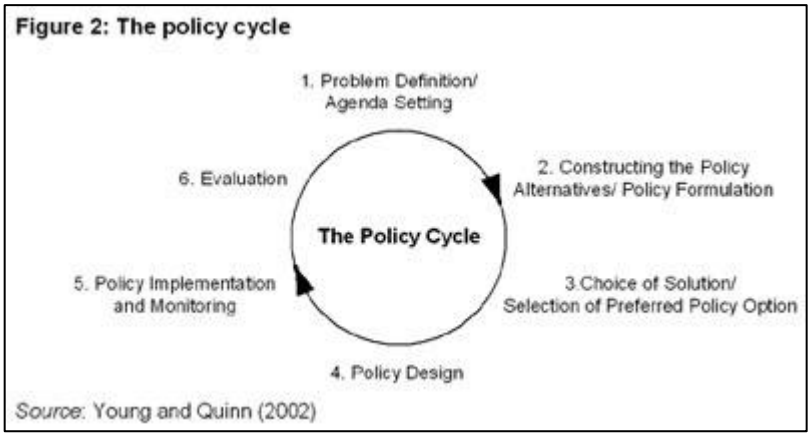


Figure 11: The Policy Cycle

The policy cycle approach positions the policy process as iterative, where the process is repeated at different time junctures rather than having a single clear beginning and end. However, it still depicts the policy process as a discrete set of stages that sequentially follow one another. The policy cycle notion suggests that later versions of policies are fundamentally shaped by preceding policies, as suggested by the theory of path dependency (Pierson, 2000), which can be defined in various different ways. Nonetheless, the basic postulate is that policy makers are unlikely to significantly change policies that are already in place, due to the costs and difficulties of reversing existing policies. Policies, rather than having a 'termination date', simply continue and at best are subject to incremental changes.

As shown in Table 3, later versions of the stages framework eliminated the stage of 'termination', which featured consistently in early versions. This stage receives little attention in policy discourses, as this is not always the logical outcome of policies that perform poorly (Geva-May, 2004). Policy persistence, despite the outcomes from evaluations, can be ascribed to "an organizational tendency to persistence, stability, and equilibrium" (Geva-May, 2004, p330). This partly explains why ineffective policies remain, because politicians and policy makers find it easier to maintain the status quo.

Critique of the Stages Framework

Critics of the stages framework, starting with Lindblom (1959), disagree with several of the premises that underpin the framework. This led to the development of a number of alternate theories and frameworks for understanding and analysing the policy process. The main criticism of the stages framework is that it is too simplistic and bound by its linearity, which contrasts with the real world in which policy is complex and messy. Policy stages often overlap. Later stages sometimes precede earlier ones, or might even occur in parallel (Lindblom, 1959; Kingdon, 2003; Sabatier, 2007). The events and actors in one stage of the process influence and affect those in other stages.

The stages framework is regarded by some as hierarchical, promoting a top-down approach to the policy process. Its linear nature ignores, for example, the influence of implementation context on problem identification or agenda setting. The second criticism is that it tempts policy researchers to focus on only one stage of the process, resulting in the examination of that stage in isolation and without the benefit of the entire policy context. This is especially pertinent when separating the policy formulation stages from implementation, as in real life the latter is influenced substantially by the former (Hill & Hupe, 2002; Gilson et al., 2003; Gilson et al., 2006; Fischer et al., 2007; Dye, 2007; Sabatier, 2007). A third criticism, levelled in particular by Sabatier (2007, p7) is that the stages framework is unable, no matter how it is applied, to examine causality in the policy process (Sabatier, 2007; Jann & Wegrich, 2007). Sabatier (p7) asserts that the stages process "never identifies a set of causal drivers that govern the policy process within and across stages".

Some of these criticisms aptly reflect the structural weaknesses of the stages framework, such as the hierarchical nature of the stages and their linearity. Others, such as criticism about research on individual stages only, are less justified. The selection of single stages for research and analysis, at the expense of the policy process as a whole, reflects the interpretation and application of the framework by analysts and researchers. This is not a problem inherent to the framework. In fact, Lasswell (1970) placed great emphasis on adequately understanding and taking into

account context, and also the multiplicity of actors that operate in policy processes. The intention of the original framework was less about depicting the stages as linear and mutually exclusive, and more about breaking down the complex policy process into manageable sub-processes. Given the complexity of policy processes, the identification of a clear set of causal drivers towards a set of clear outcomes would at best be a difficult task.

Despite the criticisms levelled against it, the stages framework is still frequently used in policy analysis across a variety of sectors, including the health sector, and in different country contexts (Buse et al., 2007; DeLeon, 2007; Jann & Wegrich, 2007; Torgerson, 2007; Walt et al., 2008). Perhaps it is precisely its 'simplicity' and its systematic, stepwise approach that holds appeal for researchers and policy analysts in a process that is otherwise overwhelming.

Alternate policy analysis frameworks

Since the introduction of the stages framework, the policy analysis field has grown considerably. Policy analysts brought modified and new perspectives to bear on public policy making that partly or wholly refuted the stages approach. Some of the new frameworks emphasise aspects of the policy process that they felt were not adequately addressed in the stages framework, such as the frameworks that focus on the roles of policy actors. Others adopt a completely different perspective towards policy making, such as focusing on the idea of multiple streams in the policy process, and provide alternate conceptual models for thinking about and analysing policy processes. Some of the most commonly used alternative frameworks are discussed next.

The 'root' and 'branch' approach: Rational choice vs Incrementalism

In his classical article, "The Science of muddling through", Lindblom (1959) challenges the depiction in the stages framework of the policy process as organised and methodical, and insists instead that it is messy and complex. To create sense out of this messy policy environment, two disparate policy decision models emerge that

explain alternate ways in which politicians make policy decisions. The two decision models are metaphorically juxtaposed as the 'root' and the 'branch' approaches. The 'root' approach, similar to zero-based budgeting[20], clearly identifies a set of policy objectives and a set of ends or desired outcomes. This is the first formulation of *rational choice* theory in policy making (Lindblom, 1959; Dye, 2007). Here, policy formulation involves the identification and selection of the most suitable means to achieve an end and facilitates clearer linkages between policy objectives and desired outcomes. Each policy process starts afresh and requires a detailed evaluation of all potential policy choices. The criticisms of the root approach are that it is seldom used because of the intensity of the process. As it is logistically impossible to explore a large number of potential policy options, policy makers are limited to a few choices only. Whilst it is put forward as a potential model for exploring causality in the policy process, the shortcoming is that the proposer of this approach gives no indication of how to deal with the many potential confounding variables in the pathway of "causality". This casts doubt on the idea of a policy being an independent variable in its own right, since a multiplicity of other factors influence whether the ultimate policy goals are achieved. This resonates with the concept of the multiple determinants of child health (Sanders & Werner, 1997; Chopra & Sanders, 2004), where policy is but one of several instruments in the pathway towards improved child health outcomes.

The 'branch' approach directly contrasts with the rational choice theory or 'root' approach (Lindblom, 1957). It describes policy development as the making of small, incremental policy changes at best, as policy makers and administrators are generally more comfortable with this approach. It characterises politicians as inherently conservative, accepting of the legitimacy of established programs and tacitly agreeing to continue existing policies (Dye, 2007). This also ties in with the

[20] Zero-based budgeting implies the drawing up of a brand new budget each year, based on needs and requirements rather than on what the budget was the year before. Incremental or historical budgeting simply adds or subtracts a small percentage to what the budget was the year before.

theory of path dependency described earlier. In the 'branch approach', policy objectives, policy choices and intended outcomes are seen as intertwined and not neatly differentiated into stages, resulting in the conclusion that "making policy at best is a very rough process" (Lindblom, p86) and, at best involves a "muddling through" (Lindblom, p86). In subsequent discourses on policy complexity, it is clear that these assertions still hold sway. The 'branch' approach describes what is known today as *incrementalism*.

Incrementalism is now accepted as a viable and commonly-applied strategy in policy-making (Kingdon, 2003, pp79–83; True et al., 2007, p164; Dye, 2008, p18). It is also applied commonly to economic policy, where the common approach is that small changes are applied to budgets each year and, rather than start from scratch with a zero-based budget, a percentage increase or decrease based on variables such as inflation determine the subsequent budgets (Dye, 2008). Succinctly put by Dye (p20), "it is easier for a government of a pluralist society to continue existing programs rather than to engage in overall planning toward specific societal goals".

The Multiple Streams Framework

The *multiple streams* framework also contests the notion that policy processes are organized in a clear and 'zero-based' manner that starts with one stage and ends with another. This framework postulates that in society several streams, such as politics, problem and policy streams, operate independently and with little influence on one another, until a political window of opportunity arises that causes the streams to interact towards the furtherance of a particular policy agenda and common policy purpose. (Kingdon, 1984; Kingdon, 2003). Whilst each stream has an independent set of activities, these may overlap and engage with activities in other streams. The utility of this framework is that it helps in the understanding of how politics and policy agendas influence these streams. It further aids in understanding what processes and circumstances drive otherwise independent structures to converge and work towards a common purpose. The original multiple streams theory was derived from a case study

of a health policy process but has since been applied in the study of policy processes across many other government sectors.

This framework aptly describes a recent policy process in South Africa in the field of safety and security – that of the revision of the Firearms Control Act (Shung-King & Proudlock, 2002; Kirsten, 2004; Shung-King, Proudlock & Michelson, 2009). In this process several independent 'streams' came together in response to a political call for tighter firearms control. It included the political stream of the Parliamentary Portfolio Committee on Safety and Security, a large non-governmental anti-firearm lobby, academic institutions that brought forth new research on the harmful effects of firearms on the health and well-being of children and adults, and the Department of Safety and Security that drafted the policy. The result was the successful promulgation of new and tighter firearm legislation, with each stream receding to its own business following the release of the new law. The challenge is for individual streams, as was the case for the academic research stream in the Firearms Control Act process, to anticipate these windows of opportunity and engage in the policy processes that these opportunities provide.

The Punctuated Equilibrium theory

The *punctuated equilibrium* theory of Baumgartner and Jones (2007) proposes that policy mostly proceeds along steadily, with small period incremental changes. Then, when a window of opportunity arises, an existing policy might be altered drastically or a completely new policy introduced. It seems to combine the incrementalism and the multiple streams theories by seeking to understand both stability and drastic change in political and policy processes. It seeks to understand what maintains equilibrium and what brings about these 'bursts' of change. An interesting observation in this theory is that in periods of stability, policy tends to be subsumed within policy subsystems, such as within the health sector for example. Policy subsystems (Sabatier 2007) refer to specific sectors, such as health or education, or circumscribed geographical areas such as states or provinces. However, in periods of disequilibrium, policy issues tend to be forced onto the macro-political

agenda. As also espoused by the multiple streams theory, it is primarily major changes at macro-political level that create the environment in which significant policy change can occur.

This theory is useful to study periods of significant political transformation, such as occurred in South Africa in 1994. By the definition of punctuated equilibrium, the entire South African reform process can be characterised as a massive "punctuation" in the "equilibrium" of apartheid. This theory certainly applies to health reform in South Africa, where major health reform coincided with significant political changes – the promulgation of free health care within the first 100 days of the new Government of National Unity being a prime example of punctuated equilibrium (Republic of South Africa, 1994b; Wilkinson et al, 1997; McCoy, 1996; Leatt et al, 2006).

Analysis of policy actors through theories and frameworks

Whilst the earlier frameworks and theories in this chapter focus mainly on the policy processes themselves, a cluster of theories (Lipsky, 1980; Walt & Gilson, 1994; Kingdon, 2003; Sabatier, 2007; Dye, 2007) argue for the importance of examining and understanding the roles and influences of policy actors in the policy process. Actors hold multiple roles and positions in the policy process: as drivers of policy, as decision-makers about policy, as participants in various stages of the policy processes (as implementers of policy, for example), as recipients of policy, or as champions of policy. Regardless of their role, actors hold a certain measure of power and exercise it in different ways (Walt, 1994; Erasmus & Gilson, 2008). They are also subject to the emotive aspects that come with the policy territory. For example, the 'passion' of actors who hold positions of power – for or against a policy – can significantly influence policy choices (Gottweis, 2007).

In public policy processes, policy has traditionally been considered the domain of the 'policy elite', meaning those who operate in the upper echelons of government structures (Dye, 2007). Notwithstanding this, the importance of actors at the implementation end of the policy process has increasingly received attention (Lipsky,

1980). Examples are presented here of frameworks that take both a top-down and a bottom-up perspective on actors.

The *advocacy coalition* framework (Sabatier and Weible, 2007) was developed in search of a policy theory that could provide a more nuanced analysis of the policy process than the stages framework did. The central argument of this framework is that the real policy action happens not in stages but in policy subsystems. Policy subsystems are therefore better units of policy analysis. Policy subsystems are regarded as units within which specialisation occurs in response to the vastness and complexity of the policy issues in modern societies. Specialisation is reported to occur along functional lines, such as in health or education, or along territorial lines, such as a particular state in the country. These policy subsystems are populated by a range of individuals, across different levels in government and also outside government. These individuals are drawn together into coalitions through a set of common beliefs, where they exercise their beliefs and power to influence the development, interpretation and application of policy. Subsystems are fluid and change according to circumstances and issues, and so do the advocacy coalitions that individuals form part of. The three key tenets of this framework are (Sabatier & Weible, pp191–2): that most policy making occurs among specialists within a policy subsystem, but that these subsystems are subject to broader political and socio-economic influences; that individuals within subsystems hugely influence actions and decisions; and that the best way to deal with the multiplicity of actors in a subsystem is to draw them into advocacy coalitions. Contrary to what may appear, the theory does not assume the presence of subsystems, but rather sets out to identify whether they exist, in what forms, how they are populated, and how individuals exercise themselves within these contexts. Whereas the multiple streams theory examines collective actions across large policy streams within society, this theory examines collective actions within smaller subunits within policy processes. Sabatier (2007), who fiercely criticises the stages framework for its inability to determine causality, proposes that this is possible through analysis of these advocacy coalitions and the subsystems in which they operate.

A second theory that focuses on the role of individuals, but approaches it from the bottom of the policy process, is that of *street-level bureaucracy* (Lipsky, 1980). This theory is unique in that it focuses exclusively on the role of front-line service providers who are usually located at the end of the policy process, namely at implementation level. The premise of street-level bureaucracy is that the implementers are actually the most powerful links in the policy chain. They make government policy come alive, as they are directly in touch with the recipients of these policies. In many respects, they ultimately determine the success or failure of policy. Frontline service providers, contrary to what is expected, do not necessarily follow the prescriptions of policy task masters and managers. Instead, they lend their own interpretation to what policies mean and how they should be executed. Within the confines of their work environments, frontline workers find ways of facilitating or sometimes obstructing policy, but mostly bend policies in ways that help them cope with the stress and frustrations of their positions. The most interesting assertion of this theory is not so much that individuals exercise their own brand of power in the policy process, but more importantly that the actions of individual frontline workers become government policy.

This is one of the few policy theories that feature in South African health policy analysis literature. These South African studies used the theory of street-level bureaucracy to explore the impact of health policies on front-line workers and how frontline workers in turn engaged with the policy in their work environments (Walker & Gilson, 2004; Gilson et al., 2006; Erasmus & Gilson, 2008). This theory was used in analysing nurses' experiences with the Free Health Care policy, implemented in South Africa in 1994 (Walker & Gilson, 2004). Nurses indicated their frustrations with lack of consultation and information-sharing about this policy with frontline workers, as they only encountered the policy on the day it was announced in the media. They also bemoaned the lack of consideration of the extra workload that came about as a result of the policy, and the inadequate attention to the additional resource requirements. Researchers explored how nurses' personal feelings about the policy

influenced their service provision practices. Whilst nurses indicated their support for the policy, they nonetheless described themselves as "bitter, but satisfied" (Walker & Gilson, p1254). Here nurses agreed to put their personal dissatisfactions aside for the greater good of serving the public. An alternative stance might have been that nurses could have used their power by refusing to see clients or deliberately controlling the number of clients they could serve. In a second policy analysis experience, the policy required nurses from two different health authorities to merge and work under a single health service provider. Dissatisfaction with the remuneration implications and terms of the merger caused nurses, even those who were not directly affected by the policy, to register their discontent by refusing to adhere to the policy terms. The policy had to be abandoned as a result, demonstrating the power of street-level bureaucrats (Gilson et al., 2006).

Interrogating governance through policy analysis frameworks

The preceding theories all highlight the importance of "context", and none is more important than understanding the public institutional contexts in which policy making occurs. The *institutional analysis and development* (IAD) framework is ground-breaking in addressing this dimension of policy analysis (Ostrom, 2007). The IAD framework proposes three layers of governance and allows for the exploration of the roles and functions of each layer, how they inter-relate, and how individual layers and their inter-relationships influence policy making. Similar to the advocacy coalition framework, it also explores the presence and functioning of action arenas within each governance layer.

In the IAD framework a distinction is made between 'rules-in-use' and 'rules-in-form'. The latter refer to the written rules, while the former refer to those "dos and don'ts that one learns on the ground that may not exist in any written document" (Ostrom, 2007, p23). Three levels exist: the *constitutional level*, which is the highest level where rules are made; the *collective choice level*, where rules are turned into further policy decisions and action plans, and the *operation level*, where the rules and action plans are executed.

Hill and Hupe (2006) further modified these levels to more accurately reflect the functions of each level. They renamed each level and expanded on the roles and functions for each level. They also make reference to a useful simplification of three levels within the policy process which they call *nested games*. As they describe this, there is "the 'high game' in which it is decided whether or not a policy will be made. Then in the 'middle game' the direction of the policy is determined. The 'low game' is about the practical side of the policy making and implementation is central here" (Hill & Hupe, 2006, pp559–560). They offer the following modification to the IAD framework: the first level is renamed *constitutive governance*, which concerns both the content of policy and also the organizational arrangements for its delivery; the next level is called *directive governance*, which concerns the development of a set of collectively desired outcomes and facilitating the conditions in which to achieve these outcomes; and the final level is *operational governance*, where plans become reality. Despite the different terminologies in each of the three frameworks, there is common agreement on the three levels of governance. An important caution across all three approaches to institutional analysis is that the three levels are not uni-directional and insular, but multi-directional and inter-related actions that take place between and within the levels. The original framework of Ostrom is still most commonly referred to in the literature.

A policy analysis framework more suited to developing countries

The problem with the policy frameworks dealt with so far is their bias towards stable and established Western democracies. Most of the leading policy analysis theorists are either American or West European. The case studies that these frameworks are derived from invariably come from North American or West European examples. For example, the theories that underpin the institutional analysis and development framework are based on well-established stable institutional structures of the American federal system and European governments (Ostrom, 2007). The case is different in many developing countries, where changes are frequent in political regimes, political persuasions and institutional structures. In South Africa, for

example, health institutions are either newly established, have repeatedly undergone significant alteration in the past two decades, or are in the process of being altered again (Schneider & Barron, 2008; Naledi et al., 2011). The utility of some frameworks, such as multiple streams theory, although derived from North American case studies, has shown to extend to other developing contexts such as South Africa, but in general a gap has existed for the development of a policy analysis framework that is more sensitive to the political institutional challenges of middle- and low-income countries, with contexts that are likely to be different to those of Western democracies.

The *policy triangle* (Walt & Gilson, 1994) provides such a framework, where emphasis is placed on the dimensions of the policy process that present particular challenges in health policy analysis and in particular in developing country contexts. In the policy triangle framework (Figure 9), the policy analyst is alerted to consider the all-important issues of context, process, and content as three points of a triangle, with actors occupying the centre of the triangle. The importance of context and actors is not unique to the policy triangle but features also in earlier policy analysis frameworks. Early policy analysts already saw the necessity to "operate with the explicit conception of the entire policy process and the whole social process" (Lasswell, 1970, p6). When put together with content and process, the policy triangle provides a comprehensive approach in a single framework.

The rationale behind the inclusion of the other three dimensions in the triangle is the skewed emphasis, in health policy in particular, on policy content, prior to the development of the triangle. This happened because it was technical experts who tended to dominate in health policy analysis and they consequently tended to focus on the technical content of policies (Walt & Gilson, 1994). Context is particularly important in developing-country policy analysis, because developing-country political regimes change more often, with more rapid alteration of the context in which policies are developed (Walt & Gilson, 1994). Walt and Gilson place great emphasis on understanding the national and international context, with particular reference in the

developing country context to health policy reform (Walt & Gilson, 1994). They point out the pivotal influence of context on the kinds of policies that are developed and the manner in which policies are developed. Their premise is that contexts in developing countries change far more frequently than in their western counterparts and simply cannot be ignored when studying policy processes in such countries. In addition, in-depth analysis of policy process in developing countries is said to be overlooked, partly due to the difficulties of identifying and studying such processes when governments are not always stable. The placement of actors in the centre of the triangle emphasises their importance on the policy process. This is especially so for health policy in developing countries, as the range and number of actors is large, especially when considering the influence and strong presence of multiple international agencies in such countries (Walt & Gilson, 1984). Given the relative paucity of policy analysis in developing countries, a simple framework such as the triangle provides might inspire increased output of policy analysis.

The utility of the policy triangle as a framework for health policy analysis in low- and middle-income countries has indeed been demonstrated in a review conducted 14 years after its first introduction (Gilson & Raphaely, 2008). The review included 164 policy analyses from low- and middle-income countries over a 13-year period. Among the policy analyses where a clear theoretical framework was used, the most commonly employed overarching framework was the policy triangle. This gives added endorsement to the policy triangle intent, which is to provide a simple, more relevant framework for these contexts.

A surprising gap in the policy triangle, however, is the absence of a more explicit consideration of equity, given that it was developed particularly with developing countries in mind, and for health policy specifically, where equity is a key concern (Braveman, 1998; Vitora et al., 2003; Petticrew et al., 2004; Wilkinson & Pickett, 2009; Gilson et al., 2006; Graham, 2007; Nkonki et al., 2011). Although equity might be an implied consideration in any of the four dimensions of the triangle, unless it is made explicit there is no guarantee that policy analysts will consider it.

The application of equity in policy analysis frameworks

As indicated in the previous section, equity is a key concern, in the health sector and in developing countries in particular. One of the intentions of this chapter was to find, from the literature, policy analysis theories or frameworks that guide aspirant policy analysts on how to deal with equity in policy analysis. Disappointingly, this aspect of the review yielded little fruit.

Despite the promise of the policy triangle (Walt & Gilson, 1994) as a viable framework for policy analysis in developing countries, it does not explicitly address equity in the triangle framework. Similarly, in all the other frameworks examined in this review, the matter of equity or equality receives little more than a cursory mention. This might be a consequence, as already indicated, of the predominant orientation of these frameworks to Western democracies, where inequity is less of a consideration. In her framework on institutional rational choice, Ostrom (2007) is the only author who addresses the concept of equity – but all she provides is a definition of 'redistributional equity' and then only in one short paragraph. The institutional analysis and development framework gives no indication of how to consider redistributive equity in the three levels of governance that it addresses. The social construction of target population framework (Schneider & Ingram, 2007) addresses concerns about who gets included in policy processes and why. It specifically considers the status quo whereby those "least advantaged" are generally excluded from active participation in policy processes. This framework merely advises the policy analyst to consider matters of disadvantage and discrimination in policy target groups, without providing clear direction on how to address these issues in policy analysis.

The policy framework for the development of equity-orientated policies (Braveman, 1998) is the one framework in which equity is an explicit and key consideration. The entire framework has been developed with a focus on equity in various stages of the policy process. This framework adopts a planning cycle approach and, like the stages framework approach, proposes eight sequential, but

iterative, steps, each with a set of equity requirements and considerations. While it goes beyond the other frameworks in its explicit equity focus, it focuses on only two aspects of the policy process: the kinds of equity information required to inform the different stages of the policy process, and the kinds of actors that must be included so as to facilitate the development of pro-equity policies. Unlike the policy triangle, it ignores the issues of context, process and content. The general failure in adequately addressing equity in health and health care (Braveman, 1998; Whitehead, 1992; Vitora et al., 2003; Gilson et al., 2006; Sander & Chopra, 2006; Graham, 2007; Moreno & Maurecio, 2009; Nkonki et al., 2011) might partly be the result of the general lack of frameworks that provide explicit direction on how to consider equity in policy analysis.

EquiFrame, which is a framework for analysis of the inclusion of human rights and vulnerable groups in health policies, is the best example so far that this review has found of a thorough pro-equity policy analysis framework (Amin et al., 2011). As it was published only in December 2011, it could unfortunately not inform the analysis of this research. It does, however, provide many useful insights and aids to a better understanding of what a pro-equity framework entails. The framework was developed in response to current gaps in policy in considering the health and human rights of persons with disabilities. Persons with disabilities constitute a particularly vulnerable social group which is often neglected in mainstream policy interventions. The principles of the EquiFrame framework can equally be applied to other vulnerable groups, such as children who live in poverty. In this framework the redistributive aspects of policies receive particular attention. It particularly examines whether policies promote the kinds of services and interventions that would benefit members of vulnerable groups to the same extent as the general population. It also pays attention to the 'soft' elements of health care, such as perceptions, attitudes, and values of health care providers and how these affect access to health care services. The framework offers a useful tool by which to assess policy documents for their consideration of the rights of persons with disabilities. Assessment is done according

to a grading scale for each criterion, which gives a cumulative score at the end. Policy documents are then scored as 'high', 'medium' or 'low' in performance.

The utility of this framework is demonstrated in its application to selected policies in a developing country and it has great potential utility for assessment of policy for other vulnerable groups – although the criteria in the tool are focused strongly on issues that relate to persons with disabilities, and while some of the criteria can be generically applied for different vulnerable groups, it will require reconfiguration to address the specific aspects that relate to particular groups. Specific modification would be required in a research study of this nature to focus on children more generally and specifically when examining child health policies in socio-economically disadvantaged situations. A potential combination of the Braveman and Equiform frameworks holds great promise for the development of a third framework that will inform policy analysis of pro-equity policies more broadly.

Policy analysis frameworks and implementation

In most of the policy analysis frameworks reviewed thus far, implementation of policy is either explicitly identified as an important part of the policy process, or implied to be an important step. For example, in the stages framework and the subsequent policy cycle, implementation is the penultimate stage (Lasswell, 1959; Brewer, 1974; May & Wildavsky, 1978; Dye, 2007; Jann & Wegrich, 2007). The street-level bureaucracy theory (Lipsky, 1980) focuses attention wholly on the implementation level, as this is where frontline service providers operate and exercise their power. The advocacy coalition framework postulates that policy subsystems operate at all levels of institutions, and this implies the presence of advocacy coalitions at implementation level. In the institutional analysis and development frameworks (Hill & Hupe, 2006; Ostrom, 2007) the last level identified is the operational level where policies are implemented.

Hudson and Lowe (2004) provide a useful synthesis of the paradigms for implementation in these policy analysis frameworks. They make the point that frameworks promote either a 'top-down' or a 'bottom-up' approach to policy

implementation. Top-down frameworks, such as the hierarchical stages framework, suggest that implementation is directed from higher levels within the policy-making organization (Elmore, 1979–1980). These frameworks imply that implementation actors follow a set of instructions from above and implement it without questioning or resistance. Theories that promote a 'bottom-up' perspective of implementation, such as street-level bureaucracy theory, suggest that the most powerful influence over implementation lies with implementation-level actors (Lipsky, 1980; Walt & Gilson, 1994). The beliefs and perceptions of these actors profoundly influence whether and how policy is implemented. It is here where the parameters for implementation are defined and executed, sometimes quite contrary to what the actual policies say (Lipsky, 1980). Hill and Hupe (2006) caution against this normative approach of creating mutually exclusive categories of top-down and bottom-up implementation. They emphasise the complexity and inter-relatedness of levels, groups and individuals in effecting implementation. Instead of concentrating on either top-down or bottom-up perspectives, implementation experiences should be examined from a range of vantage points. This will allow for a more rounded perspective of factors that promote and hinder implementation.

The policy analysis theory that comes closest to a truly bottom-up approach to policy development, and that starts the process at the level of implementation, is that of *backward mapping* (Elmore, 1979). Backward mapping was developed in antithesis to 'forward mapping', which is the same as the 'top-down' approach to planning. It contrasts sharply with all other frameworks, where the starting point of analysis is in the higher levels of decision-making.

Backward mapping proposes that the entire policy process must start at the traditional end point of implementation and work its way up. Its premise is that "it begins not with a statement of intent, but with a statement of the specific behaviour at the lowest level of the implementation process that generates the need for a policy" (Elmore 1979, p604). The further premise is that: "The logic of backward mapping connects policy decisions directly with the point at which their effect occurs" (1979,

p616). In his article on backward mapping, Elmore (1979) also introduces the concept of street-level decisions, subsequently developed further by Lipsky (1980), since street-level bureaucrats and their decisions are crucial to the process of backward mapping. Backward mapping is said to help in the identification of 'tipping points', or leverage points, through which better implementation might be achieved. Asking what the most critical set of behaviours is that generates the need for a policy, whether they be organisational requirements or individual behaviours, identifies the starting point for a policy. Once the policy objectives are defined, the process then goes backward through all levels of the system and asks two questions: what the impact of that particular unit or level would be on the behaviour that is the target of the policy, and what resources the unit would require to have that effect. In the final stage of analysis the analyst or policymaker then describes a policy that directs resources at the organisational units likely to have the greatest effect.

Conclusion

Walt and Gilson assert that, "policy analysis matters because it helps us to act effectively" (1994, p360). By inference therefore, the employment of the best policy analysis approach to guide the future development of health policy also matters. However, as is evident from the literature, each policy analysis framework has advantages and disadvantages, and gaps and limitations. The choice of policy analysis framework is therefore not a straightforward one. In a policy process that commonly spans a period of ten years (Sabatier, 2007, p3), a mixture of different frameworks might be used across the policy's lifespan. Frameworks are also context and issue-specific, as it is hardly conceivable that a complex military policy process will employ the same approach as developing a health promotion programme for young children. Also, stable democracies, for example, could apply the IAD framework quite effectively, but in unstable weak states where political regimes and institutional structures frequently change that might not be possible. Nonetheless, the same basic principles and conclusions emerge across frameworks: policy development and implementation are complex processes; understanding the context in which policies

are made is crucial; and central to the processes is a multiplicity of actors who interpret, understand, apply and influence policy development and implementation in a variety of ways.

Currently there is no single policy analysis framework that can adequately address all the dimensions of a complex policy process, and sometimes a combination of frameworks is required. The approach in this research has been to use a mix of policy analysis frameworks to guide the inquiry and to contextualise analysis and conclusions. Furthermore there is a paucity of policy analysis frameworks for the consideration of equity in policy analysis. The recent EquiFrame framework holds great promise in this regard, but is not quite specific enough to examine pro-equity issues that relate to children. There is opportunity therefore to address this gap on pro-equity policy analysis frameworks further.

The various policy analysis frameworks are generally applicable across all government sectors, including the health sector. Caution must be exercised to identify peculiarities in the health context that might require an extension of the analytic frameworks (Walt, 2008). In particular the presence in many countries of a significantly large private sector, and of international donor agencies in developing countries, requires consideration when examining actors and institutions (Walt, 2008).

Finally, policy analysis frameworks should be seen as a set of guidelines on how to critically assess and evaluate otherwise complex and messy processes. To negotiate this complex world requires tenacity, creativity and an open mind on the part of policy researchers. It also requires an acceptance that policy analysis will ever only provide some insights, and some of the answers to a constantly changing set of policy dynamics. For some of the time, policy analysts will just be ‘muddling through’ (Lindblom, 1959).

Chapter 3: Methodology

Introduction

This thesis employs a retrospective policy analysis study design to examine the research questions of interest. Mixed methods are used to conduct the policy analysis. The first component of the research is a documentary analysis of selected foundation health policies that shaped overall reform and governmental child health policies developed in South Africa since 1994. The documentary analysis assists in sketching the context of child health policy reform and identification of the broader health reform goals, and provides some of the answers on the process of child health policy development. The documents also provide an understanding of how equity was conceptualised and incorporated in the content of general and child health specific policies. The second component is a case study of a national child health policy, the National School Health policy. The case study serves as a lens through which to examine the research questions in greater detail and to relate the findings back to child health policies more generally. In both the documentary analysis and the case study, qualitative methods are used to collect and analyse data. Thematic coding is used to distil key information in the documentary analysis. For the case study, primary data collection involved in-depth elite interviews with Department of Health officials at the national, provincial, and district levels of the health system. Interview data comprises the more substantial part of the research findings.

This chapter outlines the theoretical rationale for adopting qualitative methodology; the approach taken in the documentary analysis; the rationale for, and selection of, the case study; and the primary data collection approach used in the case study.

Brief overview of retrospective policy analysis

Policy analysis is both a prospective and retrospective practice (Buse, Mays and Walt, 2005). Retrospective policy analysis is the analysis of a policy after it has been

adopted and/or implemented (Buse, Mays & Walt, 2005). It "looks back to explore the determination of policy (how policies got on to the agenda, were initiated and formulated), what the policy consisted of (content) and whether the policies achieved its goals" (ibid, p16). This type of policy analysis relies largely on documents and on the opinions and insights of persons who have been involved in the process. It may involve formal evaluations of the policy implementation. Retrospective policy analysis is employed to learn from past policy experiences, garner lessons to inform future policy processes, and assess the progress with policy goals (ibid). Government officials are drawing increasingly on such analysis to inform their policy activities. The United Kingdom, for example, has internal policy analysis units "to work with departments in developing their key policies" (http://www.cabinetoffice.gov.uk/strategy.aspx). In South Africa, whilst individual government departments do have policy units, from the researcher's knowledge these units in the Department of Health do not actively develop policies. Individual policy makers therefore often draw upon academic and research institutions to assist in the conduction of policy analyses.

Why choose qualitative methodology for primary data collection and analysis?

Qualitative methodology has many different definitions. The simplest and broadest definition is one given by Snape and Spencer (2008, p3) where they reiterate the words of Strauss and Corbin: "By the term 'qualitative research' we mean any type of research that produces findings not arrived at by statistical procedures or other means of quantification". However, qualitative methodology involves a wide range of research approaches and methods that are derived from several different disciplines. Nonetheless, Ritchie and Lewis identify key features of qualitative research that set it apart from the positivist, quantitative approach that is often characterised as the "competitor" or the "opposite" methodology. They identify five main features of qualitative methodology: (1) the provision of in-depth and interpreted understanding of the social world of research participants; (2) small samples that are purposively selected; (3) data collection methods which involve close contact between researcher

and research participants, and are interactive and developmental, allowing for emergent issues to be explored; (4) detailed and information-rich data; (5) analysis which is open to emergent concepts and ideas and which may produce detailed description and classification, identify patterns of association, or develop typologies and explanations (Ritchie & Lewis, 2003). Despite contestations by the purists in both quantitative and qualitative approaches, researchers now accept that each methodology has utility depending on the nature of the research question, and that it is not an "either/or" decision, but sometimes necessary and desirable to use both quantitative and qualitative methods to answer research questions in the same project (ibid).

This policy analysis required detailed information on how each stage of the policy process developed, who the actors were, how decisions were made at each stage of the process, and what the factors were that influenced both the policy process and policy implementation. Existing child health policy documents in South Africa did not reflect this level of detail. In addition, little or no information exists on the implementation of child health policy. The researcher identified the best primary sources for this information to be policy makers, managers, and service providers at different levels of the health system, given their integral involvement with the development and implementation of child health policy. Quantitative methods are less suited to soliciting detailed experiences, perceptions and insights about these processes (Dicocco-Bloom, 2006). The researcher therefore opted for the use of qualitative methods to elicit perceptions, experiences and practices of policy makers, managers, and service providers regarding child health policy formulation and implementation.

This is the researcher's first substantive engagement with qualitative methodology. Negotiating the complex and varied world of this methodology – characterised by observations such as, "no single, accepted way of doing it" and "its execution depending on a range of factors such as researcher beliefs, characteristics of research participants, audience for the research, funders, the position and environment

of researchers themselves" – presents a significant challenge to a novice qualitative researcher (Ritchie & Lewis, 2008). The researcher drew upon the guidance of a supervisor with substantial qualitative research experience and available academic texts on the subject to strengthen her research capacity.

The documentary analysis

Introduction

The documentary analysis helps to inform the broader health reform context in which child health policy reform occurred by outlining the following: the overall goals and strategies for the South African health care reform process; which child health priorities are addressed in current national policies; the characteristics, scope, direction and content of child health policies; and, in particular, how child health policies considered equity in their development. The documentary analysis purposively examines selected key documents that lay the foundation for health system transformation in general (Table 6, Chapter 4) and child health in particular (Table 7, Chapter 4). For the latter group of documents all national government child health policy documents developed in the post-apartheid period, that is 1994 to the present, are included together with their supporting documents (Table 8, Chapter 4).

Theory behind documentary analysis

Documentary analysis is a recognised methodology in social and health science research (Appleton & Cowley, 1997; Elston & Fullop, 2002; Denzin and Lincoln, 2005). One benefit it has as a research method is the availability, usually, of numerous documents of different kinds, containing a wealth of content and information that often eliminates the need to generate data *de novo* (ibid). Documents may be the only source of information of policy processes, since policy actors come and go, leaving behind no or little institutional memory. Documentary analysis eliminates the need for collecting data from people, and circumvents some of the ethical issues related to research with human participants. It does present some limitations however, such as the incompleteness of official documents. Abbott et al. assert that "analysis may also

be ‘positivist’ in its approach, taking at face value the meaning of texts” (Abbott et al., 2004). This requires particular vigilance, since government documents are often political statements that require critical and contextual interpretation. However, when rigorously and appropriately applied, documentary analysis has good utility in understanding past and present policy aspirations of government and other policy-making bodies. It also provides useful adjuncts to data collected via other methods, such as interviews with policy actors.

Documentary analysis may have a quantitative component where, using content analysis, the number of times certain words and phrases occur is counted and trends and associations are identified. More commonly, qualitative methods are used such as thematic analysis for analysing documentary content. This thesis employs a purely qualitative approach in the documentary analysis and uses thematic analysis for addressing the research questions of interest from documentary content.

Steps in documentary analysis

Conducting a documentary analysis requires a systematic approach that is rigorously applied to each document. A commonly used approach in documentary analysis involves the following steps: development of clear inclusion and exclusion criteria for the documents; development of a pro-forma analytic tool that is systematically applied to each document; systematic interrogation of each document; recording of results in a database, much like the ones used in qualitative research methods; and finally analysis of the content of documents, using an approach similar to the analysis of qualitative data (Appleton & Cowley, 1997; Elston & Fulop, 2002; Denzin and Lincoln, 2005). Variations in these steps might occur, depending on the nature of the research project and the type of documents sourced.

Challenges with documentary analysis include understanding the contexts in which documents were developed, incomplete documentation, researcher bias in the interpretation of the documents (although a rigorous and clear framework of analysis minimises this), and the ‘fixed-quality’ aspect of document content that cannot be altered to improve study results. The documentary analysis for this study included

only national government policy documents and encountered all the aforementioned challenges. The rigorous analytical framework and the triangulation of documentary information with the information obtained from the other data collection methods helped to minimise these challenges.

Inclusion and exclusion criteria for documents

A set of inclusion and exclusion criteria for the child health policy documents was developed, based on the research questions and the logistical resources (primarily money and time) that were available to conduct the research.

Inclusion criteria:

- National government policy documents
- Documents that exclusively focus on child health
- Documents developed in the period 1994–2009
- Documents labelled as policy, policy guidelines, policy and implementation guidelines
- Supporting documents such as workshop reports, policy roundtable discussion reports and minutes of meetings that relate specifically to the development of the selected child health policies.

Exclusion criteria:

- Provincial child health policy documents, as these documents are not consistently available across provinces and mostly reflect existing national policy documents anyway.
- Documents labelled as clinical guidelines, clinical protocols and programmes, as these tend to focus on single conditions and quite specific interventions, and mainly relate to the practical steps of implementing the particular intervention. An example of this is the vitamin A supplementation programme, an intervention that focuses solely on providing vitamin A capsules to children who need it and primarily provides clinical guidelines on how to deliver this programme.

- General health policies, for example human resource and pharmaceutical policies, because even if they did make some reference to child health this would have broadened the scope of the study beyond logistical capacity and would also not have provided insights specific to child health policy development.

Based on the criteria, nine national child health policy documents are included in the review. Four are labelled as policy, three are policy guidelines, and two are policy with implementation guidelines (Table 7, Chapter 4). Only six supporting documents linked to the SHP have been located and are included in the review (Table 8, Chapter 4).

In addition, six general documents were purposively selected. Based on the researcher's knowledge and the frequency with which they are referred to by health system analysts in South Africa, these are the key foundation documents that guided overall health system reform. These documents are summarised in Table 6, Chapter 4.

The pro forma

The following information, derived from the research questions outlined in Chapter 1, was elicited for each document.

- The title and date of the document
- The nature of the document, that is, whether it was a policy document or workshop report
- The main aim of the document
- Which policy issue the document addressed
- How the issue got into the policy domain
- The actors involved in the policy process
- A description of the policy formulation process
- The policy options considered
- The key features of the policy content

- Whether policy implementation guidelines were available
- Whether the policy implementation had been formally evaluated and what the key findings were
- Whether and how equity was addressed throughout the policy and implementation documents

Text from each document, categorised by question, was recorded on an excel spreadsheet. A set of themes was identified using thematic analysis. Manual coding was done on printed sheets containing the results, where themes were identified and colour-coded. For example, text that described policy actors was colour-coded pink, and policy drivers were colour-coded red. Themes were grouped from across documents and re-entered into a new excel spreadsheet. A second round of analysis identified further themes and sub-themes. This constituted the final results that informed the analysis and write- up of this research.

Limitations of the documentary analysis

It was not possible to locate all the supporting documents that may have provided a more comprehensive understanding of the context and process of the policy processes. Supporting documents, when requested from key people who were involved in the policy process, and/or responsible at a national level for overseeing the particular service area, were reported either to be unavailable, misplaced, or non-existent. A number of officials and academics who were originally involved with the policies had moved on from their positions and had either not passed on documents or lost them. This appears to be the consequence of a high turnover of senior staff and poor hand-over mechanisms. In one case, the chairperson of the task team responsible for compiling a requested document referred the researcher to several health officials in order to locate three workshop reports that were very relevant to the policy formulation process. None of the officials knew the whereabouts of the workshop reports containing records from the deliberations of more than one hundred persons

from various government and non-governmental organisations who participated in the process.

The quality of the documents was variable. Some policy documents, such as the 1995 Maternal, Child and Woman's Health policy, had not gone through the official policy endorsement process, and were still labelled as "draft", more than ten years after completion. Technically these documents do not form official government policy, but in practical terms they were documents that informed activities of the national MCWH cluster and added to the understanding of child health policy.

The case study

The use of case studies in social science research is common but not without contestation (Yin, 1994; Tellis, 1997). Robert Yin, the most prominent proponent of this research approach, defines a case study as "a research strategy that focuses on the exploration of a complex phenomenon and the related context" (Yin, 1994), and regards it as "an ideal methodology when a holistic, in-depth investigation is needed" (Tellis, 1997). The case-study methodology has wide application across several disciplines, especially in the social sciences, and has been used to address research questions in many different contexts. Proponents of the case-study method regard it as a focused, time- and resource-saving method to obtain an in-depth insight into a situation of interest. It can be used to examine differences or commonalities across a given set of variables or research questions of interest. Depending on the nature of the research and the selection of the case study, it may allow for the extrapolation of findings to a more general context. Alternatively, it may be used to examine a peculiar feature or unique issue in greater depth. Opponents regard the case-study method as a weak and limited way of exploring research questions that has utility only in providing descriptive accounts to supplement other more robust research methods. However, Yin has demonstrated their value by highlighting several examples of case studies that have added to knowledge and understanding of complex research questions. Case study as a methodology is generally underrepresented in policy analysis, despite its potential utility in examining the complex phenomena of the

policy-making environment (Gilson et al., 2003). Policy analysis literature from low- and middle-income countries shows growing use of the method (Gilson & Raphaely, 2008). Ultimately, it is the scope and methods of the case studies themselves that must be able to withstand scrutiny. Researchers can ensure the legitimacy of their approaches by selecting more than one case study in a single research project, applying a rigorous methodology in the case studies, and employing additional methods to complement case study results.

This research uses a case-study approach for two main reasons. Firstly, based on experiences elsewhere, a well-selected single policy serves to scrutinise the situation of interest more closely, and allows a detailed examination of the research questions (Gilson et al., 2003). The case-study approach was also chosen for more pragmatic reasons, since resource limitations did not allow for all child health policies to be analysed in detail.

The qualitative data collection method of choice used in the case study comprises in-depth semi-structured face-to-face "elite" interviews with individual health officials who operated at the national, provincial, and district level of the South African health system. This is expanded upon in subsequent sections.

Case study selection

The National School Health Policy, a preventative child health policy officially launched in 2003, has been selected as the case study of choice. Background details of this policy are provided in Chapter 1. Various factors recommend the selection of this policy as a case study.

The School Health Policy is a good example of the integration of a previous "vertical health" programme into a comprehensive primary health care service. This move from "vertical" programmes to fully integrated comprehensive primary health care services constituted a significant part of health system transformation and the move towards a primary health care approach within a district health system. A number of preventative health care policies, such as the National SHP, were developed to guide this process. Anecdotal reports suggest that similar challenges

might have been experienced in trying to implement other similar preventative child health policies. It seems reasonable therefore for challenges and successes from the SHP development and implementation process to be extrapolated to child health policy more broadly.

Moreover, the preventative nature of the SHP also permits an analysis of how health facilities that are subjected to a high curative health care load, especially in the context of the HIV epidemic, coped with the addition of one more preventative child health service intervention. This tension between curative and preventative health care activities has been, and still is, a major factor in South African health care services.

This policy targets a category of children (viz., school-going children) who constitute a significant sub-population of children but have previously been neglected in formal health care provision. Promoting longer-term health, and thereby enhancing a child's ability to learn, is a particularly important component of public health and is a key focus in the Primary Health Care approach. Before 1994 the school health service was particularly inequitable; white school children in urban areas received consistently excellent services, whilst the availability and quality of services to all other groups of children varied considerably by race and geographic location. An analysis of this policy addresses the research questions of whether, and how, inequities in health care provision have changed with the introduction of a national child health policy. The School Health policy process, as well as school health service provision, were relatively uncontaminated by macro-political interference, such as was the case with HIV-related policies. The researcher purposively avoided complex international and national political dimensions in the case study, since they would have introduced a further set of variables and complexities into the analysis. Successful implementation of the school health policy is dependent on good inter-programme collaboration within the Department of Health as well as good inter-sectoral collaboration with the Department of Education, and will provide some insight into how these complex relationships are negotiated. This policy has not yet been evaluated and undertaking the policy analysis five years post-implementation,

aside from being timely, ensured a fresh policy analysis untainted by prior opinions and perceptions.

Sampling of interviewees

Senior officials from each level of governance in the health system (national, provincial and local) play a very important part in the policy process and are crucial to the success or failure of policy (Walt, 1994; Walt & Gilson, 1994; Dye, 2007). In this study Department of Health officials from national, provincial and district levels were interviewed. In South Africa, child health policies for the country are developed by the National Department of Health. Provincial departments of health amend and interpret the policies for their provincial contexts and district health managers and service providers are responsible for the implementation of the policy. Service providers in the case of the school health policy are mainly nurses. Previous studies have shown nurses to be a very powerful group in determining failure or success of policy implementation and including them in the study was essential (Gilson and Thomas, 2006; Gilson et al., 2006; Walker & Gilson, 2004).

Interviewees were identified using purposive sampling (Lilleker, 2003; Richards, 1996). The researcher's prior professional experience and personal knowledge of the child health policy environment in South Africa helped in the identification of the initial sample of senior managers involved with child health at the national and provincial levels. Additional persons were identified from appropriate websites. Snowball sampling was used to identify additional interviewees. Provincial level officials helped in the identification of district-level managers and school health service providers, who in turn helped to identify additional managers and service providers where required.

The interviewees

In total, 81 health officials participated in the interviews. Their location, designation and numbers are depicted in Table 4 and Table 5.

Table 4: National and Provincial interviewees

	National Dept of Health	Eastern Cape	Free State	Western Cape	Non-case-study province
Deputy Director-General	1			1	
Senior manager at level of chief director	1		2	1	
Middle manager at level of director and assistant director	4		3	2	
School health co-ordinator and/or predecessor	0	1	1	1	8
SHP task team member	2				
Child health specialist	1				
TOTAL : 29	9	1	6	5	8

Source: Generated by researcher

Table 5: District interviewees

	Eastern Cape	Free State	Western Cape
District Manager		1	
Sub-district manager	2		1
District Primary Health Care or MCWH manager	1	1	8
Facility manager	4	3	2
School health co-ordinator	2	1	1
School health nurses	5	3	10
Other primary level nurses	5		
TOTAL: 52	19	9	22 + 2 school principals

Source: Generated by researcher

Over the interview period, the researcher travelled more than 7000 kilometres to various intra-provincial districts and sub-districts in four provinces. Nine interviewees were national level health officials, operating at six different levels of management in

the National Department of Health. The majority of the national level interviewees were located in the MCWH cluster. A Deputy Director-General, who has direct oversight of child health and who reports directly to the head of the National Department of Health, was the highest level health official interviewed. Remaining interviewees included two chief directors, two directors, an assistant director, and a child health specialist. Two additional people, no longer associated with the Department of Health and who served on the National Policy Task Team for school health, were also interviewed. A further 12 senior and middle-level provincial health officials across the three provinces participated in the interviews, all with varying degrees of responsibility for both child health and school health. Exact positions of these officials differ, as provinces have differing organograms. Three of the twelve (one in each of the three case-study provinces) were persons responsible for managing the school health service. In the Eastern Cape only one provincial level health official participated in the interviews. This was due to the delay in receiving permission for the study from the province. Other senior health officials were unable to participate at short notice. Telephone interviews were conducted with provincial school health co-ordinators in the six non-case-study provinces to get a national overview of the service. Twenty-nine nurses responsible for the delivery of school health services were interviewed. The remaining 25 interviewees operated at different levels of district management, and included district and sub-district managers, specific health programme managers in child health and overall primary health care, and health facility managers.

The national school health co-ordinator was not on the list of interviewees, as the post had been vacant for the two years prior to the research. The person who had responsibility for school health in the interim participated in the interviews. A further limitation, mainly due to resource constraints, was the absence of any Department of Education officials, these being the "recipients" of the SHS. Ad hoc opportunities arose to speak to some teachers, but these interactions were brief and, although interesting, not substantively helpful.

A final source of data was a provincial workshop in one of the provinces where all school health co-ordinators and senior personnel from the education department were present.

Location of research

Interviews started at the National Department of Health in Pretoria. Information gathered at the national level provided the overall context and direction for the researcher in undertaking the research at the provincial and district levels. The researcher selected three provinces, one from each of the three income bands (high, medium and low income) for provinces in South Africa (Children's Institute, 2006). This was not intended as a direct comparative analysis, as would be the case in quantitative social policy research. Instead, the three provinces, by virtue of their differences, enabled the examination of policy interpretation and implementation in different contexts. This scope permitted the researcher to develop a more nuanced understanding of how context influences child health policy performance.

The nine provinces are further divided into 52 health districts and in turn, these districts are subdivided into 232 sub-districts. Each province has an average of 5–6 districts, and each district an average of 4–5 sub-districts, depending on the size of the population and geographical area. Districts have been divided into quintiles, based on the Multiple Deprivation Index (Barron et al, 2006a; Barnes et al, 2007). Quintile 5 is least deprived and quintile 1 most deprived. Based on this index, all districts in the Eastern Cape are in quintiles 1 and 2; all districts in the Western Cape are in quintile 5, with the Free State districts mostly spread between quintiles 3 and 4. This research targets health facilities from a mix of rural and urban, rich and poor districts in each of the three provinces, since intra-provincial socioeconomic variation is a consistent feature across all provinces. The three provinces that are included are geographically contiguous, which minimised logistical travel difficulties for the researcher. In addition, they have a varied history of school health service provision, adding to the 'richness' of the data. The three provinces included in the research are the Western

Cape (one of two high income provinces), the Free State (one of three middle-income provinces), and the Eastern Cape (one of four low-income provinces).

The Western Cape typically achieves the best health indicators in the country and has the highest per capita expenditure on health. Almost 90% of the Western Cape population is urban and resides in and around the city of Cape Town. A very large informal settlement with approximately one million residents is located on the outskirts of Cape Town. Nine percent of children in South Africa (just over 1.5 million) reside in this province, and it has the lowest proportion of children living in income poverty. This is the only province with a provincial health service plan, and is the province most advanced in the implementation of the district health system. It also has the lowest incidence and prevalence of HIV-infections. District-level interviewees were located in a mix of urban and rural and socio-economically diverse areas of the province. Interviews took place in several areas of the metropolitan city of Cape Town, and two rural sub-districts.

The Free State is a middle-income province with the second smallest child population in South Africa of just over 1.1 million children, close to 70% who live in urban areas. It is a province with geographical contiguity to six other provinces and the country of Lesotho. One former homeland from the apartheid era was incorporated into the Free State. The Free State performs reasonably well in key child health indicators, and has reportedly been the first province to achieve 100% district coverage of school health services. Interviewees were located in the city of Bloemfontein and in a smaller town and two rural sub-districts one of which is described as ‘deep’ rural.

The Eastern Cape has the second highest child population, tied with Gauteng province – each with 16% of South Africa’s child population. The two provinces diverge in economic terms, as Gauteng has the second lowest and the Eastern Cape the second highest proportion of children living in income poverty. Close to 80% of children in the Eastern Cape live in a rural setting. Eastern Cape typically has the lowest per capita expenditure on health, and it is widely regarded as the poorest

province in the country with the least efficient administration of government services. This province incorporated two of the poorest former homelands and thus began its post-apartheid history with a significant handicap. In the incidence and prevalence of HIV infection, Eastern Cape is second only to Kwazulu-Natal province. Interviewees were located in two large towns and in several rural areas, one of which is described as a 'deep' rural setting.

Obtaining access

Permission to conduct interviews and access was obtained through a long period of negotiation that lasted almost four months. Communication to obtain permission from the national and provincial head offices took place by email and telephone between England and South Africa. The ease with which permission and access were obtained was influenced by the researcher's personal relationship with senior people in the respective offices, the efficiency of the offices, and the bureaucratic rules governing research in a particular province. In some instances permission was obtained by speaking to just one person, who facilitated the entire process. In others, permission was not as easily obtained; in the province from the socio-economically poor band it took numerous emails and telephone calls – up to 20 telephone calls daily over several days – to identify the person ultimately responsible for giving research permission. The entire permission-seeking process, although time-consuming and at times frustrating, provided insight into the capacity and efficiency in each province. Final permission for the Eastern Cape province was obtained only two working days prior to the interviews, which resulted in difficulty in accessing senior health officials in that province.

In addition to obtaining permission from the various head offices, several additional (and often implicit) layers of getting permission for interviews at district level unfolded in the first two weeks of the researcher's arrival in South Africa. This required several additional telephone calls and negotiation processes. The extent of these implicit layers of permission (and the time that it required to negotiate them) was under-estimated by the researcher.

Interview process

A set of three topic guides was developed to guide the interviews: one for national interviewees, one for provincial interviewees, and one for district health officials and health service providers, mostly nurses (Appendices A, B, C). A fourth topic guide was developed for use in telephone interviews with provincial school health co-ordinators in the six provinces not included in the in-depth case study (Appendix D). Topic guides were reviewed by the researcher's supervisor, by peers in South Africa, and by correspondents at New York University. The guides were piloted in trial interviews and then revised accordingly.

Interviews typically lasted one hour, whether in person or by telephone. Some that involved groups lasted approximately 90 minutes. Permission was obtained from each interviewee, after explaining the nature and purpose of the research. Permission was also sought from each interviewee to record the interview. In only one instance this was refused by an interviewee who was part of a group. She indicated her introverted personality as the reason for doing so. However, as the interview progressed with other members of the group, she felt reassured and agreed for her input to be recorded. Interviewees were invited to indicate if they wished certain parts of the interview to be deleted. In a few instances interviewees requested that their statements not be recorded, at which time the recorder was set to pause. Interviewees were assured that their anonymity would be maintained; however, senior health officials were also informed that their identity might be inadvertently revealed, due to their level of seniority and unique portfolio at national or provincial level.

Service coverage

The final part of the research attempted to obtain available health service data on the coverage of the school health service for the first six years of implementation. Very poor routine data on school health services meant that this was often not possible, as only fragments of coverage data were available. This is an unfortunate gap, since this policy in particular lent itself to a pre-and post-policy coverage

analysis. Detail on the challenges with school health service data is provided in Chapter 5 on 'Implementation'.

Analysis of results

Interviews were transcribed by the researcher into MS Word documents, with assistance from a paid transcriber from South Africa. Having a locally-based transcriber helped with understanding context and nuances in the interviews. A formal contract with the transcriber bound her to a confidentiality clause regarding the interview content and interviewee identify.

Results were analysed using the framework analysis approach of Ritchie and Lewis as a guide (Ritchie & Lewis, 2003). Interview text was read thoroughly, starting with national level interviews. A short two to three paragraph summary was made for each interview, identifying the key issues that emanated from the interview. This provided the researcher with a good overview of the main issues that arose. From the nine national interviews a set of themes were identified and each theme was assigned a different colour in the working document. Text corresponding to the theme was also colour-coded on the printed interviews. Remaining interviews were coded according to these themes and, where necessary, further themes were identified. An additional set of sub-themes was identified under each theme and assigned the same colour, with a single word descriptor indicating the nature of the sub-theme. For example, under the theme of 'implementation challenges' sub-themes labelled 'data-issues', 'staffing', and 'transport' emerged. Data from themes were grouped and put into separate spreadsheets according to each theme. The grouped data were further analysed for sub-themes, and original sub-themes were revised accordingly. Emergent themes derived from the interview content were related back to *a priori* research questions and grouped into a final set of themes for purposes of presenting the research results.

After considering the use of available software programmes, the researcher decided to manually code and analyse the research results. The main advantages of software programmes relate to the saving of time, being able to deal with large

quantities of qualitative data, and improving the validity and audibility of qualitative research (Bazely, 2007; St John & Johnson, 2004). Some of the disadvantages include the focus on volume and breadth rather than on depth, time and energy spent on having to learn new software packages, reification of data and the move towards 'quantification' of qualitative data, and increasingly deterministic and rigid processes (ibid). The researcher elected to manually code and analyse data for several reasons. Manual analysis of qualitative data is a tried and tested method still used by a number of experienced qualitative researchers. Conflicting accounts from peers and senior staff on the additional benefits of using a software programme caused the researcher to conclude that the time and effort of learning a new software programme might outweigh additional benefits. Also, a significant part of coding and analysis inevitably involves manually sifting through data. Upon reflection as a novice qualitative researcher, richness of the experience in coding and analysing data manually may have been lost in the application of, and reliance on, a software programme.

The role of the researcher in the School Health Policy process

The researcher's own role in the School Health Policy process does have a bearing on the collection, interpretation, and analysis of the research informing this project. Prior to commencing her doctoral studies, the researcher worked for a period of ten years at a Children's Policy Research Institute in South Africa. Part of her work involved doing research for, and participating in, child health policy development in South Africa. This role included the provision of empirical evidence for policy makers, facilitating policy roundtable discussions, critiquing policy drafts that have been circulated for broader comment, training policy makers in child health policy development, and participating in task teams responsible for developing national child health policies. One of these task teams was the National School Health Policy task team. The researcher was invited in her capacity as an academic researcher to serve as consultant to the process. In this role, the researcher and a colleague facilitated the nine provincial and national workshops during which the policy content was developed. They played a leading role in writing the policy and the implementation

guidelines and submitting them to the task team for further action. They also produced cost estimates for the implementation of the SHP. The researcher had no further role in the process beyond this. The next substantive contact with the policy was for purposes of the doctoral research. Overall, the researcher's involvement in the SHP process yielded both benefits and challenges.

Benefits

The researcher has intimate knowledge of the South African policy development environment and of the context of child health policy development in particular. This experience has enabled her to obtain easier access to interviewees, saving much time and money. A certain measure of trust had already been established with interviewees in senior positions, and this facilitated the sharing of information during interviews. It also saved time in establishing rapport in the initial period of the interviews.

Challenges

A potential challenge was maintaining objectivity throughout the process, but almost six years had elapsed since the researcher's last intimate engagement with the school health process in South Africa and this allowed her to reflect on the process afresh and with renewed objectivity. In addition, the researcher was acutely aware of her potential subjectivity and this constant self-reflection served as an 'internal' check. Finally, triangulation occurred at every stage of the process: between the different data sources, between different data collection methods, and between different sites of research.

Ethics and feedback

Ethics permission for the research was obtained from the Oxford University Research and Ethics Committee. In addition, ethics permission was required by one of the provincial health offices and was obtained from the associated University of Cape Town Research and Ethics Committee.

Officials from each relevant national and provincial Department of Health head office provided written permission for the research. In addition, the researcher obtained oral permission from each relevant manager at different service levels to interview staff working in their division. This was always dependent on producing the head office letter of permission. At the individual interviewee level, a consent form was produced and interviewees were invited to give signed consent if they so wished. All interviewees were happy to proceed without formally signing the consent form.

All interviewees asked to get feedback on the research, and the researcher provided them with a summary report of the main research findings. The researcher also provided a more substantial report to managers at national and provincial head offices and to district-level officials who requested it.

Interviewee and research site anonymity has been maintained as far as is possible.

Chapter 4: Child health policy development in South Africa: context, process and policy positions

Introduction

The prolific policy development that marked the early post-apartheid period provides an opportunity to reflect on the way government policies were conceptualised and developed to address societal needs and challenges. This is the first of four empirical chapters that examine this set of issues for government policies on child health. The assumptions that underpin this thesis are: that public policy development is a significant activity of government, and that a health reform process of the magnitude such as occurred in South Africa merits rigorous examination of the way that it unfolded. In relation to child health reform in South Africa, this research examines policies as important instruments for shaping child health services, given that the provision of good quality, equitable child health services was and still is a crucial health reform objective.

The analytical framework embodied in the policy triangle (Walt & Gilson, 1994) prompts policy analysts, in addition to the usual analysis of policy content, to consider three other important analytical dimensions: the context in which policies are developed; the processes by which policies are developed; and the actors who influence the conceptualisation, process and content of policies. The policy triangle underscores the importance of actors in the policy process in locating them at its centre. This centrality of actors in the policy development process is endorsed by a number of other authors, and they propose various ways of thinking about the positioning and configuration of the actors in the process (Lipsky, 1980; Sabatier, 2007). This chapter addresses all four dimensions proposed by the policy triangle. It uses Lasswell's stages framework to interrogate the different phases of the policy process, but stops at the point of implementation, which will be the subject of the next chapter. It also introduces the issue of equity in child health policy development, which will be considered in detail in Chapter 7.

This chapter considers the following issues: (1) Whether or not appropriate child health policies were developed by the National Department of Health, in the sense of addressing the key health challenges for children identified in the post-apartheid period; (2) Who the policy actors were, and the influence of their position and power on child health policy development; (3) The characteristics of child health policy processes and how these influenced policy content; (4) The kind of child health services promoted in the content of the policies; (5) Whether the kind of services promoted by child health policies were in keeping with the aspirations of the broader health reform agenda.

The chapter begins with an outline of the political and health system context in which child health policy reform occurred. Guided by the analytical frameworks outlined in Chapter 1, it then provides an analysis of key national child health policies developed from 1994 to 2009. It begins by examining the appropriateness of these policies in meeting the key child health challenges as identified in Chapter 1. It then examines why policies emerged on the national agenda, followed by an analysis of the actors, process and content of the policies. It introduces the question of whether and how policies addressed equity, which is examined in detail in Chapter 7.

The chapter draws on the documentary analysis of the six overarching policy documents, identified as the key documents that guided health reform, the nine national child health policy documents and the supporting documents for the national School Health Policy as outlined in Tables 6, 7 and 8**.** Secondly, it draws on the 81 interviews conducted with policy makers, health managers and service providers. Thirdly, it draws on the experiences and insights of the researcher as a policy task team member on the SHP process and child health researcher for ten years at the University of Cape Town. The SHP case study provides the core material for the analysis of actors and child health policy process.

Table 6: Overarching policy documents shaping health sector reform

Policy Document	Year of release	Brief overview of document
The African National Congress (ANC) Health Plan	1994	The ANC Health Plan was developed by the majority political party and became the foundation document for the transformation of the health sector. The main principles in the ANC Health plan are based on the philosophy of the Alma Ata Primary Health Care approach.
The Reconstruction and Development White Paper	1994	The White Paper on Reconstruction and Development was an inter-sectoral document outlining key areas for reform in each sector. It underpinned the Reconstruction and Development Programme (RDP). It also outlines priority interventions called Presidential Lead projects, including free health care and the primary school nutrition programme, that were launched in the first hundred days of the new Mandela[21] administration. The White Paper outlines implementation strategies for achieving Reconstruction and Development goals and contains policy and programme proposals for a number of different ministries.
The National Maternal, Child and Women's Health draft policy,	1995 (Remains draft, as it is not officially endorsed).	This is the first overarching important document for child health service provision, developed by the national Maternal, Child and Women's health (MCWH) cluster. It outlines important health service reforms for women, mothers and children. It contains proposals for the organisation, management and delivery of child health services, across levels of care.
The White Paper on the Transformation of the Health System	1997	This White Paper was published in 1995 as a precursor to a new Health Act. It built on the principles and proposals of the RDP White Paper and ANC Health Plan. This White Paper provides the framework for the structure, roles and responsibilities across the three levels of health care governance (national, provincial and district) and contains proposals for specific priority groups, including children.
The Primary Health Care (PHC) Package for South Africa – a set of Norms and Standards,	2000	This PHC document spells out the service interventions required by primary level health care facilities in order to achieve improved primary health care to all (Department of Health, 2000d). Health service interventions for children constitute a substantial part of this package and include the school health service (SHS). The PHC package was targeted for full implementation in all districts by 2006.
The National Health Act	2003	This law is the defining health law of South Africa and provides the legal framework for the roles, responsibilities, functions and financial arrangements for the different levels of the health system (National, Provincial and District) and the different governance structures (National, Provincial and Local government) that have responsibility for health care. It also spells out roles, responsibilities and functions of academic, research and parastatal organisations in relation to health care. The first draft of the Health Act was released for comment in 1995 and it took eight years to finalise.

Source: Generated by researcher

[21] Nelson Rolihlala Mandela became the first president of the new Government of National Unity that was formed after the Apartheid Regime was replaced by a democratically-elected government.

Table 7: Key child health policy documents, 1994-2009

Policy document	Year of release	Brief overview of document
Free Health Care policy	1994	This was the first policy for children post-Apartheid and provided for free health services for children under 6. It incrementally expanded to include all free care for children at the primary level, and children with moderate and severe disabilities at all hospitals.
Health Promoting Schools policy (HPS) (Draft)	2000	This document is meant to provide an overarching framework for the development and delivery of Health Promotion initiatives in and through schools, including communities. It has five pillars, of which the provision of services in schools, such as the school health service, is one. The HPS programme is partially operating, but the policy is still in draft form.
Policy Guidelines for the management and prevention of Genetic Disorders Birth Defects and Disabilities	2001	This policy document outlined how to integrate the prevention and management of genetic disorders into various components of the health care system.
Youth and Adolescent Health policy guidelines	2001	This provided options for a range of health care interventions for adolescents and youth. The document did not contain any specific policy requirements. Specific policies had to be developed at provincial level.
National School Health Policy and Implementation guidelines	2003	It provides a package of screening, preventative and health promotion services to be delivered to children in schools.
National policy for children with chronic health conditions (Draft) (Not yet officially endorsed)	2003	This policy document makes proposals on how to manage children with long-term/chronic health conditions. It is still not adopted as official Department of Health policy.
Child and Adolescent Mental Health policy guidelines	2003	This document puts forward suggestions on how to develop and deliver mental health services for children. It requires that each province develops their own policy for mental health services for children and adolescents.
Infant and Young Child feeding Policy	2007	This policy provides guidelines on how to manage the nutritional and feeding requirements of infants and young children.
Policy and Guidelines For The Implementation of the Prevention of Mother-to-Child Transmission (PMTCT) Programme	2008	This policy document provides the specific services and interventions required to address the PMTCT of HIV-infection.

Source: Generated by researcher

Table 8: Child Health Policy supporting documents

Supporting document	Year of release	Summary of document purpose
1. Workshop on an integrated policy for School Health (Abrahams, and Wigton)	1997	Proceedings of the national policy roundtable discussion on school health
2. Workshop on an integrated policy for School Health. Discussion Document (Abrahams, Wigton, de Jong)	1997	Synthesised local and international literature to inform roundtable discussions
3. Report on nine provincial school health policy workshop (Abrahams,a)	2001	Summary of the discussions, proceedings and decisions of nine consultative provincial workshops to inform the policy content
4. Report on the national school health policy workshops (Abrahams, b)	2001	Summary of the discussions, proceedings and decisions of the final national consultative workshop to inform the policy content
5. Chronic Disease workshop report (Shung-King)	1999	Proceedings of the national policy roundtable on chronic diseases in children
6. The ebb and flow of child health policy development in South Africa: three case studies reflecting the role of the Children's Institute at the University of Cape Town in shaping child health policy in South Africa	2006	An analysis of three policy cases from the perspective of an academic research institute, this included the school health and chronic disease policy

Source: Generated by researcher

Background to child health policy reform

Health sector reform debate seeking to better meet the health needs of South Africans date can be traced back as far as the 1920s (McIntyre, 2010). A particular landmark occurred in 1946, when, prior to the formalisation of apartheid, the then Minister of Health, Dr Henry Gluckman, made revolutionary health system reform proposals (National Health Service Commission, 1944). The politics of the time led to his proposals being rejected,[22] but many of them found expression in subsequent deliberations on health, as evidenced by similar health aspirations contained in the Freedom Charter of the ANC (African National Congress, 1956; van Niekerk, 2009).

[22] Long before the advent of democracy in 1994, concerted efforts were made to redress inequities in health and health care. A significant, not to say trail-blazing report drawn up by Dr. Henry Gluckman in 1944, who became South Africa's first Minister of Health in 1945, made bold recommendations to improve health care for the majority population of black Africans at the time (National Health Services Commission, 1944). He suggested the development of primary health care services for blacks and, in particular, used the wide disparity in infant mortality rates between white and black infants as part of his rationale. His recommendations were later rejected by the Nationalist government.

In the run-up to the first democratic elections in 1994, working groups were established to debate different aspects of the intended health care reforms. A paediatrician led the deliberations on child health, giving children a prominent place in this process (Personal communication: Marian Jacobs; Peter Lachman).[23]

The working group deliberations culminated in the writing of the ANC Health Plan, which was the foundation document for health care reform (African National Congress, 1994). Many of the proposals in the ANC Health Plan were similar to those originally made by Gluckman. The release of the ANC Health Plan heralded a period of unprecedented health sector reform, aptly described by a senior manager in the National Department of Health as "grand policy making". The ANC Health Plan describes this immense task as follows:

> The challenge facing South Africans is to design a comprehensive programme to redress social and economic injustices, to eradicate poverty, reduce waste, increase efficiency and to promote greater control by communities and individuals over all aspects of their lives. In the health sector this will involve the complete transformation of the national health care delivery system and all relevant institutions. All legislation, organisations and institutions related to health have to be reviewed . . . (Foreword, ANC Health Plan, 1994)

Equity appears as the first of nine guiding principles in the "Health Vision" of the Plan. The Plan further acknowledges the importance of social determinants of health in achieving equity.

> The health of all South Africans will be secured and improved mainly through the achievement of equitable social and economic development (Guiding principles, ibid).

The Plan next advocates adoption of the Primary Health Care (PHC) approach as the underpinning philosophy for the health system.

---

[23] Personal communication: Professor Peter Lachman, Great Ormond Hospital, London, 2009; Professor Marian Jacobs, Faculty of Health Sciences, University of Cape Town, South Africa, 2009.

> The African National Congress initiated a process of developing an overall National Health Plan based on the Primary Health Care Approach (Foreword, ANC Health Plan, 1994)

The tenets of the PHC approach call for the primary level as the cornerstone of the health care system, the integration of health service programmes (as an alternative to vertical[24] programmes), inter-sectoral collaboration, the prioritisation of vulnerable groups including children, and the delivery of equitable, affordable and accessible health services (Declaration of Alma-Ata, 1978; African National Congress, 1994). The adoption of the PHC approach marked an ideological shift from hospital-based, curative health care to community-based health care that prioritises prevention and health promotion. The ANC Health Plan also emphasises co-ordination and decentralisation, in antithesis to the previously fragmented and centralised health system. The plan identifies the District Health System[25] as the delivery vehicle for primary level services. Child health policies had to consider these principles in both their development and content.

The place of children in health care reform

Children are identified as a vulnerable group deserving of special attention in all overarching policy documents, leaving little doubt about their priority in the early period of health sector reform. Evidence of this is the prioritisation of children and pregnant women, as particularly vulnerable groups, for the provision of free health

[24] A Vertical programme or service is a programme or service that is delivered and managed by a separate group of staff and managers, exclusively concerned with that service from district to national level, and does not necessarily connect in a systematic way with other components of the health services. In South Africa these programmes included Family Planning, School Health, Orthopaedic and Mental Health services.

[25] A District Health System is a more or less self-contained segment of the national health system. It comprises first and foremost a well-defined population living within a clearly delineated administrative and geographic area, whether urban or rural. It includes all institutions and individuals providing health care in the district, whether governmental, social security, nongovernmental, private, or traditional. A district health system, therefore, consists of a large variety of interrelated elements that contribute to health… Its component elements need to be well co-ordinated by an officer assigned to this function in order to draw together all these elements and institutions into a fully comprehensive range of promotive, preventive, curative, and rehabilitative health activities (WHO, 1988).

care: “Free health care will be provided in the public sector for children under six” (African National Congress, 1994).

This political statement of intent became practice when Nelson Mandela pronounced it during the first 100 days of his presidency. The Reconstruction and Development White Paper, which contains no fewer than 19 references to ‘child’ or ‘children’, entrenched free health care as one of two child-focused lead projects in the overall reconstruction and development process (Republic of South Africa, 1994a). The other was the Primary School Nutrition Programme.[26] The White Paper on the Transformation of the Health System, which succeeded the ANC Health Plan as the blueprint for health care reform, contains 119 statements and proposals on children. In particular, it advocates for the improvement of children’s access to health care in socio-economically disadvantaged areas, the provision of comprehensive and integrated district child health services, and improvements in the quality of services provided.

However, this strong emphasis on children was not sustained in all overarching documents. The National Health Act, the last of the documents to be released in 2003, paid limited attention to children. It contains only one definitive policy position for children, that of free health care provision.

> . . . the State and clinics and community health centres funded by the state must provide –
>
> (a) pregnant and lactating women and children below the age of six years . . . with free health services (Chapter 1, National Health Act, 2003)

The remaining 12 statements on children refer primarily to matters of medical consent and treatment.

The diminished focus on children in the National Health Act seems to indicate a ‘back-tracking’ on the high priority accorded to children in the earlier documents.

[26] The Primary School Nutrition Programme aimed at providing nutritional support to impoverished children in schools. The aims of the programme include hunger alleviation, improving nutritional status and thereby improving potential to achieve educational outcomes.

The researcher experienced this back-tracking first-hand. She was part of a team that made the only submission on behalf of children in the public parliamentary hearings on the National Health Act. This occurred during the second political administration, which came into office in 1999. The attending Minister of Health lauded her submission as "passionate advocacy on behalf of children". Nonetheless, the Minister of Health and a senior official from the National Health Department took a position indicating that children would not receive greater priority than other groups (Proudlock & Shung King, 2003). In support of this observation the national MCWH policy, despite its strategic and practical importance for child health, was not officially adopted as national policy and remains in 'draft' form, 14 years after its development. The erstwhile national child health director offered the following explanation for this:

> *. . . things kept on coming up and new ideas kept on coming forward and for that reason, one felt that all the other policies needed to be developed. . . . I think that was the reason why it always got left behind, because of all the other policies overtaking it . . .* (National Policy Task Team member)

A further manifestation of this dilatoriness, as will be elaborated on in later sections, is the delay of more than a year in official approval of the national SHP, because the National Health Council[27] kept on "*postponing child health items on its agenda*" (National School Health Policy task team member).

Nonetheless, the environment for child health policy reform was predominantly favourable and held out great promise for the development of equity-orientated, redistributive child health policies. The next section examines whether and how the nine key national child health policies followed through on the overall reform goals of the health system in their design and development.

[27] Formerly known as MINMEC and the highest official decision-making body in the National Department of Health. It comprises the national and provincial ministers and provincial heads of health.

The development of child health policies: 1994–2009

Did child health policies align with identified child health challenges?

The child health policies (Table 7) address a wide spectrum of health conditions that coincide with the main causes of child mortality and morbidity, as identified in Chapter 1. For example, the Prevention of Mother-to-child Transmission of HIV (PMTCT) policy and implementation guidelines (Department of Health, 2008) address prevention of HIV infection that currently accounts for 40% of deaths in children below 5 years of age (Bradshaw et al., 2003; Bradshaw & Nannan, 2006). This policy is complemented by the Infant and Young Child Feeding Policy, which addresses breast and formula feeding for babies born to HIV-positive mothers (Department of Health, 2007b). By addressing malnutrition, this policy speaks to one of the main underlying causes of death and illness in children. Four of the policies address health issues for children who were previously neglected in health care, thus filling important policy gaps. These are school-aged children and adolescents, and children with disabilities, chronic diseases and mental health problems (Department of Health, 2003a; Department of Health, 2000b; Department of Health, 2000c; Department of Health, 2001b). Older children, and those with the aforementioned health conditions, feature amongst the important and neglected areas of child health, as already indicated.

In reality however, the policy agenda for child health was less considered than the coherence to key health challenges seems to suggest. The policies evolved without an overarching strategic plan for child health; the researcher found no documentary evidence of any such strategic framework, and interviewees also alluded to this absence. Child health policy makers did not have clear guidelines on which new policies to develop, how existing policies needed to be revised, or on the appropriate prioritising and sequencing of these policies. The MCWH policy and the PHC Package, intended to provide strategic policy direction for child health, give equal weighting to the long lists of issues contained in these documents (Department of

Health, 1995; Department of Health, 2000d). This presented a dilemma for managers who were required to develop and execute child health policies.

> *. . . part of the problem with the National Department of Health has been a failure to prioritise. Instead of saying we are going to do these things and we are going to do them well, we're doing 1001 different things not very well . . .* (Child Health specialist, National Department of Health)
>
> *I think National has looked unconvincing at times as to what we should prioritise* (Senior Manager, Western Cape).

The absence of a strategic child health plan, compounded by the politics of HIV and AIDS in South Africa,[28] resulted in a perverse combination of prematurely developed and significantly delayed child health policies. Four examples reflect this. The Policy and Guidelines for the Implementation of the Prevention of Mother-to-child Transmission of HIV (PMTCT) programme (Department of Health, 2008) appeared in 2008 as the last of the nine policies. This was despite HIV and AIDS ranking as the number one cause of mortality in young children, at least since 1998. The Policy Guidelines on the management and prevention of Genetic Disorders, Birth Defects and Disabilities (Department of Health, 2001a) were the first to be released subsequent to the Free Health Care policy (Republic of South Africa, 1994b), despite the small number of children affected by this issue. Trauma and violence, which is the most common cause of death in children older than 4 years of age, has yet to be addressed through policy. Similarly, there is thus far no national policy on neonatal health care, despite neonatal mortality accounting for more than 30% of deaths in the first year of life.

[28] The politics of HIV and AIDS in South Africa has drawn considerable national and international attention, especially over the past ten years. The Mbeki administration was notorious for its reactionary presidential stance on the link between HIV and AIDS, modelled on the position of internationally-scorned AIDS dissidents. In this time the appointment as Minister of the late Dr Manto Tshabalala-Msimang caused much criticism, as she promulgated policy positions in line with those of the President, causing the Department of Health to show poor leadership and significantly delaying action on the HIV/AIDS pandemic. The enormous complexity of this issue, evidenced by numerous articles and commentaries from both local and international academics, NGOs and the media prevents the researcher from going into greater detail, is potentially a subject for a multitude of additional theses.

Broader policies that are meant to provide a framework for more specific policies do not yet exist. For example, the Health Promoting Schools (HPS) Policy, although initiated in 2000, is still not finalised. This policy should have preceded the SHP, as school health is a sub-component of the HPS strategy. Consequently, the SHP developed in the absence of its "parent" policy. This illogical child health policy sequencing mirrors examples from the overall reform process. The National Health Act, intended to provide the legal framework for health care reform and which should have preceded all other health policy development, was only enacted nine years into the reform process.

On the one hand, these examples of illogical policy sequencing reflect the magnitude and complexity of the reform process. On the other, they reflect deficiencies in the processes and structures within which child health policy reform occurred. An important factor is poor leadership and managerial capacity, such as the post of national child health director being left unfilled for four years during the peak of the early child health policy reform period (Shung-King et al., 2000). As one highly-placed interviewee commented:

> *I have never been entirely convinced that the National Chief Directorate of Child Health has given significant, progressive leadership in terms of child health* (Senior provincial manager, Western Cape).

This lack of leadership resulted in unfettered actions by powerful individuals. The power of one individual champion directly resulted in the development of the Genetic Disorder policy ahead of other policy priorities (Personal communication).[29] In the case of the HPS policy, the responsible manager blamed competing priorities, workload pressures, a high staff turnover and a lack of leadership as reasons for the policy's delay. Another factor is the structural fragmentation of child health in the National Department of Health (Figure 2 in Chapter 1), which led to nine child health

[29] Personal Communication: Dr. Lesley Bamford, Child Health specialist, MCWH Cluster, Department of Health, January 2009; Professor David Sanders, School of Public Health, University of the Western Cape, September 2010

policies being developed in four different clusters, each with their own policy agendas.

> *I think all programs think about their programs as vertical . . . sometimes you get competition in the same unit* (Senior manager, National Department of Health)

Performance pressure on national managers in the **e**arly reform period is another factor. The production of policy became an end rather than a means, since policies were part of the expected outputs for managers.

> *. . . on a national level, policy documents had to be developed and we were involved in the process of policy development* (National SHP task team member).

The researcher's observation during the SHP process was that the child health director at the time viewed the SHP as her swan song and pushed for its development despite the absence of an overarching HPS policy. She retired soon after its release.

The drivers of child health policies

The preceding section indicates that child health policy reform was not driven by a clear strategic plan. It is important to explore then, which other drivers shaped the child policy agenda, as this helps to explain the kinds of policies that emerge. Three main drivers for child health policy emerged from the interviews: politics, power, and passion. This impression coincides with the researcher's observations during her tenure as child health policy analyst, and it also resonates with drivers identified by other policy analysts (Walt, 1994; Kingdon, 2003; Buse et al., 2005; Sabatier, 2007). Politics, as used in this chapter, alludes to those who hold political power and how this influences policy making. Walt (1994) sees health policy as synonymous with politics and explores "who influences policy making, how they exercise that influence and under what conditions" (Buse et al., p6). Buse et al. (pp21, 26) describe power in policy making "in a relational sense as having 'power over' others". They observe that power is exercised when "A has B do something which B would not have otherwise done" and "is the ability to achieve a desired outcome

irrespective of the means". They identify three dimensions of power – decision making, non-decision making and thought control – and note that it is important to understand who has power.

Passion, as a feature in the policy process, is eloquently described by Gottweis (2007, p237). He comments that policy studies frequently pay insufficient attention to phenomena such as trust, emotions, and passions, and that "many key policy decision processes seem [not] to be. . .the outcome of the application of scientific rationality. . . [and] can only be explained by the appeal and impact of the personality of a key decision-maker", to which the researcher would add "or policy implementer". From the researcher's experience with the interviewees, the enthusiasm and commitment, or despair, with which managers and service providers approach policy development and implementation featured as an important element.

What drove the Free Health Care policy was the strong political agenda of the ruling party, which at the time advocated for redistribution and equity (Republic of South Africa, 1994b). The unusually rapid turnaround time for this policy of 100 days from the inauguration of the new Government of National Unity powerfully demonstrates what is possible in a time of good political intent. In contrast the delayed PMTCT policy demonstrates the consequences of 'obstructive' political power. The foreword of the PMTCT policy refers to the Constitutional Court ruling that obliged the then Minister of Health to provide anti-retrovirals to pregnant and breast-feeding women. This came about as Thabo Mbeki, the second South African president, and his Minister of Health supported the dissident notion that HIV does not cause AIDS. This stance delayed the development of all HIV-related policies. Government released the PMTCT policy 14 years post-Apartheid and seven years after the Constitutional court ruling.

Interviewees identified the passion of individuals and organisations as important influences in child health policy reform.

> *The thing is the 'champion'. Things will move faster if you have a champion* (Senior manager, National Department of Health).

Passion coupled with the power of individuals yielded interesting vignettes for the drivers of the SHP. School health arrived on the national agenda through a policy roundtable discussion initiated by the Children's Institute[30] in 1997. Yet the process of developing a national school health policy only commenced in 2000. Three 'policy champions' accelerated the process by exercising their passion for children and school health in various ways. The appointment of a national school health manager resulted in the formation of a task team charged with developing a national SHP. Her drive went beyond work responsibility, as pressure from her local community to deliver a SHS similar to that of a neighbouring community spurred her on to initiate the development of a national policy. The next 'champion' was the Children's Institute, an academic organisation with a mandate to bring research to bear on policies and programmes for children. The researchers from the institute, who were passionate about their work for children and who initiated the first national school health discussion, subsequently engaged in active lobbying of the Department of Health during a period of dormancy from 1997 to 2000. Two researchers (including the thesis author) were co-opted onto the task team.

> *It helped a lot that there was an 'institute' involved in the policy process, because that kept it alive for the years in which it wasn't yet on the agenda . . . There was constant follow-up, and the question was being asked, 'what's happening now' . . . which stoked the embers and acted as a channel for the information to flow* (National SHP task team member)

The most powerful champion for the SHP was an influential senior national health manager with a very personal agenda. Her child was turned away from school because of an incomplete immunisation schedule, an issue that the SHS would ordinarily address. In response she instructed the national child health director to prioritise the SHP development. As recounted by a task team member:

> *there was an incident with someone at National level with their own child around a school health issue that seemed to elevate the need for a School*

[30] The Children's Institute at the University of Cape Town was formerly known as the Child Health Policy Institute (CHPI). The name change occurred midway through the SHP development process.

> *Health Policy, or put it on a National agenda more strongly. So it was a personal experience of someone at that level . . . at the end, years of work for us, trying to motivate for it and lobby for it to happen, that was the deciding factor . . . Or maybe it was a combination of things and that was one of them.* (National Policy Task Team member)

However, the absence of champions also has powerful implications in agenda setting. The National Health Council (NHC) referred to earlier only allowed one or two child health issues on their 6-weekly meeting agenda. The final approval and legitimation of the SHP by the NHC took a year as it was constantly displaced from this agenda by other issues. A National SHP task team member indicated that:

> *no-one at the NHC cares about children and neither does our senior manager. We have no-one to fight for child health* (Middle manager, National Department of Health)

Child health policy actors

The previous section mentions powerful national actors determining the child health reform agenda. A range of other actors, operating at different levels of the health system, also powerfully influence policy development. The policy triangle puts actors at the centre of the policy process as influencers of policy choices, content, and implementation (Walt & Gilson, 1994). Braveman, in her pro-equity policy framework, emphasises the inclusion of actors that will be affected *by* policy (Braveman, 1998), contending that if they participate in policy development then equity considerations are more likely to find expression in policy.

The researcher's insights on policy actors in child health reform are derived primarily from the interviews about the SHP process, as process information is limited in the other eight child health policy documents. The researcher found that child health policy development processes, certainly at the time of the SHP development, are typically top-down and centrally controlled. National officials, usually in middle or senior management positions and supported by technical task teams, lead the policy process. The SHP process involved 'actors' from several clusters in the Department of Health, ranging between national, provincial and district structures, other government

departments (Education and Social Development in particular), and certain NGOs involved with school health activities. For the remaining eight child health policies, the researcher identified the actors from the 'acknowledgement' or 'contributor' sections of the policy documents. From the documented lists of actors, it is clear that the Department of Health took an inclusive approach in policy development. For each policy process, no fewer than 20 individuals and organisations are documented as participants in the policy process. In the Youth and Adolescent Health policy process 12 government departments, 14 NGOs, 5 faith-based organisations and 2 academic institutions participated. The large number of non-governmental organisations in the Youth and Adolescent Health policy was unique, since actors came most commonly from the policy elite, holding middle and senior management positions in the National Department of Health, or from provincial and district structures. The involvement of different clusters denotes an attempt to co-ordinate child health policy issues across clusters. All nine policy processes drew on actors from sectors outside of health, thereby promoting an important inter-sectoral approach to child health policy development, given the many social determinants of child health. In the case of the SHP, having officials from education as participants in the policy development process was a recognition that implementation of the SHS takes place in the education domain.

A pertinent issue in developing countries is the involvement of international agencies in shaping country-level policies (Moyo, 2009). As pertains to child health, the two main agencies are the WHO[31] and UNICEF.[32] In South Africa these agencies participated in a number of child policy processes, thereby bringing international practices to bear on local child health policies. In the policy documents, international

[31] WHO: World Health Organisation: An agency of the United Nations responsible for co-ordinating international health activities and aiding governments in improving health services. (www.who.int/about)

[32] UNICEF: United Nations Children's Fund. An agency of the United Nations that administers programmes to aid education and child and maternal health in developing countries (www.unicef.org/about/who)

agencies are listed either as funders or technical advisors. It is difficult to establish the extent to which global agencies directly shaped these nine child health policies, but contrary to experiences in other developing countries of authoritarian international agencies (Sanders & Werner, 1997; Gilson & McIntyre, 2004; Ridde, 2006), a national manager indicated that they had ultimate discretion on whether and how to incorporate international programmes.

> *I see their role as very positive, not only financial, but technical support and sharing new concepts. I know that even when you attend international short course or meeting, they say this is how you can adopt and adapt to how it suits your country* (Middle manager, National Department of Health)

From the researcher's knowledge, at least two of the nine policies, the PMTCT policy (Guay et al, 1999; Shaffer, et al, 1999) and the infant and young child feeding policy, are directly based on international practice. The SHP was primarily shaped by local experience and insights.

The presence of academics and researchers in at least four of the nine policy processes is congruent with the international trend of bridging the research-policy gap (Chaskin and Rosenveld, 2008). This is more evident in later policies as the practice of evidence-based policy became more prominent internationally. From the researcher's own experience, as well as from opinions expressed by SHP task team members, researchers were regarded as objective technical experts who could support health officials in the policy process.

> *"At the time, because it was a given that at National level policies had to be made, they respected the opinion of the institute . . . There was research presented to them from a place they held in high esteem . . . they knew there was this organisation that could help make the policy happen, they had the resources"* (National SHP task team member)

The researchers, who had significant responsibility throughout the SHP process, found that they played multiple roles throughout the policy process. They were evidence providers, workshop facilitators, policy writers and also provided cost estimates for implementing the policy. Despite their high levels of responsibility, they

had little decision-making power, which rested solely in the hands of national health officials. When dissensions arose, the opinion and decisions of national officials held sway and this created periodic tensions. In one instance the researchers suggested that the policy process be put on hold until the relationship between the Departments of Health and Education was secured, as it compromised the development of a truly inter-sectoral policy. Department of Health officials refused, as they were under pressure to complete the policy. Consequently, any proposals that directly involved the Department of Education had to be abandoned.

> *. . . This was unfortunate because it gave an opportunity to develop something really inter-sectoral, with buy-in, but we had to kick that off the table because National Health felt we could not write anything on Education if Education was not on board . . . the lack of that good cooperation in the process at the beginning prevented us from looking at a different way of delivering the service* (National SHP task team member)

The power of national officials during the policy development phase contrasts sharply with their feelings of powerlessness in exercising implementation oversight over provinces. These federal system tensions are addressed in detail in Chapter 6.

From the researcher's participant observation status during the SHP development, she noted at provincial and district level that nurses were the dominant actors owing to their strong vested interest in school health. Two groups of nurses with different agendas participated in the nine provincial workshops (Abrahams and Shung-King, 2001a) – school health nurses from the old vertical service and primary level nurses who had nothing to do with SHS delivery at the time. In provinces where a strong vertical SHS operated, nurses invariably motivated for the retention of a vertical SHS. Their concern was the survival of the SHS, which they felt would disappear in an integrated system with many competing priorities (ibid). Other participants labelled them as 'narrow and self-serving'. The opposite viewpoint dominated in provinces with no or few 'vertical' SHS nurses. They advocated for an integrated SHS, as they felt that an exclusive group of school health nurses will not contribute to other clinic activities. The remaining workshop participants with lesser

vested interests advocated for integration, as this was the prevailing national strategy at the time. Outnumbered by other actors, the 'vertical' school health nurses capitulated. Despite their strong vested interest, they felt that they did not have sufficient power to oppose an inevitable policy choice. A policy task team member succinctly captures the nurses' dilemma:

> *The school health personnel experienced moving from a vertical to an integrated approach as a huge threat also of losing an enormous amount. So maybe in a way the model or the approach we went with in the end was, for them, a trade-off, because they had to give up continuing with the vertical approach and having a policy at the end of the day. I don't think they reached a level of being satisfied with what was proposed* (National SHP task team member)

These choices by nurses confirm the assertion that policy choices are hardly ever value free, but are invariably influenced by contexts, politics and powerful individuals (Walt, 1994: Walt & Gilson, 1994; Fischer et al., 2007; Sabatier, 2007).

Absent actors

Despite extensive consultation efforts, four sets of actors with crucial roles in the process did not actively participate in the SHP development, namely Department of Education officials, managers from the Health Promoting Schools programme, district managers and SHS recipients. The first two sets of missing actors reflect a weakness in the policy process itself and the second set of missing actors reflect a weakness of the health system at the time.

The Department of Education officials had to promote the inter-sectoral links between health and education, since the SHS is delivered to children who fall under the custodianship of the Department of Education. The Health Promoting Schools official had to facilitate the integration of the overarching HPS programme and the SHP (Abrahams & Shung-King, 2001a, Abrahams & Shung-King, 2001b). Aside from making technical contributions, they also had the additional 'political' dimension of promoting and facilitating structured relationships between school health and their programme, in the case of health promotion, and their sector in the

case of education. Despite the prominent listing of these officials as participants in various stages of the policy process, the researcher has knowledge of their minimal input into the policy process. The education and health promotion representatives attended the first task team meeting only, and were then reduced to mere token membership of the team. No clear explanations were offered for the non-participation of education officials. One possible explanation from the researcher's observation is that while Department of Health task team members had decision-making authority the representatives from the Department of Education and the Depart of Social Development held more junior positions and had to defer to their superiors in making decisions – inadvertently thwarting the original purpose of their participation. In addition, senior health officials did not support the child health managers in forging collaboration with the Department of Education – resulting in senior Department of Education officials ignoring their requests for participation in the task team. Their non-participation profoundly influenced the ability of health officials to develop a well-coordinated inter-sectoral school health policy (Abrahams & Shung-King 2001a; Abrahams & Shung-King, 2001b; Shung-King, 2006). It also impacted on implementation, as Chapter 5 demonstrates. The second researcher on the policy task team describes the situation:

> *it was so much more of a political agenda between them. There was all this kind of positioning . . . fighting over . . . territory . . . , not showing up at each other's workshops . . . It was very unfortunate in the way that it got in the way. The agendas of the two departments were so extremely close . . . they would have been able to meet both their agendas . . . I am not sure what was going on . . . the policy itself may have been so much stronger if the two departments had worked together more closely.* (National SHP task team member)

A consequence of this non-collaboration was that a potential policy strategy that integrally involved the Department of Education in the delivery and management of the SHS had to be aborted.

The Health Promotion Cluster manager indicated work pressures as her main reason for exiting from the policy process. Task team members felt that senior

managers in the Department of Health did not hold the health promotion manager accountable to the SHP process and as a result the SHP and HPS policy processes continued independently. In mitigation of these shortcomings, the SHP implementation guidelines proposed the development of structured relationships between the Departments of Health, Education and the Health Promotion Cluster as a pre-condition for the SHP implementation. The outcome of this is examined in Chapter 5.

The absence of district managers, who are crucial actors in policy implementation, was due to the immaturity of the District Health System (DHS) with poorly established district management structures. The implementation repercussions of this were significant and are examined in the chapters that follow. Task team members proffered 'logistics' and the absence of national or provincial organisations that represent SHP recipient groups as the main reasons for their exclusion from the process. Going by the equity framework of Braveman, the SHP process should not have proceeded without the involvement of the recipients of the policy, which includes children, principals, teachers and school governing bodies. Braveman contends that the omission of recipient-actors will increase the likelihood of policies not adequately considering equity. Chapter 7 shows that, indeed, child health policies did not adequately consider equity, but, as shown later, it is not appropriate to apportion the blame for this entirely to the absence of recipient-actors.

Characteristics of child health policy development

Understanding how a policy process unfolds and why certain policy positions came about provides useful insights for future policy development (Chaskin & Rosenveld, 2008; Sabatier, 2007; Walt & Gilson, 1994; Walt, 1994). Insight into the process of child health policy development is derived primarily from the SHP and its

supporting documents, as the other eight policy documents contain little process detail and do not have supporting documents that usually contain such detail.[33]

A systematic policy analysis approach

Policy makers should ideally draw on *a priori* policy theories and frameworks to guide their policy development, as this is good practice (Gilson & Raphaely, 2008). From the researcher's personal knowledge of three of the nine child health policy processes, this was not the case. This insight is confirmed by the documentary analysis, as none of the child health policy documents reported on the use of theories or frameworks that guided their development. Senior managers confirmed the absence of formal guidelines for policy development in the national health department and indicated that policy format and process is at the discretion of individuals. The national policy and planning unit that should provide such guidance does not.

> *There is no sort of formal relationship and I think their capacity is very limited. I think if you want to, you can ask them for advice but its not obligatory and I don't think they have capacity to provide much support"* (Child Health specialist, National Department of Health)

Nonetheless, all nine policy processes followed steps akin to those of the stages model of policy analysis (as outlined in Chapter 2). All policy processes started with policy initiation, the manner of which varied according to the nature of the issue. Next, policy makers engaged in rounds of consultation, following which they developed policy proposals and wrote the policy document. Policies then undergo a process of legitimation, finally ending at the NHC before they are released to provinces for implementation. While this step-wise process is not officially required in the Department of Health, it may be an implicit "way of doing things" that is passed on from one manager to another. The researcher notes that the stages policy

[33] When the researcher requested supporting documents from national health officials, documents were unavailable, non-existent, or stored in an unknown location. Officials ascribed this to high staff turnover and poor hand-over mechanisms.

process closely resembles the steps of the planning cycle, which to her knowledge[34] most managers in South Africa are familiar with. This may explain the resemblance of the policy processes to the stages model.

From the SHP experience, and as argued by policy analysts (Sabatier, 2007), the steps were not always linear, and many complex interplays took place between actors, contexts and policy development stages throughout the six year period from initiation to final policy release. For the purposes of this research, some of these steps are examined to gain better insight into child health policy development. The first step examined here is that of consultation, since the first step of policy initiation/agenda setting has already been addressed in a previous section of this chapter.

Extensive policy consultations

While child health policy reform was centrally driven, national officials always involved their provincial counterparts, thus making consultation an integral part of the policy process. According to some interviewees, the need to consult is partly driven by federalism, where national officials are obliged to consider their autonomous provincial counterparts in decisions that affect them.

> *The truth of the matter is, much as policies are supposed to be developed by the National Department of Health, we cannot independently sit in an office and decide to develop a policy which someone else must implement* (Middle manager, National Department of Health)

From the researcher's position as a South African citizen, she feels it might also be a mitigating response to the apartheid era, during which exclusion and 'voicelessness' of the majority population was the norm. Alternatively it is just good practice, as Braveman recommends, to consult with those who will be affected by the policy.

The SHP consultations were the most extensive, involving about 400 actors, and took different forms. The most prominent were the initial policy roundtable

[34] The researcher taught on three different courses involving child health managers, and other middle and senior managers from the national and all provincial Departments of Health

discussions that placed school health on the national agenda, and the nine provincial- and national workshops that shaped the policy strategies and content. These consultations served two purposes: to promote collective ownership of the SHP and to draw on insights and suggestions of actors from different levels of service provision, different components of child health services and different sectors.

> *hence we had those marathons to try engage people so that when the policy is actually finally in place, they are able to identify* (National Policy Task Team member)
>
> *It was very rewarding that it was so extensively consultative and that we actually got to speak to people who were actually working with it* (National Policy Task team member)

From the researcher's participation in the SHP process, it was clear that, beyond the consultations, the ultimate responsibility for final policy decisions rested with the National Department of Health, a power that they exercised to varying degrees, depending on the nature and circumstances of the policy issue. Interestingly, despite the intensity of the SHP consultations, the benefits appear to diminish over time and also when moving from the centre to the periphery. Nine years later a senior national health official disappointedly indicated that '*provinces were not adequately involved'*. He noted that while the legitimation of the SHP involved all provincial health ministers and heads of health departments, their decisions did not filter down to their provincial managers who had the responsibility for implementation. His view is borne out by provincial and district-level interviewees who mostly scoffed at national consultation efforts. Despite the involvement of their nursing colleagues during the SHP consultations nine years before, district officials felt that:

> *they don't consult the people on the ground who are experiencing all these things. Because even this policy, we were never consulted* (District programme manager, Eastern Cape)
>
> *did not have any contact with anyone with the school health . . . just knew that there was a policy, but I never saw it by my own naked eyes.* (Provincial School Health Co-ordinator, non-case-study province)

Managers and service providers echoed their exclusion from policy processes and indicated that they typically saw the policy only at the implementation stage. Referring to their policy experiences nurses indicate that:

> *The top brass are deciding for us what to put on the Policy* (School Health Nurse, District X, Eastern Cape)
>
> *Just stuffed down your throat. Some of them don't even get it on paper. If you don't go to P'ville (the district head office in that area) you won't know anything"* (School health nurse, District X, Free State)

The effects of this perceived lack of consultation, coupled with the absence of a facilitated hand-over process of national policy to provinces, is examined further in Chapters 5 and 6.

In contrast a senior manager regarded consultations as useless unless those being consulted can meaningfully contribute to the policy content. He expressed weariness with the practice of extensive consultation with colleagues at lower levels in the system:

> *the one thing we're very good at in this country is in consultative policy formulation. Actually, exhaustingly so. Provinces and Districts get exhaustively consulted. Whether they participate, is a different issue. . .* (Senior Provincial Manager, Western Cape)

Child health policies have reasonable evidence bases

In the SHP process, harnessing evidence on service delivery models relevant to the South African situation was challenging. A policy task team member recalled:

> *the international evidence was always tricky in view of our different circumstances, applying things here and resource differences, but I think I was very satisfied that the consultations provided us with so much information of what was going on* (National School Health Policy Task Team member)

The review of local literature did not produce adequate information on the implementation context for the new SHS, such as health service capacity and available staffing. This information was derived from participants during the

provincial workshops, highlighting the potential value of consultations. A task team member confirmed this:

> *Even if there were gaps in that, I think I was very happy with the evidence we got from the consultations. For me, that almost was what mattered more, because it was for them that we were gathering information from them* (National Policy Task team member)

The quantity and quality of the evidence used to inform policy, as determined by the list of references in the nine child health policy documents, varied and seem to depend on the presence of academics and researchers in the process. Policy documents such as those for the SHP and PMTCT policy, developed by task teams that had a presence of academics, had long lists of peer-reviewed articles that informed policy content. This was not the case for task teams that primarily involved health officials such as the team for the child and mental health policy guidelines, indicating the value of cross-pollination between academia and government.

How SHP choices were shaped

From the supporting documents on the SHP, it is evident that three policy options, pre-determined by the SHP task team, shaped the debates on the SHP. (Abrahams & Shung-King, 2001a; Abrahams & Shung-King, 2001b). Policy options were derived from recommendations from the initial national policy roundtable, together with insights and experiences of task team members. The first option proposed the integration of the SHS into district-level PHC services, in keeping with the overall Department of Health goal of integration of PHC services. Integrated services were to be delivered, resourced and managed through district health facilities. The second option recommended the retention of the vertical SHS. The third option advocated for the abolition of the SHS; some task team members felt that it was worthy of consideration in the face of many competing priorities and resource constraints. A fourth option of a SHS integrally linked to existing Department of Education activities was abolished, for reasons explained in the section on ‘actors’.

The no-service option was summarily rejected by policy actors. From the researcher's vantage point, this appeared to be due partly to the perceived need for a SHS, but partly also to the difficulty of making decisions to abolish or defer health activities. The norm at the time was to try and cover every possible aspect of health, despite formidable obstacles. A national interviewee concurred with this, and indicated that "no-one ever wants to say no." The final policy option was shaped by a combination of factors: a health system that advocated integration over 'verticalisation'; vocal provincial and district policy actors – especially general primary health care nurses who favoured integration; and a general reluctance by policy makers to possibly defer a necessary, but potentially ill-timed national policy. So in the case of the SHP, policy choices were shaped mostly by local context and actors, rather than by evidence.

Child health policy features and content implications for child health service provision

Features of policy documents

Policy content directly influences health service structure and functioning and therefore merits deeper analysis (Walt & Gilson, 1994). The researcher identified common themes and features across the nine policies that had implications for child health service development.

Firstly, despite all nine child health policies being labelled as national policy, the documents vary considerably in intent, type of content, size of the evidence base, and editorial quality. There are many ways to define a policy, a policy guideline, a programme or a protocol (Walt, 1994, Buse et al., 2007), but regardless of the absence of international definitional consensus, internal organisational consistency is important to avoid ambiguity and confusion. A quick review of UK child health policy documents reveals a consistent approach to the categorisation and presentation of policy documents (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance). This internal consistency was not present in South African child health policies.

> *It is a very grey area. A policy can mean many sorts of things. I am not aware of any degree of clarity regarding that* (Child Health Specialist, National Department of Health)

> *There's still a lot of grey area between what is a policy, what is a protocol and what is guidelines* (Middle manager, Free State)

Four different kinds of child health policy documents exist: three are labelled as 'policy', three as 'policy guidelines', two as 'policy with implementation guidelines', and the Free Health Care policy is a Government Gazette Notice. In general, documents labelled as 'policy' contain definitive policy positions with clear guidance on what the policy requires. The 'policies with implementation guidelines', namely the School Health and PMTCT policy documents, go further and provide a detailed set of options to guide provincial implementation plans. The documents labelled as 'policy guidelines' provide a wide range of policy options, with no indication of which are preferable or mandatory. These documents explicitly require the development of province-specific policies based on the guidelines. The two documents that best exemplify this approach are the Youth and Adolescent Health and Child and Adolescent Mental Health policy guidelines. The Adolescent Mental Health policy guidelines are described as:

> a framework to assist health care professionals at all levels. . . . .devise integrative strategies for providing mental health services to children and adolescents (Department of Health, 2000c)

A National Health official gives the following rationale for policy guidelines:

> *you needed policy guidelines so that provinces could do their own policy because each province was slightly different. So you then actually provided them with a broad policy guideline* (National Policy Task Team member)

Yet there is no evident process by which the National Department of Health decides which areas of child health warrant 'policy guidelines' rather than 'policies'.

> *Every Committee that was appointed to develop policies or develop policy guidelines or to develop programs had their own criteria almost. There wasn't set criteria that laid down exactly how it had to be done* (National Policy Task Team member)

From the documents, it appears as if single, more specific issues such as PMTCT or School Health become policy, whilst broad areas of child health that cover a wide spectrum of child groups and multiple interventions such as for youth and adolescent health, become policy guidelines.

Having national policy documents with such different intentions has fundamental implications for implementation. For example, the "policy guideline approach" presupposes that provincial health officials have the capacity to develop province-specific policies. However, a scan of provincial Department of Health websites by the researcher revealed an absence of province-specific policies for Youth and Adolescent Health and Child and Adolescent Mental Health. Provincial school health co-ordinators cited limited capacity and vagueness of the policy guidelines as the reasons behind this.

The structure and quality of policy documents also differ. For example, the Child and Adolescent Mental Health policy is poorly written with many spelling and grammatical errors and only six non-peer-reviewed references. The PMTCT policy and implementation guidelines are well-written, easy to navigate, and with robust evidence to support the content. Presenting policy documents of good quality is important, as it influences how front-line workers engage with and implement them.

> *They must introduce a policy or a guideline when they give it to us . . . there are so many problems reading that document . . . doesn't take you a day, it's a thick document . . . Maybe condense a certain part to say this is how you. .*
> (Facility manager, Eastern Cape)

The differences in quality of policy documents reflect the varying capacity of national officials to draft, or oversee the drafting of, good policy documents. The oscillation between 'policy' and 'policy guidelines' hints at confusion amongst national officials about how prescriptive their policies should be and how much autonomy provinces should have in developing province-specific child health policies. Chapter 6 further explores these implications.

Policy implications for child health service structure and provision

Eight of the nine child health policies predominantly promote traditional facility-based services that only benefit children who are able to get to health services. This is contrary to the reform principles that advocate for a combination of community- and facility-based services, particularly to address the needs of children living in poverty and who have poor access to health care. Child health policy documents do not indicate how health services would meet the needs of these children. Although the SHP promotes a community-based school health service, it also does not cater for children who are not in school.

In keeping with the national goal, all policies advocate for the integration of child health services. This means that a single district team manages and provides child health services. Inadvertently the nine policies required many new and revised responsibilities of front-line health workers, in particular nurses. Each policy document has long lists of required activities. This presupposed that health facilities are fully functional, have maximum staff capacity and that staff have the range of skills required by these policies. The insufficient attention to the implementation context during the policy-making processes had many negative unintended consequences, which are examined in detail in Chapters 5 and 6.

> *the big problem with these policies and programs and everything is that they do not even assess the situation on the ground before. .It doesn't matter whether there's skilled staff or enough staff, we must just do it."* (Clinic manager, Urban sub-district, Eastern Cape)

> *. . . it was grand policy making . . . It wasn't implementation. People were saying "you keep telling us about health system, tell us what is going on in the district" . . . We were talking about governance . . . they kept on reminding us that we needed to worry about implementation. We were so obsessed with governance issues and boundaries and what not, we forgot about what is going on out there . . . I think it has come back to haunt us.* (Deputy Director General, National Department of Health)

Lack of co-ordination of the multiple activities required by national policies resulted, for example, in multiple demands on nurses.

> *When we came into Government in 1994, 1995, 1996, we were all enthusiastic about our little programs. So every program wanted to have a policy and a strategy of their own.* (Deputy Director General, National Department of Health)

Despite the emphasis on inter-sectoral collaboration in overarching and child health policy documents, in their content they exclusively focus on health service interventions as a means of addressing child health problems. This might have its genesis in the same difficulties as experienced in the SHP process, where inadequate interactions between health and other sectors disenables the health sector to make policy proposals that require the active participation of other sectors. The SHP tried to remedy this by stipulating the need for a formalised relationship between the Departments of Health and Education as a specific implementation requirement.

Discussion

Child health policy development in South Africa occurred as part of a prolific policy development period in the health sector, during which children were given high political priority and inalienable health rights. In particular, addressing past inequities in child health status and service provision was a primary health reform goal.

The policy triangle framework suggests that successful development of policies depends on alignment of political goals, involvement of appropriate policy actors, a robust policy process, and evidence-based policy choices (Walt & Gilson, 1994). Furthermore, good practice is the development of timely, evidence-based and equity-orientated policies, especially in developing-country contexts where significant disparities in health care exist (Braveman, 1998; Sabatier, 2007; Petticrew et al., 2004; Walt & Gilson, 1994; Gilson, 1984). South African child health policy development, whilst displaying some elements of good practice, also had many deficiencies.

This analysis of child health policies reveals that despite the favourable post-apartheid political environment, child health policy makers in the Department of Health only partially capitalised on the opportunity to develop new, equity-orientated

child health policies. Consequently, amidst important advances made in South African child health policy reform, many gaps, missed opportunities and contradictory policy actions occurred. The research findings indicate that some of these consequences were avoidable through good leadership and strong, co-ordinated institutional structures. The South African child health policy development also confirms that, policy development, at the best of times, is a complex and difficult task (Lindblom, 1959).

Amongst the factors that influenced child health policy development, macro-politics (i.e. politics at the ministerial level and upper echelons of the Department of Health) played a significant role. This 15-year reform period spans three different political administrations, with each one having influenced child health policy development in different ways. As shown, the continuity in prioritising child health issues, and the momentum of the policy reform process, varied between administrations. This emphasises the pivotal influence of politics on health care reform. The Free Health Care policy during the first administration is evidence of how, during a time of peak political energy, the windows of opportunity for developing appropriate timely policies are immense. In contrast, during the second political administration, the delay in finalising the PMTCT policy demonstrates the powerful impact of obstructive political will (Schneider & Stein, 2001). At the time of this research, a third political administration had come into power in 2009. The focus of the new Zuma administration appears to be 'delivery' and efforts to address the factors that contribute to poor delivery of social services are underway (Development Bank of South Africa, 2008; Harrison, 2009). In a news article headlined "Dysfunctional policies have to go" President Zuma indicated that:

> The African National Congress's election manifesto will introduce policy changes while tightening functional ones. . . continue those practices that have been successful . . . change those that have not worked well in the implementation of our policies. Transformation in the fields of . . . health was imminent. (http://www.inet.co.zahttp://www.inet.co.za, 11/27/2008)

Consequently, since the appointment of a new Minister of Health in 2009, a renewed phase of major policy reform is underway. Already three of the policies reviewed in

this chapter, including the SHP, are being revised with the aim of improving implementation (Personal communication, Professor Alan Flischer, January 2009; Dr Lesley Bamford, January 2009; Ms Ray Mohlabi, June 2010).[35]Lessons from the first wave of child health policy reform can therefore inform these new developments.

Lessons from other Southern African policy experiences may also inform these new policy developments in South Africa. From their experience with policy development in South Africa and Zambia, Gilson et al. (2003) conclude that technical policy analysts must take cognisance of the political contexts and politicians must take cognisance of technical expertise. In the South African child health policy processes, child health policy makers did not successfully translate the 'political' goals of health system reform into the content of child health policies; for example the key political goal of equity received only superficial attention in child health policy documents. In turn, policy makers did not always make use of available technical expertise in academic institutions to develop the best possible evidence-based policy documents, such as shown in the Child and Adolescent Mental Health policy.

In addition to the key role of politics, the issues of 'power' and 'passion' in child health policy development featured strongly. Power, in the case of child health policy development, was not confined to those in the policy elite group, but also manifested in overt and covert ways throughout all levels of the system. This included the obstructive power of those who refused to participate in the SHP process and the enabling power of those who clearly wanted to see the SHP come to fruition. Passion, whether exercised for individual gain, such as the case of the DDG whose child was turned away, or for the greater good, such as nurses who compromised their own positions for the benefit of the SHS, featured prominently. In addition to the influence of macro-politics and politicians, this chapter demonstrates the powerful effect of other actors, such as academics, health officials and even the non-participating

[35] Personal Communication: Professor Flischer, University of Cape Town, January 2009; Dr. Bamford, National Department of Health, January, 2009; Ms Mohlabi, National Department of Health, June, 2010

education officials, in shaping the direction and content of policies. Getting the right actors in the policy room and ensuring good sustained relationships between key actors are two important lessons. Also, as per the advice proffered by Braveman (1998), ensuring the participation of those most affected by policy, which was not the case in the SHP development process, might better facilitate pro-equity policies.

Examining the role of actors and policy champions through the SHP lens yielded interesting insights. Firstly, that the listing of actors in a policy documents does not necessarily imply their active participation in the policy process. Conclusions on the role, contribution and power of actors can thus not be drawn from documents alone, but require interrogation of additional information sources. Secondly, that the power of non-participating key stakeholders has as profound an impact on policy decisions and policy direction as that of actively participating actors. This is borne out in the effect of the non-participating education officials on the policy choices of the SHP and bears out the points raised by Buse et al. (2007) that power amongst actors take different forms. The absence of key actors also profoundly influences the process, especially those who have a significant role in implementation or for whom the policy is intended, such as is the case with district managers and the SHS recipients. This is further explored in Chapters 5 and 6. It suffices to say here that it highlights the need for a carefully facilitated process when translating national policy into provincial implementation plans. If this is done, then there will be room for remedial action of deficiencies that occurred during the policy development process.

This analysis further demonstrates that whilst the process of policy development for children and adults follow the same 'technical' pathways, children do require special consideration in health reform. One of the issues highlighted by this research is that policies for children should not be subjected to the same lengthy processes as is normally the case in policy development. Children's physical vulnerability demands faster action. Such long delays may prove fatal to children, as the window to intervene and avert mortality is much smaller for children than adults. HIV is a quintessential example, where adults take approximately ten years to progress from HIV infection to

AIDS, whilst it takes two years for children in resource-poor settings to progress from HIV infection to death (Osmond, 1998; Kozinets, 2001). The delay in releasing the PMTCT policy resulted in thousands of child HIV infections and subsequent deaths (Actuarial Society of South Africa, 2005; Bradshaw et al. 2003; Bradshaw & Nannan, 2006). This viewpoint is reiterated by international child health policy analysts as they call for the prioritisation of children, especially in periods of major health reform (Perdahl et al, 2010; Wise, 2010; Russ et al, 2010; O'Dowd, 2011). The nine child health policies generally took five to ten years from initiation to completion, similar to the period estimated by Sabatier (2007, p3). The prominent political priority granted to child health on the one hand, and the lack of urgency in the completion of child health policies on the other, indicates a mismatch between political rhetoric and the executive practices of the Department of Health. This is possibly one of the primary reasons why child health policies have not impacted on child health outcomes as intended.

Like many other South African health policy processes, child health also experienced the effects of weak institutional capacities where policies were either poorly developed or poorly co-ordinated, and with no clear strategic framework to guide their development (Gilson et al., 2003; Gilson et al., 2006; Draper et al., 2009;). O'Dowd (2011) cautions in particular against fragmentation and poor co-ordination of child health services through poor policy co-ordination. He argues that this heightens the vulnerability of children, since their health needs, more so than those of adults, require an integrated approach. Their different stages of development are a continuum, and service continuity and co-ordination between different service providers and between health and other social sectors is critical (Westwood & Shung-King, 2010).

An important contributory factor in the delay or neglect of some of the child health policies is the National Department of Health practice of developing guidelines rather than more definitive policy. While this approach respects provincial autonomy, it also reflects the tentativeness of national level officials in their policy-making roles.

As shown in the case of the Youth and Adolescent Health policy and Child and Adolescent Mental Health policy, broad national guidelines place too much responsibility on capacity-poor provinces, with the consequence that provinces neglect to develop province-specific policies for these important areas of child health. In the case of the Youth and Adolescent Health policy, development of a new policy, expected to be more specific and prescriptive for provinces, was commissioned by the National Department of Health (personal communication, Scott Burnett, Director of Youth Friendly Services, loveLife, 28 October 2011). This situation is not unique to child health. The Mental Health Policy for adults suffered a similar fate. In an article reflecting on why this policy had not performed as intended, the researchers indicate that:

> there is uncertainty at provincial level regarding whether the 1997 policy guidelines should be considered national policy. At national level the guidelines is not considered as policy and a new policy is currently being developed. (Draper et al., 2010)

Considering the high volume of policies developed in the post-apartheid period, it is reassuring to note that most child health policy processes were systematic and thorough, and displayed some characteristics of good practice when measured against recognised policy models such as the stages framework. This demonstrates good intuition on the part of policy makers who had little or no formal policy analysis training (personal knowledge of researcher as member of SHP task team). Policy processes also strove to be evidence-based. The participation of academics and researchers helped to bridge the research-policy gap, as also shown in experiences with child policy development elsewhere (Chaskin & Rosenfeld, 2008).

Despite credible policy development processes, the content of child health policies had fundamental shortcomings. The intention of child health policies should be to promote child health services that could ameliorate the many and varied health challenges faced by South African children. Yet the child health services promoted through child health policy documents at times contradict the principles espoused in the overarching policy documents that guided overall health care reform. For

example, despite the strong emphasis on community-based care in the PHC approach, child health policies predominantly promote facility-based health services that place the onus of obtaining health care entirely on users (Shung-King et al., 2005; Leatt, 2006). Consequently those most disadvantaged through poor socioeconomic conditions and inaccessible geographical terrains are in the same position of poor service access today as during the apartheid era. This exposes a disjuncture in the policy-making process between systemic health system aspirations and micro-policy strategies and reflects the absence of clear strategic guidelines and policy co-ordination mechanisms. The predominantly universal approach of child health policies and its implications for reducing inequities in child health service provision is explored further in Chapter 7.

In conclusion, the translation of political intentions into good quality, equity-orientated child health policies did not materialise as envisaged in the original health care reform goals. This was despite policies addressing important child health issues and displaying features of good policy practice. A lack of leadership, weak institutional capacities and confusing institutional arrangements within the Department of Health and between health and other sectors are possible explanations for poor policy development. As is the case with many other international policy processes, this chapter also clearly illustrates the seemingly inescapable role of politics, power and passion both in promoting and obstructing policy.

Chapter 5: Implementation of the National School Health Policy

Introduction

Following on from the examination of the process of child health policy development in the previous chapter, this chapter and the next now focuses on implementation as the crucial final component in the policy trajectory. Chapter 5 examines the implementation outputs of the School Health Policy (SHP), including coverage and quality of the school health service (SHS), and seeks in particular to determine whether greater equity in SHS provision was achieved. Chapter 6 follows on and looks to see why these SHP outputs occurred as they did.

Contemporary policy analysis theories plainly indicate that implementation is an integral part of the policy process and that actions and decisions during the policy development process influence policy implementation (Hill & Hupe, 2002; Gilson et al., 2003; Gilson et al., 2006; Fischer et al., 2007; Dye, 2007; Sabatier, 2007). Importantly, analysts caution that initial policy intentions may not be implemented as envisaged if attention is not paid to the requirements for translating policy to implementation (ibid). In general, the policy development process shifts from official policy-making bodies to executive departments for the development of implementation plans, and finally to front-line service providers for implementation (Dye, 2007). In South Africa the National Department of Health is primarily responsible for the development of national child health policies through the MCWH cluster whilst provinces, through equivalent structures, are responsible for implementation. The ultimate implementation occurs within health districts, which fall under the jurisdiction of provinces.

Theories on policy implementation espouse two distinct approaches: top-down and bottom-up (Sabatier, 2007; Hudson & Lowe, 2004; Elmore, 1978; Lipsky, 1980). The top-down approach operates when central actors who make policy instruct local level implementers on what to do and how to do it without taking their views into

account either during policy formulation or during the preparation for implementation. The bottom-up approach operates when local level implementers are integrally involved in crafting polices that shape implementation and then in the development of implementation plans. The two approaches may operate in unison, with different emphases at different stages of implementation. It is important therefore to give due consideration to the insights and perceptions of both central and local actors when exploring implementation issues. This research considered both the 'top-end' of implementation – meaning how the policy process itself impacted on implementation – and the 'bottom-end' – meaning what happened at local level. It also considered whether there was a policy translation process that occurred before implementation began.

The SHP process, as described in Chapter 4, whilst driven from the top, took great care in providing forums for 400 provincial and district-level actors to give input into the content of the policy. Several years later, however, local level actors were as disgruntled about their exclusion from the policy process as if the consultations had not taken place. The conclusion that the researcher came to was that a policy translation process, in preparation for implementation and with the participation of district actors, might have obviated these perceptions. The implementation of the SHP, in sharp contrast to the widely consultative policy development process, was essentially top-down, with little consideration of the capacity, perceptions and insights of district-level managers and service providers. This resulted in significant gaps and weaknesses in the policy implementation phase, as this chapter demonstrates.

In its examination of SHP implementation the research considered the views of the policy elite at national level, of provincial health officials, and of district-level managers and nurses. Given the continuum of the policy process, it also explored the links between SHP development and its implementation. This chapter examines the coverage[36] of the school health service (SHS), the SHP implementation models that

[36] Coverage is a commonly used term in the health sector. It refers to the extent to which a service provides the required "quantity" of service provision that it is scheduled for. For example, immunisation coverage refers to the number of children that were immunised, as a proportion of the

evolved across research areas, whether and how the integration of the previously vertical school health service (SHS) evolved, how inter-sectoral collaboration manifested locally, and how the predominant curative facility-based paradigm of health services impacted on the delivery of a preventative community-based service. It also identifies some explanatory factors for implementation performance. Given the top-down implementation approach, the chapter also examines how nurses as 'street-level bureaucrats' shaped the SHP implementation (Lipsky, 1980).

The content and requirements of the SHS package of care

The SHP determined that all school-going children will be beneficiaries of the School Health Service (Department of Health, 2003a). The SHS is a preventative and health promotion intervention, and in its construction it embodies many of the elements of the Primary Health Care (PHC) approach.[37] It is community-based, in the sense that nurses visit children in schools, rather than children having to visit health care facilities for this service.

The SHP has three key goals:

- Integration of the previously vertical SHS. This means that the staffing, management and resources for the SHS, together with all other primary level health service interventions, are under the jurisdiction of a single district-based management team.
- Delivery of a standardised SHS across the country, meaning that the service components and instruments, such as routine data collection forms, of the school

total number of children that should have been immunised. School health coverage, is measured at different degrees of aggregation. The indicator used nationally refers to the number of districts that have a school health service as a proportion of the total number of districts. It can also be calculated as the proportion of schools that have received the SHS as a proportion of all schools that should have received a SHS. Similarly for pupil coverage, which refers to the number of pupils that received the SHS against the total number of pupils that should have received it.

[37] As indicated in Chapter 4, the PHC approach was the health care philosophy that underpinned the health care reform process.

health service had to be the same in all districts[38]. The SHP implementation guidelines detail what these service components and instruments are.

- Delivery of an equitable SHS across the country. This meant that a service of comparable quality had to be provided to all children, regardless of their race, socioeconomic status or geographical location.

The SHS has two essential components in its package of care: a health assessment of children in their first year of primary school; and health promotion activities for all pupils in primary and secondary school (Department of Health, 2003a). The health assessment component is divided into three phases and formed the core initial mandate for the SHS delivery. Phase one involved the delivery of a core set of activities including vision, hearing and oral health screening. Phase one activities were to be administered to every Grade 1 (or Grade R[39]) pupil by 2006. Then, as capacity allowed, activities in Phases two[40] and three[41] were to be added. At the time of this research, administration of a tetanus and diphtheria vaccine, to children at age 6 and 11, was also added to the SHS package. When health problems are identified, the SHP requires that children are referred to the relevant services. For general health problems, they are referred to clinics, and for specialist problems, referrals are to services such as dentistry and optometry.

The health promotion component includes a wide range of activities, ranging from health talks, special workshops, curriculum-linked health promotion and first aid activities with teachers (ibid). These activities have to be delivered age-appropriately

[38] As indicated in Chapter 4, the main problems with the vertical SHS were that each area and province delivered a different set of activities in a different manner.

[39] Grade R is the Reception year and refers to the year before children enter Grade 1. Some schools have a reception year and others do not. Where schools have a reception year, the health assessment is done on those children, as well as Grade 1 children who entered the school for the first time. Grade R is not yet compulsory in South Africa, thus not all children attend the reception year.

[40] Phase two activities primarily involve an oral health assessment.

[41] Phase three activities include: a mental health assessment, where required (which includes addressing issues of child abuse and injuries, beyond the obvious identification and referral that might manifest during a Phase one assessment); a more sophisticated hearing assessment than that of Phase one; a full physical examination beyond the hearing and eye test; weighing and measuring; and a quick and crude examination for obvious physical disabilities.

to children from Grade 1 to Grade 12. Health promotion activities require co-ordination with the Department of Education, as a number of policies and programmes in education also have health foci. For example, a specific subject called 'life orientation' includes a number of health topics and forms part of the curriculum in primary and secondary schools. Health promotion activities also require a close collaboration with the broader Health Promoting Schools programme, as the school health activities form a subset of the broader HPS strategy. Districts had to deliver the SHS within their allocated district budgets since neither the national nor provincial Departments of Health provided additional funding for SHS delivery.

Importantly, the findings indicate that most research areas had not yet implemented Phases two and three, hence the results in this chapter relate primarily to the implementation of Phase 1 of the SHS.

Coverage of the SHS

According to Braveman (1998) in her equity-orientated policy development model, collecting accurate data about service provision and health outcomes at various phases of the policy process, including at implementation, is crucial in planning for the elimination of inequity and for monitoring whether equity has been achieved. Health service coverage is a commonly used measure of the progress with health service provision. Coverage of a health intervention essentially refers to the proportion of individuals or service units that receive the intended intervention, against the total number that should be receiving the intervention (ibid). Coverage is typically measured through routine health service data, and collecting this data for the SHS was therefore important.

The SHP proposes different indicators for SHS coverage for different levels of management, and it gets more specific and detailed when moving from national to district level. At national level, the indicator used to monitor progress with the SHS implementation coverage is aggregated to "the percentage of districts with a fully functioning SHS" (Department of Health, 2003a, p14). Using this indicator as a measure and based on the implementation progress in provinces, a fully-functioning

SHS at the time of this research referred to the full implementation of Phase 1 (i.e., the health assessment part of the SHS package). The initial target set by the National Department of Health was that Phase 1 of the health assessment package had to be implemented in 100% of districts by the end of 2007.[42]

Based on this indicator, the 2006/7 and 2007/8 Department of Health annual reports cited a SHS district coverage across the country of 94% and 100% respectively (Department of Health, 2006; Department of Health, 2007a). This simply meant that the SHS existed in every district of the country, but this indicator does not reflect how many schools in the district received the SHS or how many Grade 1 pupils in schools received the Phase 1 assessment. This research examined what this national level statistic meant in the three case-study provinces.

How soon after the release of the national policy did implementation begin?

The researcher established how prompt provinces had been in the implementation of the SHP following its release in 2003. This gave an indication of how prepared provinces were to respond to the requirements of the SHP. She found that the implementation timeframes for the SHS varied greatly across provinces and between districts and sub-districts of the same province. This reflected the differing capacities of provinces and districts to respond promptly to the national SHP. In the urban district of the Western Cape, the SHS continued uninterrupted from the apartheid era. It only altered in management and specific activities following the SHP release. In the three rural districts of the Western Cape, the director in charge of rural districts at the time questioned the importance of the SHS and suspended it in 1995. Several interviewees referred to this situation and the manager, who had since been promoted, readily acknowledged his own cynicism about school health. This reflects the impact of powerful actors on service provision, with the oppositional senior

[42] Interviews took place in January and February 2009, a year after the deadline for reaching the initial Phase one target and a year after the DOH annual report indicated a 100% coverage of phase one of the SHS.

manager single-handedly dismantling the SHS in the rural districts. The SHS therefore had to be re-established in the three rural districts with the advent of the national SHP. Even within the same district, capacities to initiate the SHS differed substantially. In one of the rural districts, two adjacent sub-districts commenced the service in 2003 and 2006 respectively. By 2009 the remaining two rural districts still had many areas without a SHS. This situation in Western Cape reflects the typical urban-rural bias in service delivery and at the same time illustrates the difficulties of re-establishing a service after it is disbanded.

In the Free State province, the SHS had been suspended for eight years prior to the release of the policy and had to be re-established. In this province the service is almost non-existent in urban and rural areas alike, with only pockets of SHS provision within each district. In one of the rural research sites the SHS was initiated in 2006 and collapsed again in 2007. Bloemfontein, with the largest proportion of the provincial population, has a very limited service. Eastern Cape resembles the Free State in that only a few areas have a consistent service. Interestingly, Eastern Cape rural areas appear to perform better than their urban counterparts in that all the rural research sites were at least actively attempting to establish a service.

A similar situation to that in the Free State and Eastern Cape emerged from interviews with the school health co-ordinators in five of the six non-case-study provinces. The co-ordinators cited many challenges in setting up the SHS and, in four of the six provinces, were still largely unsuccessful. Two of the larger and better resourced provinces had retained a number of nurses from the previous vertical service and that allowed the SHS to continue in the majority of sub-districts of these two provinces. The sixth province did not have a SHS or provincial school health co-ordinator at all.

SHS coverage across research sites

Despite the 100% district coverage reported by the National Department of Health, the poor quality of SHS data made it difficult to determine coverage levels in research sites. None of the research sites had consistent, complete or reliable coverage

data. The best available information came from nurses, who kept their own records on the number of schools they covered in their area. Coverage at this level meant the number of schools that nurses reached with the SHS, set against the total number of schools that they were responsible for. Individual pupil coverage could not be determined, as this level of data does not exist. Nurses simply had the number of pupils they had assessed, with no denominator data. Some only kept a record of the pupils who were identified with problems. The nurses' accounts revealed that, in the districts where a SHS was provided, coverage levels varied substantially (Table 9). From the nurses' accounts, most schools receive Phase one of the SHS biennially at best. In the Free State, the manager responsible for the SHS indicated that only 45% of sub-districts had an operating SHS. On average, in the Free State and Eastern Cape the SHS is delivered at a frequency of once every three to five years and in some instances the projected frequency of visits to each school goes beyond ten years. In a few notable exceptions nurses managed to cover 100% of the schools in their area, but this was limited to small geographic areas with a small number of schools. The following comment is typical of responses from the nurses:

> *I've got plus minus 70 or 60 schools but I've only covered 20 since 2005. (Nurse, Rural sub-district Eastern Cape)*

Aside from the nurse's uncertainty on the exact number of schools she is responsible for, based on her current rate of service delivery it will take 12 to 14 years to reach each school at least once a year. This translates into an annual coverage rate of less than 10%. It means that in more than 50 schools Grade 1 pupils will not receive the service in any given year. Similarly in a city-based sub-district of the Free State, where one school health nurse is responsible for close to 400 schools, it will take more than ten years to visit each school once.

> *So in reality it's . . . 372 schools. Actually . . . it will take a few years to just go to each school once if nothing changes . . .* (Sub-district School Health co-ordinator, Urban area, Free State)

Nurses also pointed out that 100% school coverage does not mean 100% coverage of all pupils, because not all schools receive a follow-up visit and those who are absent on the day of the SHS provision are not revisited.

Differences in SHS coverage manifest at clinic level as well. In a rural area of the Eastern Cape two nurses work alongside one another. The one is responsible for 132 schools and the other for 140. They covered 47 and 6 schools respectively in one year, translating into coverage rates of 35% and 4%. This indicates the dependence of the SHS on individual capacities and performance. In an adjacent rural district, the school health nurse who is solely allocated to the SHS attained 100% coverage of her 26 schools. She also conducts a follow-up visit to each school within the same year. Her colleague in a nearby urban town, who provides the SHS as one of several other responsibilities, was unable to cover the eight schools in her area. Their counterpart who was responsible for most of the schools in the urban town decided to leave the SHS without informing her managers, as she felt that the service was not achieving anything. At the time of her interview, which was two months after her departure, she had yet to inform her managers. Explanations for these varied performances in seemingly similarly-resourced areas are explored in chapter 6.

...../Table 9

Table 9: Nurses' accounts of SHS coverage across research sites

District	Sub-district	Geographic location & socioeconomic status	MDI*	Schools per nurse§	Estimated coverage per year
WESTERN CAPE					
Metro district	Research area 1 (MP)	Urban -poor	5		100% coverage, with some follow-up visits where problems have been identified
	Research area 2 (G)	Urban – poor and middle-class mixed	5	9, 17 and 23 schools respectively for each of three nurses	100% coverage, but not always able to do follow-up visits
	Research area 3 (L)	Urban – largely poor, with few middle-class	5		100% coverage, with some follow-up
	Research area 4 (A)	Urban – largely poor, with few middle-class residents, with large informal settlements on fringes	5	33 schools between two nurses	100% coverage with follow-up visits, more at some schools than others
Rural 1	West-Coast	Rural and poor	5	17–30 schools per nurse	100% coverage, with some follow-up with mobile clinics
Rural 2	Southern Cape	Mixture of urban towns and rural areas			100% coverage with follow-up visits where required
FREE STATE					
Motheo	Research area 1(BF)	Urban city	3	372 schools with one nurse	Estimated frequency of school visit at current staffing level: once every 5 years. At time of research, average coverage levels per school close to zero
	Research area 2(B)	Rural – poor and middle-class mixed		No school health service	No coverage
	Research area 3(A)	Deep rural-poor		5 schools with one nurse	Once annually, with follow-up visits. 100% coverage
Lejwele-putsha	Research area 1	Mix of towns and rural areas	4	435 schools with 2 nurses	Less than 10% estimated coverage
EASTERN CAPE					
Amatole	Research area 1(K)	Mix of rural areas and small towns, service population largely poor	2	40–70 schools per nurse	Coverage of 10%–50%. Higher nurse to school ratio produces greater coverage
	Research area 2(B)	Mostly rural and deep rural	2	140 and 132 schools respectively	Coverage of 4% and 35% respectively with almost no follow-up
Chris Hani	Research area 1 (S)	Rural -poor	1	One nurse with 26 schools	100% coverage, with a 6-monthly follow-up visit to each school
	Research area 2 (Q)	Urban town-service population mix of middle-class and poor	1	15 schools with no allocated nurses	No coverage
	Research area 3 (E)	Peri-urban area-poor	1	10 schools, with one nurse allocated on rotational basis	100% coverage, with some follow-up visits to each school

Source: Generated by researcher

*Multiple Deprivation Index ranking of districts[43]

§Expressed as a range where there is more than one nurse

[43] Ranking scale: 1= most deprived and 5=least deprived. Note that the ranking reflects the average for the district. Individual sub-districts within districts might be ranked lower or higher than the district average, but the Multiple Deprivation Index rankings do not yet extend down to sub-district level.

Transport dependence of the SHS and its impact on coverage

Transport emerged as one of the support systems that significantly influence SHS coverage. Unhappiness with their allocated transport dominated in the interviews with nurses. Adequate transport for nurses to travel from clinics to schools is critical in rural areas especially, where distances are great and robust vehicles are indispensable for poor quality roads in mountainous terrain. Availability of vehicles varies between research sites. About half of all nurses/school health teams have a vehicle allocated solely for their use. In the aforementioned rural site in Eastern Cape, the two nurses working alongside one another have differential access to transport which contributes significantly to the differences in their performance. The one responsible for 132 schools has a vehicle allocated solely for his use. He knows the transport manager well and indicated that this was the deciding factor in allocation of the vehicle:

> *if you want to reach a school you don't have to go and ask somebody for the transport. You just take the car and go there* (Nurse, Rural sub-district, Eastern Cape)

His colleague, who is responsible for 140 schools, is facility-bound for weeks at a time because of transport unavailability.

> *I'm having the challenges of transport . . . We rarely got transport to go to school. Like last year I think I only visited six schools out of 140. So you see, I don't enjoy doing school health services, because of transport. You want to go and work but there is no way, so it's discouraging a lot* (Nurse, Rural sub-district, Eastern Cape)

The irony of her situation is that she moved from a previous job to school health because she had a valid driver's license. Aside from lack of allocated transport the SHS is also relegated to the bottom of the list when transport has to be shared with other outreach programs. This caused nurses to refer to the SHS as "the stepchild of PHC programs".

Difficulties in measuring SHS coverage

The routine health information system operating in a district does not include data on SHS provision. Consequently the policy goal of improving school health coverage and reducing inequity in SHS provision cannot be monitored routinely. South African health districts have a routine monthly report (RMR) in which data from various aspects of the health services are captured and processed (Health Systems Trust: District Health Barometer, 200 – 200; South African Health Review, 200–200). School health data do not form part of this RMR.

> *The big thing is that school health is not part of the RMR. So this is separate data that they have to collect, fill out and they've got to send to me* (Sub-district manager, Rural area, Western Cape)

Nurses displayed little confidence in their own data and when the researcher asked for school health data a long-serving and experienced school health nurse indicated that

> *It would be a useless exercise, because the stats is a total mess-up* (School health nurse, urban area, Western Cape)

Every nurse raised similar concerns about the data. In every interview, without fail, nurses asked the researcher to help them with access to proper data collection forms. From the researcher's observation of the data collection forms used by nurses, their concerns were justified. The data collection forms varied from a loose page on which nurses scribbled some information about the schools and the children they examined, to more structured forms. Even in the Western Cape, which has the best-developed SHS, every area recorded school health data differently. The available data collection forms also reflect mainly numerator data, as nurses have difficulties in obtaining denominator information from the Department of Education, such as the numbers of schools or pupils. Despite the requirement from provincial and national school health co-ordinators to have quarterly school health reports submitted for all districts, nurses in all the areas reported that they did not consistently do this. As reiterated by the acting national school health co-ordinator at time

> *"Some provinces are not submitting their quarterly School Health Services reports"* (Middle manager, National Department of Health)

The inconsistencies in the data collection both reflect and compound the lack of standardisation and the unsystematic implementation of the SHS across the country. They also reflect a greater difficulty of monitoring the implementation of new policies. Braveman's (1998) suggested requirement of appropriate data to monitor equity goals is not possible for the SHP in the current system.

The health problems identified through the SHS

The main health problems that are identified in the Grade 1 health assessment are common across all research sites. The commonest of these are dental caries, which nurses say constitute the majority of their referrals. Some put it as high as 70%.

> *the Grade's that we are seeing, the most common problem, though we don't take it as a problem now is the dental cavities, most of their teeth they have got dental cavities* (Nurse, rural area, Eastern Cape)

Next commonest are various skin conditions, visual problems that require corrective lenses, intestinal worm infestations, and nutritional problems. Occasional referrals are done for hearing problems. In addition, nurses encounter many minor ailments on their visits to schools. Nurses reported that the correction of visual problems gives them the greatest sense of satisfaction, since these children commonly lag behind in their education and corrective glasses significantly improve their prospects. At an urban clinic in one of the research sites, the facility manager proudly displays a newspaper article about the many children who received corrective lenses through the SHS. An important factor here is the availability of good referral services, in particular dental and optometry services, without which mere identification of a health problem confers little or no benefit.

Aside from these physical health conditions, nurses indicate that they often encounter children with psychosocial problems, but are unable to perform a full assessment due to the unavailability of private spaces. They also indicate that the time needed for a full mental health and/or social circumstance assessment precludes them

from doing it thoroughly. These needs of children require psychological and other rehabilitation services which according to nurses are simply not available in small towns and rural areas.

> *I've got a child who is a query mental retardation and then I was told here in the District office that I have to refer these children to the OT. Then I think late last year the OT were not available, I was told by Mrs. N. I must stop referring them because they are not now available – the OT* (Nurse, rural area, Eastern Cape)

Similarly, social problems require social workers in the communities where children live, and these are also not commonly available. Consequently, some nurses in the rural areas indicated that they attend to problems that go far beyond their immediate job descriptions.

> *Here when you are working in the rural places, you are everything. You are minister, you are policeman, you are social worker, I don't know what else* (Nurse, rural area, Free State)

Quality of the SHS

Provision of good quality health care is an important goal over and above the presence or absence of a particular health service (Institute of Medicine, 1999). Quality in health care has many varied definitions, but one common definition from the American Institute of Medicine is "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes" (ibid). This formulation suggests that the mere presence of a service is not enough to meet user needs; it also has to be of good quality. This requirement is recognised in all nine child health policy documents, which all contain statements about the importance of a good quality child health care service. The national SHP stipulated in its list of principles for the SHS that:

> the quality of the service should be ensured. (Department of Health, 2003a)

However, among the many indicators proposed in the implementation guidelines of the SHP, not one specifically related to the quality of the SHS. In the six overarching

policy documents, policy makers intimate that the provision of good quality of care must receive sufficient attention.

> The state will play a more active role in encouraging efficiency and high quality care in both the public and private sectors: . . . the emphasis will be on the quality of services . . . (ANC Health Plan, 1994)

The researcher elicited information about the quality of the SHS from nurses' own assessments of their service quality. Direct observation of the delivery of the SHS was not possible during this research and, as indicated, data on quality of care are not collected routinely. Nurses measured the quality of their SHS provision by the frequency of school visits, their ability to conduct the SHS activities during school visits to a sufficient standard (nurses commonly indicated this to mean that they were able to execute all the required health assessment activities in the allocated time, correctly and with the proper equipment), their ability to follow up children whom they have identified with problems, and the availability of referral services to respond to the identified problems.

Quality of care was clearly of concern to nurses, despite their own perceptions that policy makers and officials at national and provincial level did not pay sufficient attention to this aspect.

> *They've never looked at quality, they've only looked at quantity* (Nurse manager, rural district, Western Cape Province)

The majority of nurse interviewees indicated dissatisfaction with the quality of the service they provide.

> *We want to give the best but we cannot always give the best quality* (Nurse, Rural district, Western Cape Province)
>
> *I felt in my heart, I don't feel satisfied for the type of nurse that I am, for the type of quality that I render in my nursing career* (Nurse, Urban district, Western Cape)

Nurses also felt that the pressure to deliver quantitative statistics and the drive to 'turn out the numbers' interfered with their desire to deliver a SHS of sufficient quality care.

> *If we focus on numbers I can give them numbers to hell and gone, but it's the quality of work that you deliver that's important for me* (Nurse, urban district, Western Cape)

The quality measure that nurses felt most strongly about was the unevenness in SHS provision, since with the current coverage rates many cohorts of children simply did not get a service. Next, they bemoaned their inability to conduct the health assessments properly because infrastructural deficiencies meant that space and privacy in schools were at a premium. Children with social or suspected mental health problems required longer assessments and private spaces for their consultations, and these did not exist. Nurses reported that these assessments were then done hurriedly or not at all.

> *We don't have consulting rooms so we have to use the class, the corner of the class. They don't even have screens so you just take the boys out and leave the girls in and you work with them, there's no other way* (Nurse, urban district, Western Cape)

The lack of a functioning referral system also caused much concern. For a screening service such as Phase 1 of the SHS, availability of referral services is not just necessary to address the identified health problems, it is also regarded as unethical not to respond to health problems unearthed through screening services (Andermann et al., 2008; Wilson & Junger, 1968). The majority of nurses reported that they were unable to follow up children whom they identified and referred with health problems. This was due to the low nurse/school ratios and the pressure of having to visit as many schools as possible annually. It was therefore left up to parents, and sometimes teachers, to take children to the referral services, which did not always occur. In addition, the referral services were not available in all areas.

> *The referral system really does not satisfy me. It doesn't. Cause if I refer them directly to B, B complains there is too much overload of this children . . . but they have got to be seen by somebody* (Nurse, rural district, Eastern Cape)

The availability of referral services had a definite urban–rural bias. Nurses in all the urban research sites indicated that referral services were within easy reach of the

communities that they served and were readily available. Nurses in rural areas indicated that referral services were often not available, or were located in faraway cities or larger towns. They were left with children who were identified with health problems, but for whom referral services were not available.

> *I feel that I'm left alone to do the things . . . say if I identify tooth decay, what do I do then? I cannot extract the teeth, I cannot bring the child to the dentist and the problem is there* (Primary Health Care nurse, rural district, Free State)

Nurses also reported that many children were unable to access referral services, owing to distance and exorbitant transport costs. From nurses' experiences, they indicated that parents were not able to allocate scarce household money for addressing non-acute health problems such as visual, dental or hearing problems. One of the rural-based nurses indicated that she often provided children with her own money to help them with transport costs, as they would otherwise not get to referral services.

The transition from a vertical to an integrated SHS

The SHP implementation highlighted an important conceptual tension between 'integration' and 'verticalisation'. Integration of primary level health care services is a key policy goal outlined in several of the overarching policy documents of the National Department of Health such as the ANC Health Plan, the White Paper for the Transformation of the health system and the Primary Health Care package to name but a few (African National Congress, 1994; Department of Health, 1997; Department of Health, 2000(d):

> The emphasis on management support will focus on issues of coordination and integration. . . . [H]ealth infrastructure and management systems . . . will help to . . . [f]acilitate managerial and financial integration of health strategies. (ANC Health Plan, 1994).
>
> All health facilities, as far as possible, will render MCWH services on a one-stop, "supermarket" basis. Existing health facilities should review the allocation of available space and, where possible, relocate MCWH services closer to one another. The optimal integration of MCWH services must be ensured in the design of all future health facilities. (White Paper for the Transformation of the Health system, 1997)

Integration implies that different primary level services have to be delivered by the same set of health professionals and managed by the same facility and district managers, so as to facilitate co-ordination and eliminate duplication. The policy goal of integrating the SHS with other primary level health care services coincided with the overall strategy of the Department of Health (Department of Health, 2003a) and aligned with the PHC approach. It aimed to replace the apartheid era "vertical" model, where several health care interventions were delivered in isolation from one another, each with its own set of staff, managers and resources. Yet, despite the explicit policy requirement of integration, different staffing and service provision models evolved across the country. Some were in contradiction to the 'integration goal' and closely resembled the previous vertical service. Others showed fidelity to the notion of integration. Different models existed within the same province and even within the same district.

> *We've got one sister who's doing all the schools in area X . . . and that is the only thing she does . . . Then we've got the other like Y and Z . . they take turns doing the schools in the morning and. .in the afternoons go back to the clinics. So we've got two systems in place* (Nurse Manager, rural district, Western Cape Province)

In the first part of this comment the nurse manager describes staffing similar to that of a vertical programme, where nurses are solely allocated to the provision of the SHS. She then describes a service where nurses deliver the SHS as one of several health care activities, as is expected in an integrated service. This variation in structure and staffing is a microcosm of the national situation. In the urban district of the Western Cape the vertical staffing approach predominates, where all the nurses are allocated solely to the SHS. This district is also the only area in the country that has four doctors exclusively working in the SHS. The only difference from the previous vertical model is that school nurses report to district-level facility managers and not to school health-specific line managers. In an adjacent rural district, nurses deliver primary health care services, including the SHS, via mobile clinics. Theirs is a truly

integrated model where the SHS is one of several health care interventions delivered by the same team of nurses.

In the Free State, Eastern Cape and the five non-case-study provinces (the sixth has no SHS at all), a similar mix of dedicated and integrated staffing exists. Of note is that the vertical staffing model predominates in urban areas while rural areas favour the integrated approach. This indicates the availability of a greater number of nurses in urban areas that are able to fully dedicate their time to the SHS. These nurses are primarily those who provided the vertical SHS in the pre-policy period and had been retained for this purpose. The staffing model influences the coverage and quality of the SHS. The vertical model allows nurses to give the SHS their undivided attention, but runs the risk, as in the past, of not co-ordinating actions and resources with other child health programmes. The policy goal of integration as originally envisaged was thus achieved in part only, and mainly in the rural areas of the country. District managers found it difficult to juggle the budget against the staffing requirements of the SHS. In some instances specific school health posts were advertised, without the concomitant budget to match it. In other instances, provinces reportedly earmarked money for the SHS but bureaucratic delays in appointments and too few applicants for the school health posts resulted in the money being reallocated to other services.

Other health system challenges such as the scale and seriousness of the HIV pandemic compounded the challenges with integration. It was clear during the research that the preferential attention for HIV-related services was at the expense of other child health services. In one of the rural research sites, the manager of the MCWH programme and the manager of the HIV programme shared an office. The HIV manager's workstation was equipped with a state-of-the-art computer, printer and furniture. The MCWH manager's workstation was threadbare, with no computer and dilapidated furniture. HIV had inadvertently become the new vertical programme in a system that strove towards integration.

> *I was in the strongest vertical health program you could possibly think of, which is HIV/AIDS . . . HIV/AIDS has a very strong influence on service delivery, especially if you only want to build a parallel health system within a*

> *health system to do only HIV/AIDS and . . . it doesn't actually do the other things. Now you can have short term gains . . . but I strongly believe verticalisation in a system like that deters from that system's ability to give a comprehensive service* (Senior manager, Western Cape)

In addition to the variation in the staffing models, the staff mix for the SHS also differed. The SHP implementation guidelines provide a range of options for the level and qualification of staff that could provide the SHS. It is up to provinces and districts to allocate staff according to their availability. Many different SHS staffing configurations exist across the country. In the rural district referred to in an earlier quote, the nurse manager allocates nurses with different professional qualifications to the SHS. In some areas she uses professional nurses who are qualified to execute a wide scope of activities. In other areas, where professional nurses are in short supply, she uses staff nurses who have lesser qualifications and practice scopes, with reportedly good results. In some of the urban areas of the Western Cape, teams are allocated to the SHS consisting of a professional nurse, a nursing assistant, and also community health workers[44] where they are available. In the Free State, some interviewees were adamant that they will only employ professional nurses for the delivery of the SHS. Consequently their SHS remains unstaffed because of the shortage of professional nurses in this province. In the Eastern Cape the SHS is provided by professional nurses who largely work on their own.

Conflicting practices on integration in different levels of the health system

Despite the strong drive for integration at district level, the organisational arrangements of programmes within the national and provincial Departments of Health contradicted their own policy position. In general national and provincial level programmes still operate in silos.

[44] Community Health Workers are lay persons trained to perform a range of basic health care support functions. These include home-based care for sick and dying patients, assisting patients in their adherence to chronic medication and conducting training on health promotion. In the SHS the community health workers help to weigh and measure children, fill in basic data, and help with home-based follow-up visits.

> *I think all programs think about their programs vertically* (Deputy Director-General, National Department of Health)

This senior manager referred to the situation in the National Department of Health where each health issue has a separate manager. From the researcher's knowledge of the Department of Health organogram (see Chapter 1), in the MCWH cluster alone there is an Expanded Programme of Immunisation manager, a PMTCT manager, and a school health manager. This results in each manager focusing on his or her own programme, rather than linking it integrally to other programmes. Similarly, other clusters which deal with child health issues also have their own programme managers for each area, so there is a HIV manager and a chronic disease manager who also deal with child health issues

This silo approach reportedly results in unhealthy competition between programmes for resources and attention.

> *every program wants to verticalise its own program, because they say "if you don't put focus on this program and if you don't have dedicated staff, nothing will happen"* (Senior Manager, National Department of Health)

This lack of integration at the national and provincial levels affects the co-ordination of child health services at district level and results in district-level staff being overwhelmed by multiple demands from national and provincial managers. As indicated by a national manager:

> *the person looking at child health at district level is also looking at school health and other programmes like PMTCT, EPI, Human Genetics . . . so the person who is suppose to be working directly with me on school health has a number of programmes that she has to take care of. She might be reporting to more than five different people at National level* (Middle manager, National Department of Health)

A provincial manager confirms this and indicates how different programme managers place their individual requirements on district-level staff.

> *You have all these Maternal and Child Health people coming to do this and you have all the Health Promoting Schools people coming to do that and*

> *you've got all the TB people coming to do that* (Senior Manager, Western Cape)

While provincial and national managers acknowledged this as an undesirable situation, they gave little indication of how they proposed to resolve it. These fragmented institutional arrangements and the impact on service delivery are explored further in Chapter 6.

Progress with collaborative relationships: Education and the Health Promoting Schools programme

Health Promoting Schools

Chapter 4 addressed the crucial role of the Department of Education and the HPS programme in the development of the SHP. This section examines the implications of these discordant relationships for the implementation of the SHS. The management of school health and the HPS in different clusters within the National Department of Health resulted in a discordant relationship between these programmes at a national level. National managers spoke of the difficulties in achieving co-ordination between these two programmes.

> *When you look at SHS, Health Promoting Schools is the umbrella and School Health Services come underneath. The main reason why it is not working closely, because School Health Services was reporting under Maternal, Child and Women's Health, and Health Promotion had its own directorate* (Middle manager, National Department of Health)

Provinces attempted to correct this schism between the two national programmes with varying degrees of success.

> *In some provinces they came to realise that you cannot divorce School Health Services from Health Promoting Schools. In [province M] they have moved School Health Services from MCWH. It now falls under Health Promoting Schools. So there is a close cooperation. I think that's how the link should be working* (Middle manager, DOH)

From the interviews with the provincial school health co-ordinators, it emerged that in seven out of eight provinces these two programmes are managed separately

(one province has no services at all). The consequence is duplication of health promotion activities in schools and inefficient use of staff. At local level, nurses had varying degrees of success with integrating school health with HPS activities. The school health and HSP relationship is managed best by a highly experienced nurse, with a 20-year track record in school health in an urban area of the Western Cape. She also has a strong passion for school health, as was evident during the interview and from her account of the numerous requests she received to advise nurses from several different areas and provinces how to deliver a successful SHS. She delivers a HPS programme in the schools she is responsible for and delivers the SHS as part of this programme. In most instances however, nurses exclusively deliver the SHS, whilst a parallel set of health promotion staff, where they exist, deal with the HPS services.

Education

Regarding the relationship between the Departments of Health and Education at national, provincial and district level, the researcher found, as already intimated in Chapter 4, that it is unstructured, mostly informal, and generally poor. The reasons for this are explored further in Chapter 6, which deals with explanatory factors. Nonetheless, at provincial and district level, some individual managers and nurses have built up good relationships with their education counterparts. When asked whether there was a working relationship between health and education in his province, the middle manager responsible for school health in the Western Cape indicated,

> *Yes! Very much so. We're very good friends as well. Through the work we became very good friends [with] Dr M who is with Education. We've got a fantastic relationship* (Middle manager, Provincial office, Western Cape)

In contrast, at a school health workshop in the Western Cape attended by the researcher in 2009 as part of the data gathering process, health and education officials (including Dr M) met one another for the first time. Both sets of officials expressed amazement at the support and resources that they could obtain from each other – this despite the SHS having been in operation in this province long before 1994. The

relationship between the provincial health and education managers was clearly mostly at a personal level, as it did not translate into a formal collaboration between health and education.

The health and education non-relationship affected the efficiency and effectiveness of the SHS implementation, although not uniformly across all research sites, as pockets of excellent relationships exist. In two contrasting research sites, one in an urban area in Western Cape and one in a rural area in Eastern Cape, the school health nurses reported a seamless integration between the health facilities and schools. In the rural site in Eastern Cape, a very resource-constrained area, the nurse enthusiastically indicated that:

> *Ja, it's working because we are working together, especially the teachers, they are very happy with the services that we provide* (School health Nurse, rural sub-district, Eastern Cape)

The nurse in the urban area of Western Cape took the researcher on a visit to two schools where the good working relationship between the teachers and the nurse was evident. As indicated by the school principal,

> *"You see, with somebody as dynamic as R. ., she makes things work* (Ad hoc interview with school principal, Urban district, Western Cape)

In the absence of systemic inter-sectoral structures, these relationships are fostered primarily through the passion and commitment of individual nurses. Interestingly, the Western Cape nurse has been a school health nurse for more than 20 years, whilst the nurse from Eastern Cape had been in her position for less than a year. These two examples demonstrate the importance of the 'soft' elements, and that elements such as staff attitude appear to be independent of 'hard' elements like location of the service, length of service of staff, and resources. Despite these good examples, in at least half of the research sites nurses reported tenuous relationships with education officials who did not understand the requirements of the SHP. This resulted in logistical difficulties for accessing schools.

> *The relationship with the Department of Education . . . in some areas I cannot say is good, because if you visit a school ,you find that the principal has really forgotten that you have made an appointment to come and screen the learners. Maybe the principal doesn't really understand what you are going to do with at the school . . . he thinks you are coming to delay them, you are coming to disturb the curriculum* (School Health co-ordinator, non-case-study province)

Teachers cancelled appointments in favour of their own education activities. Nurses sometimes had to visit the same school twice – once to explain the SHS to teachers and get the required permission to bring the SHS into their school and then a second trip to deliver the service. At times this involved journeys of up to 250km. This situation emphasises the importance of "getting things right" during the policy development process – in this instance the relationship between health and education – because the repercussions for implementation can be significant. It further strengthens the researcher's notion of the need for a policy translation process followed by proper preparation with all stakeholders before implementation begins.

Brief comment on equity in SHS provision

From Table 9 in this chapter it is clear that significant differences occurred in various input, process and outputs aspects of the SHS provision. The nurse/school ratios varied considerably between provinces and between areas in the same province. Similarly, the kinds of resources, in particular transport, that nurses had at their disposal to deliver the SHS varied. Consequently SHS coverage within and between provinces varies significantly. The findings indicate that the best implementation of the SHS was in the Western Cape urban area, which is the best-resourced of all the research sites. Rural areas in all provinces, with the unexpected exceptions of some rural areas in the Eastern Cape, are generally less well served.

Even within the urban Western Cape, despite the stated 100% coverage of the SHS in the province, pockets exist of poor service or no service at all. Non-delivery in the Western Cape was primarily in rural districts or in the poorer parts of the urban district. The nature of these service provision differences in relation to the parameters

of race, socioeconomic situations and geography, and whether the inequity in SHS provision altered from the pre- to the post-policy era, is discussed in more detail in Chapter 7 on equity.

Discussion

The SHS is a quintessential Primary Health Care programme, as it embodies many of the important elements of the PHC philosophy. It is community-based and focuses on prevention and health promotion. It promotes a shift from vertically delivered services to the integration of services for children. It promotes inter-sectoralism, since the SHS requires active collaboration between the Departments of Health and Education. It further requires co-ordination between health programmes, in particular with the Health Promotion programme. It also addresses the health needs of a vulnerable and neglected portion of the population. Yet six years into the implementation of the SHP, the first phase of SHS provision is largely unsuccessful.

Results on coverage of the SHS show that some progress has been made in that a SHS now exists in areas where it was previously absent. However, the prevailing situation across research sites is that this predominantly preventative community-based service received little attention and support from health managers at all levels of the health system, and consequently floundered to the point of non-existence in many areas. The quality of the SHS is regarded as unsatisfactory by those who provide the service. Important components of the Grade 1 assessment cannot be delivered due to poor classroom infrastructure, which is the only space that nurses have available to them. Essential operational support systems for the SHS, such as transport, referral services and the health information system, are inadequate and distributed unevenly across implementation sites. Furthermore, routine monitoring of the SHS provision is inconsistent and inaccurate and progress with SHS coverage cannot therefore be measured. The model of provision of the SHS package is not standardised across implementation sites. Even though the SHP allows for some elements of implementation such as staffing models to be tailored according to local circumstances, it required the essential elements the SHS package to be provided in a

uniform manner. These essential elements were implemented differently across sites. The sum of all of these challenges with SHS provision means that one of the key goals of the SHP, namely that of achieving equity in SHS provision across different geographies and socioeconomic environments, remains elusive. The question that has to be asked is why, despite the favourable overarching policy context for children and strong emphasis of the PHC philosophy in the health care reform agenda, this should be so. Many explanations for the disjuncture between the SHP intentions and the SHP implementation emerged from the interviews. These are addressed in the next chapter.

Achieving good levels of health service coverage is not an easy task, and health systems in many countries struggle with this goal. Tanahashi (1978) provides a useful approach to the complex concept of coverage, still commonly cited. He proposed five different levels of coverage, demonstrating its complexity and that it is about more than just availability of health services. The five levels are: availability, meaning the presence of health services; accessibility, meaning whether users can reach health services; acceptability, meaning that services are agreeable to users; contact, meaning that users are actually able to have direct contact with health care providers; and effectiveness coverage, meaning that users get the kinds of services that they need and deserve to get. This research focuses primarily on availability coverage, but whereas inferences can be drawn on the SHS performance in relation to the other coverage dimensions, assessment of "acceptability coverage" would require the direct perceptions of users and this research did not explore coverage experiences from their point of view.

Tanahashi (ibid, p295) indicates that "health service coverage depends on the ability of a health service to interact with the people who should benefit from it, i.e., the ability to transform the intention to service people into a successful intervention for their health". Measured against this definition, the infrequency of SHS provision in most research areas means that the policy intention of providing a SHS of good coverage to the target population of Grade 1 children failed. It particularly failed children in rural areas and poorer provinces that have no access to other sources of

health care such as wealthier children might have in urban areas. This contradiction in health service coverage is still the predominant challenge for the South African health system, where those with greater health needs receive fewer and poorer health services (Development Bank of South Africa, 2008; Harrison, 2009; Coovadia et al., 2009). It is precisely why the attainment of greater equity in health service provision was and still is such a dominant policy goal (ANC, 1994; Republic of South Africa, 1994a; Department of Health, 1997; Kautzky & Tolman, 2008; Coovadia et al., 2009; Nkonki et al., 2011).

Findings on referral services indicate that, at least for this component of the SHS, accessibility coverage is poor for children who live in rural areas and small towns. Referral services are primarily located in larger towns and cities. Thus, for children living in rural areas, distance and prohibitive transport costs deny them access. As indicated earlier in the chapter, poor availability of referral services is more than just a problem of logistical access, it also presents an ethical dilemma. As stipulated by an international code of practice for screening services, (Andermann et al., 2008; Wilson & Junger, 1968) screening should only take place if definitive treatment can be offered for the conditions that the screening service identifies. Without this basic pre-condition, screening is regarded as unethical and is strongly discouraged. This presents a significant challenge in particular to the SHS that operates in rural areas. This aspect has received little attention thus far from managers and service providers.

The quality of the SHS, which consistently elicited strong and troubling responses from nurses, aligns with Tanahashi's fifth coverage level: effectiveness coverage. Tanahashi (1978, p297) makes the point that "the contact between service provider and user does not always guarantee a successful intervention related to the user's health problem". The majority of school health nurses indicated that they were wholly dissatisfied with several aspects of the quality of the SHS they provide. Although this research did not explore satisfaction from the SHS recipients' point of view, there is ample justification in the findings to assume that children did not get the

kind of service that they deserve. In particular, nurses indicated that many social and mental health problems were missed or inadequately assessed. According to Cluver and Gardner (2007), children who are orphaned, especially older children of school-going age, suffer various social and mental health effects because of the HIV/Aids epidemic. This implies that the current SHS misses many opportunities in identifying and supporting such children.

Challenges with coverage are not exclusive to the SHS and are also manifested in other child health services. For example, immunisation coverage rates differ markedly between provinces and are well below the national average in two of the poorest provinces (Saloojee & Bamford, 2006). The immunisation dropout rate for the essential measles vaccine is as high as 25% for the poorest province, whilst less than half of that for the best-performing province. For the prevention-of-mother-to-child (PMTCT) programme, availability coverage is 75% (ibid). The uptake of the PMTCT programme by pregnant women is only 55% (ibid), which possibly reflects access to the programme as well as the acceptability of the programme to women. A recent study by Leatt et al (2006) on children's experiences with access to primary level care show that, despite primary level care being free, many other obstacles prevent children from accessing these services. While primary level care is free at the point of service, exorbitant transport costs to children and their families who live far away from clinics and hospitals make the service unaffordable (Gilson and McIntyre, 2004). Several opportunity costs are also incurred, such as time away from work for parents and caregivers, and using scarce household resources to pay for transport.

Inconsistent routine data on service coverage makes it difficult to measure improvements in coverage. This in turn makes it difficult to assess whether the intended policy goals have been achieved. In addition, the lack of baseline data on the prevalence of health problems in school-aged children leaves health managers and service providers unable to measure progress with health outcomes in this group of children. Consequently availability and effectiveness coverage of the SHS cannot be determined routinely.

Challenges with health service coverage in its various forms are by no means unique to South Africa. It is a problem in both developing and developed countries. It is, however, more prominent in resource-poor settings context. In recent years countries on every continent with very different contexts have explored ways of improving universal coverage of, and access to, health services. A few examples are named here. Thailand recently instituted promising efforts to attain universal primary level coverage (Pongpirul et al., 2009). China is focusing on decreasing the current urban-rural gap in health care provision (Jian et al., 2010; Claeson et al., 2004). Croatia and Slovenia both implemented a National Health Insurance scheme in an attempt to improve previously poor coverage, in particular for the more vulnerable women and children (Hindle, 2003). These challenges are also very apparent in a study that considered universal health care coverage in a number of mainly low-income countries in the Asia-Pacific region (UNESCAP, 2007), where the poor are also disproportionately subject to poorer health service coverage – notwithstanding numerous documented policy statements that "profess to goals related to equality, equity and pro-poor health services" (ibid, p65). This is similar to the situation of the SHP and South African child health policies in general, as these policy documents also have broad statements of intent on equity and pro-poor health services, but with little follow through in the more detailed policy guidelines and implementation plans.

Tanahashi (1978, p296) ascribes poor availability coverage to the limited availability of health resources. The Asia-Pacific analysis ascribes it to more than just health resource availability. It postulates that weak health systems are the main reasons for poor availability of health services. The findings from this thesis go further than Tanahashi and the Asia-Pacific studies and postulate that, aside from issues of health system performance and resource availability, the poor provision of the SHS also has its genesis in fundamental problems with the SHP development process. Indeed, the interdependency of policy development and policy implementation is well-recognised. Pülzl and Treib (2007, p101) indicate that it is "necessary to take into consideration the impact of policy formulation on

implementation". Deficiencies in the policy development process have implications for the policies themselves, as well as for their eventual implementation. Despite the notion in South Africa that "policies are generally good and implementation bad" (Coovadia et al., 2009), the experience with the SHP confirms that deficiencies in the SHP policy development process had a direct impact on the nature of the policy, as well as its eventual implementation. Little attention was paid in SHP discussions to the "implementation context". Consequently planning for the implementation phase of this policy was inadequate. Two key findings in this chapter bear this out: the poor relationship between national and provincial health and education departments, and the limited involvement of district-level actors in the policy development and policy translation phase, with the resultant de-prioritisation of the SHP by district managers. While some may argue that these issues fall within the implementation ambit only, the disgruntlement of district-level actors about their exclusion from the policy process suggests otherwise. As indicated in Chapter 4, district managers were not yet in place at the time of the SHP development. Worse still, they were not involved nor consulted in the implementation phase and their buy-in to ensure the successful implementation of the SHP was not achieved.

Altering the SHS from a vertical service to one fully integrated with other primary level services formed an important part of the overall Department of Health strategy to improve availability and quality of services. Integration in the South African health system context means that all primary level services are integrated under one management team at district level, with no exclusive claim to resources, and are offered in a comprehensive one-stop-shop fashion (ANC, 1994: Department of Health, 97; Department of Health, 2000d). It also meant that district-level budgets were integrated and had to cover all health services. No one service received special budgetary allocations for their exclusive use. The intention of this strategy was to improve the availability, accessibility and acceptability of services, as well as make services more user-friendly and accountable to local communities. The SHS achieved partial integration only. In most areas, SHS continued to be provided as vertical

programmes in a health facility. While the SHS has the potential to drive the integration of services by its very content, this only happened to a limited extent. The integration strategy of the South African national health system coincided with that proposed by the World Health Organisation (WHO, 1996), which promoted integration as a health care delivery option with many potential gains. Many of the identified gains in this WHO report speak directly to the dimensions of coverage referred to earlier. One such gain identified by the WHO, and one of particular relevance in this thesis, is improving equity by "providing a more efficient and effective service to meet the needs of all the people" (ibid, p19). Considering all these potential gains, integration is a strategy that can potentially improve health service coverage in all its dimensions.

However, integration also depends on the attitude of service providers, who will "need to pool resources, show unity of purpose and give up some of their territorial rights" (ibid, p4). The absence of many of these conditions contributed to the failure to fully integrate the SHS. Most importantly, as the next chapter will discuss in more detail, there was no process for the SHP whereby a common purpose or common vision was created amongst key implementation actors. These gaps in implementation direction at district level were exacerbated by the lack of direction from the national level between the release of the policy in 2003 and its eventual implementation in provinces. Also, district managers were not held accountable for the lack of progress with the SHS integration, resulting in the poor coverage levels displayed in Table 9.

Notwithstanding the poor progress with integrating service delivery, integration is not the panacea for improving service delivery. The WHO report cautions against this assumption in that there are both merits and demerits to verticalisation and integration. On the one hand, there might be strategic reasons for continuing with vertical programmes as an element within an integrated system of service delivery. On the other hand, integration brings its own set of challenges. The one most pertinent to the SHS is the lack of proper prioritisation of child health services, and the absence of a clear strategy on how to address the multiple service demands that primary level

providers face. The example cited earlier of HIV highlights a set of challenges where 'verticalisation' as the dominant approach to HIV service delivery in South Africa has negative consequences for the delivery of other child health services. Again, these challenges with juggling 'verticalisation' and integration are not unique, and similar problems to those raised in this research emerge from the 15 country case studies in the WHO report.

This chapter contributes to the knowledge base on health service coverage for South African children by outlining the example of the SHP implementation. It points to gaps and challenges in the SHP development process that have contributed to the poor SHS implementation. The question that must now be asked is why this should have happened, even though the overarching policy context was favourable towards children and a PHC philosophy was strongly embedded in the health care reform agenda. Many possible explanations can be proposed for the disjuncture between SHP intentions and SHP implementation, and this troubling 'why?' conundrum is addressed in the next chapter.

Chapter 6: Poor performance of the SHP: institutional and other factors

Introduction

This chapter follows on from the presentation in Chapter 5 of findings on the performance of the SHP set against its main goals, and turns to consider the main explanations for the poor performance of the SHP. Chapter 5 showed that none of the SHP goals have been achieved and that the predominant picture across research sites is that of a school health service of poor coverage and quality. It also identified some policy process factors such as the poor relationship between health and education as possible influencing factors of implementation. These policy process factors are not considered again in Chapter 6. Instead this chapter addresses three additional sets of factors as explanations for the poor performance of the SHP.

The first set of factors can collectively be classed as institutional arrangements. These include the governance of the health system, the inter-relationship between the three levels of the health system (national, provincial and district), the organisational structure of the national and provincial Departments of Health, and the management and service delivery arrangements within health districts. The second set concerns inherent characteristics of the SHS and includes its community-based location, its preventative focus, its integrated approach across school health, health promotion and other primary level services, its dependence on a functioning referral system, and its dependence on inter-sectoral collaboration between health and education. The third set operates at the level of individual child health policy makers, managers and service providers and concerns their capacities, perceptions and actions.

Institutional arrangements of the Department of Health

The Institutional Analysis and Development framework first developed by Ostrom and later expanded on by other policy analysts, unravels the complexity of institutional arrangements and their influence on policy development and

implementation (Ostrom, 2007; Hill & Hupe, 2006; Hudson & Lowe, 2008). Ostrom identifies two common, but divergent approaches for the analysis of institutions. The first approach views institutions as an organisational entity, such as a business or a government department with clear identities and boundaries. It mainly addresses the tangible 'hard elements'[45] within organisations, such as organograms, structures and resources. The second approach addresses "the rules, norms and strategies adopted by individuals operating within or across organisations" (Ostrom in Sabatier, 2007). It relates to shared prescriptions adopted by individuals for making these organisations work, which Ostrom refers to as "mutually understood and predictably enforced in particular situations by the agents responsible" (ibid). This second is Ostrom's preferred institutional analysis approach (ibid).

Institutions are said to have these common characteristics: that they are arranged along multiple levels; that these levels interact with one another in explicit formal, and implicit informal ways; that actors at each level and "action arena" in which these actors operate are important units of analysis; and that a combination of the "hard elements" of organisational rules, structures and resources is interwoven with the 'soft' elements[46] of individual perceptions, behaviours actions (Ostrom, 2007; Hill & Hupe, 2006; Lipsky, 1980).

Ostrom contends that there are three levels of rules that "govern the actions taken and outcomes obtained in any setting" (Ostrom in Sabatier, 2007. p44). The highest level is "Constitutional Choice" where 'rules' are made that shape and guide operational decisions. In South Africa the formulation of these 'rules' occur in Parliament through laws and regulations and it includes, amongst others, the National Health Act referred to in Chapter 4. It also includes the development of national

[45] "'Hard' elements are easier to define or identify, and management can directly influence them: These are strategy statements; organization charts and reporting lines; and formal processes and IT systems." Sourced from : http://www.mindtools.com/pages/article/newSTR_91.htm on 28 November 2010.

[46] "'Soft' elements . . . can be more difficult to describe, and are less tangible and more influenced by culture. However, these soft elements are as important as the hard elements if the organization is going to be successful." Sourced from: http://www.mindtools.com/pages/article/newSTR_91.htm on 28 November 2010.

policies by the National Department of Health. The second level is "Collective choice" where decisions and plans are made on how to execute the 'rules'. In South Africa this happens in provincial departments of health, where national policy is further interpreted and developed into implementation plans. The third level is "Operational rules" that "affect day-to-day decisions" made by individuals (ibid, p44). For health, it refers to the implementation plans that direct the actions of managers and service providers in the delivery of health services (Ostrom, 2007; Hill & Hupe, 2006; Hudson and Lowe, 2008).

Rules for governance in the Department of Health

Chapter 3, section 40, of the South African Constitution makes provision for three levels of government: national, provincial and local, which it describes as follows:

> Government of the Republic
>
> 40 (1) In the Republic, government is constituted as national, provincial and local spheres of government which are distinctive, interdependent and interrelated.
>
> 40 (2) All spheres of government must observe and adhere to the principles in this Chapter and must conduct their activities within the parameters that the Chapter provides. (Republic of South Africa, 1996)

This framework applies to all activities of government, including 'health services' and "education at all levels excluding tertiary education" (ibid: Schedule 4, Part A. Functional areas of concurrent national and provincial legislative competence). For health, these constitutional provisions are further interpreted in the National Health Act. Table 10 contains excerpts from the Act on roles and responsibilities of the national and provincial Departments of Health, and for district health services. Specific functions that relate to the SHP, such as inter-sectoral collaboration and resource allocation, are highlighted from the relevant sections of the Act.

Table 10: National Health Act provisions for each level of the health system

National Department of Health	Provincial Departments of Health	District health councils within the district health system
Chapter 3 " The Director-General must : 1 (a) ensure the implementation of national health policy in so far as it relates to the national department 2 The Director-General must, in accordance with national health policy (b) issue and promote adherence ,to norms and standards on health matters, including- (vii) any other matter that affects the health status of people in more than one province; (c) issue guidelines for the implementation of national health policy (d) identify national health goals and priorities and monitor the progress of their implementation (f) participate in inter-sectoral and interdepartmental collaboration" (Republic of South Africa, 2003)	Chapter 4, 25 (1): " the relevant member of the executive council must ensure the implementation of national health policy, norms and standards . . ." 25 (2) The head of a provincial department must, in accordance with the national health policy and the relevant provincial health policy in respect of or within the relevant province: – (c)participate in inter-provincial and inter-sectoral co-ordination and collaboration (o)provide health services contemplated by specific provincial health service programmes (p)provide and maintain equipment, vehicles and health care facilities in the public sector" 25 (4) Provincial health plans must conform with national health policy(ibid) In addition, (5) Provincial legislation must at least provide for: (b) " . . . the detailed budget and performance targets for health services in the health district to which both the provincial and municipal spheres[47] of government must contribute . . ." (ibid).	"A district health council must . . . ensure co-ordination of planning, budgeting, provisioning and monitoring of all health services that affect residents of the health district for which the council was established". Members . . . must have due regard to the following principles laid down in. .so far as they relate to equity; access to services; quality; overcoming fragmentation; comprehensive services; effectiveness; efficiency; local accountability; community participation; developmental and inter-sectoral approach; and sustainability.

Source: Generated by researcher, from National Health Act of 2003

The provisions in the National Health Act leave room for interpretation. From the researcher's understanding, in 2(b) for the National Department of Health, the text "promote adherence" implies that the national department can only facilitate, but cannot enforce provincial adherence to national norms and standards. This is contradicted by the provisions for provinces, where section 25 (4) stipulates that provincial health plans "must" conform to national policy. While 2(b) implies a measure of autonomy for provinces, section 25(4) in particular seems to advocate strict adherence, implying that provinces are not allowed to ignore or reject national policy. Later sections of this chapter expand on how, in the light of these textual differences, health officials interpret and apply provincial autonomy.

[47] "Municipal spheres" refer to local government.

The impact of the 'Federal System' on the development and implementation of child health policy

A number of South African health policy analysts have identified the federal system of government as an important factor influencing the functioning of the health system (Development Bank of South Africa, 2008; van Niekerk, 2007; Naledi et al., 2011). While there is some debate on whether the South African system fulfils the classical definitions of federalism,[48] this term is commonly used to describe the relationship between the national and provincial governments. In this research a number of interviewees also identified the federal system as a significant factor influencing the development, oversight and implementation of national policy.

Notwithstanding the multiple definitions of the term 'federalism', interviewees displayed a consistent and shared understanding of this term and its use in South Africa. When asked about their understanding of the prescribed roles and functions of the national, provincial and district levels of the health system, most interviewees accurately reflected the stipulations of the National Health Act summarised in Table 10. This is confirmed in the following response from a provincial manager:

> *National office is a level where policies are made. Provinces are the level where policies are implemented. . . . Pretoria (location of National office) develops policies, then they expect provinces to implement . . . the other function that Pretoria has is to train provinces on policies that have been propagated. Thirdly to monitor implementation of these polices. . . . Provinces have the same functions as well, that we should develop policies, train the Districts on those policies and then monitor the implementation of this policies.* (Middle manager, Free State)

The interplay between the written rules in the National Health Act for national and provincial officials, their perceptions of what powers these rules accord to them,

[48] Federal:. "to do with a system of government in which several states are combined under a central authority but remain independent in internal affairs". Oxford Student's Dictionary (2002). Page 372. Oxford: Oxford University Press.

The term "federalism" is also used to describe a system of the government in which sovereignty is constitutionally divided between a central governing authority and constituent political units (like states or provinces). Federalism is a system based upon democratic rules and institutions in which the power to govern is shared between national and provincial/state governments, creating what is often called a **federation**.(Source: http://en.wikipedia.org/wiki/Federalism)

and their capacities to execute their designated roles and responsibilities, provide an interesting picture. Health officials expressed feelings of disillusionment and disempowerment on these matters. The issue of provincial autonomy elicited the strongest responses. National level officials viewed provincial autonomy as inhibiting of their central power to intervene and 'promote adherence' when crises and incompetence arose within provinces. These feelings of disempowerment have contributed to national officials stepping back from providing oversight and support to struggling provinces.

> *The National office really does not have a punch now. According to legislation, if the health services are falling apart, then the National Minister has to intervene and take back that Western Cape and say that it will have to be run by the National Offices . . . Things have got to fall apart to such a degree. Nowhere from 1994 up to now has any Free State been taken back to be run by the National Office. As you know, there are provinces where it should have happened a long time ago* (National Policy Task Team member)
>
> *Even as a National Department of Health, provinces have autonomy and sometimes they will ultimately decide on what they need to do, which hopefully does not veer too far from the mandate from the National Department of Health* (Chief Director, National Department of Health)

This national incapacity manifested at the highest level of decision making, that of the National Health Council.[49] The clauses in the National Health Act that refer to the National Health Council relegate it to an advisory body rather than a decision-making authority, and phrases such as "must advise the Minister on", "may determine", "may consult", "may create" illustrate this (National Health Act, Chapter, Section 23 (1, 2, 4 and 5). This is despite the powerful positions of council members. The Minister of Health at the time reportedly favoured a more interventionist approach, but the statutory stipulations of the Act limited her.

[49] The National Health Council is the ultimate decision-making body in the National Department of Health. It was formerly called the MINMEC, which is referred to in Chapter 4 and 5. The role, functions and composition of the council is legislated for in the National Health Act. The council comprises, amongst others, the National and nine provincial Ministers of Health, together with the national director general, his/her deputies and the nine Heads of the provincial Departments of Health.

> *The current Minister would like us to be far more interventionist in the provinces and she would like the National Health Council to take decisions and then we assist the provinces in implementing those decisions. Rather than say the National Health Council is an advisory body* (Senior Manager, National Department of Health)

When, on occasion, national officials exercised oversight in the case of the SHP, they were perceived as authoritarian and this became a source of tension in the national-provincial relationship.

> *In Province Y, we found that in some areas School Health Services were not up to standard and we found they were not submitting quarterly reports to national. Then information went down to Province Y and they started doing things as requested. But it created a lot of friction between us and them. Because it was like we reported them negatively to their Head of their Department, because it moved down from the Minister of Health to the Head of the Department, and they were called and reprimanded. That was not good for them and we are not good friends any more* (Middle manager, National Department of Health)

Contrary to what one might expect, provincial officials did not view autonomy as a *carte blanche* license to depart from national policy, especially not at the expense of the development of a national standardised health service.

> *We are still in this federalist kind of way, saying National can do policy but everybody is allowed to do a slightly different variation in each sub-district. I agree, on the content we can allow that variation, but the systems should be standardised. It's a unitary National Health system (*Senior Manager, Western Cape)

The concepts of autonomy and oversight are not confined to the national-provincial relationship, but cascades down to all levels of the health system. This requires a clear definition of roles and responsibilities for all levels and sublevels.

> *Policy needs to spell out, or be spelt out by the various spheres. The roles and responsibilities, the line of command, the authority, responsibility and accountability of each sphere of a policy, because you would find that jealousy between the various spheres. Moreover, the authority the Province has over the Districts, the District has over their Sub-Districts in implementing the policy. You do find if it's not spelt out what each and every*

> *sphere has to do, and the agreement between them, you stifle, not only this policy, but any other policy* (Senior manager, Western Cape)

Explicit and clear delineation of roles and responsibilities will promote the coherence and standardisation that officials referred to in earlier quotes. For example, districts have some leeway in the implementation process, but cannot depart from the central tenets of provincial directives.

> *Within the framework and policies, you have the freedom of "how" you do it. Dr X has always said he wants us to standardise and almost have a centralised consensus. Then you have the flexibility for how you can address your local issues, so as long as there's a commonality of understanding from Province* (District Manager, Western Cape)

The complexity and challenges of these inter-relationships, where little or no clarity exist on roles and responsibilities, have a direct bearing on the implementation of child health policies. It is beautifully illustrated in the release of a new child vaccine policy that was released by the National Department of Health just before the commencement of the research interviews.

The case of the new vaccine policy

Conflicts around the release of a new vaccine policy demonstrate the challenges of: the national struggle with provincial autonomy: resource deployment from national to provinces; provincial opinions of their autonomy; and the potential implications for child health service provision.

> *We had that problem with the (Provincial) Heads of Departments last week. We needed to introduce two new vaccines. One province, and I won't tell you which one, said that if you don't give the full amount (of money), we are not doing it. So we said to them 'then you must give the money back'. We need to negotiate with them on how to do it in the best interests of having a National program* (Senior manager, Department of Health)

The policy required the addition of two new vaccines to the childhood immunisation schedule. One of the vaccines addressed diarrhoeal disease,[50] a source

[50] As indicated in Chapter 1, diarrhoeal disease is one of the top three causes of mortality and morbidity in children, particularly on children under the age of one.

of significant morbidity and mortality in young children. From the interviews with provincial managers, the Western Cape was identified as the province in question. Western Cape provincial health managers indicated that the absence of additional financial support from the national department was the reason they could not implement this policy directive. This stance elicited varying opinions from officials in the other case-study provinces. Some felt that provinces should not be allowed to ignore national policy. Others endorsed the Western Cape's position and felt that national policy makers must ensure that the necessary resources are available before implementing policies.

Beyond the financial reason forwarded for non-implementation, a senior provincial manager in the Western Cape questioned the appropriateness of this national policy decision.

> *. . . the recent decision to immunise people with rota virus in terms of diarrhoea. I don't think it's the right decision* (Senior manager, Western Cape)

He felt that it was inappropriate to administer a vaccine without addressing the social determinants of diarrhoeal disease in children, such as safe household water. He also questioned whether provincial non-response to national policy is always underpinned by their perceived autonomy or simply an inability to deliver:

> *In the evolution of the provinces, there has been a lot of mismatch in terms of what norms and standards National has set and what actually is delivered in the provinces. I am not 100% sure if that is because of autonomy or competency constraints* (Senior Manager, Western Cape)

On the other hand a national official felt that provinces misunderstood the scope of their autonomy.

> *Autonomy is a relative concept. Other people think that if you are autonomous you can leave a child to die and National cannot do anything about it because you are autonomous. Meanwhile it is not like that* (Director of Child Health, National)

It is significant that the Western Cape is one of the best-resourced provinces with the most advanced district health system and the best health indicators. These 'credentials' seem to give this province greater confidence to confront and at times defy national policy. This is also the only province with an opposition political party at the helm, and challenging the national status quo is part of opposition party politics. Dissension from national health policy is therefore more likely to have political support than in other provinces. A similar situation arose with the Prevention-of-Mother-to-Child-Transmission (PMTCT) programme (referred to in Chapter 4), when the Western Cape was the only province that, contrary to the National Department of Health stance at the time, implemented the PMTCT programme (http://www.tac.org.za/Documents/MTCTCourtCase/Tachead1.txt).

Policy translation: the missing step in the transition from national policy to provincial implementation

The level of *collective choice,* referred to in institutional analysis frameworks, is where central rules are interpreted and translated into implementation plans (Ostrom, 2007; Hill & Hupe, 2006). For the SHP, this means the collective translation of the policy to implementation plans at provincial and district level. Based on the documentary analysis and interviews with provincial managers, the researcher found no evidence of a formal process for the SHP whereby provincial and district officials jointly translated national policies into commonly understood implementation goals. This was despite the stipulated requirement in the implementation guidelines of the SHP that districts must conduct a situational analysis on the available capacity and resources to plan for the SHS implementation. This was also despite managers' acknowledgement of the importance of this exercise.

> *One has to comply with national policy but it needs to be discussed at various levels, it needs to be built into budgets and things like that. Taking it further down, I think that's the process that we are currently trying to grapple with as new District Managers, trying to make it real in some districts and into facilities as well* (District manager, Western Cape)

One possible reason for this "lack of collaborative provincial-district translation", as commented on in Chapter 4, is the feeling of some provincial managers that district-level staff do not have the capacity to interpret policies and that it was easier for them to issue instructions.

> *With all due respect, if you don't have the transactional competencies to interrogate the policies, it doesn't make much sense to send it to you* (Senior Manager, Western Cape)

Policy translation has to cascade right down to the implementers, as this is where national policy becomes reality. One extreme manifestation of the lack of translation occurred in two of the Eastern Cape research sites, where nurses had not seen nor heard of the SHP, but had to implement it. They received a copy of the national SHP for the first time from the researcher. In one of these sites the school health nurse delivered a SHS of a coverage and quality that surpassed many other research sites. She received oral instructions from her predecessor on the SHS requirements, which she duly followed. It illustrates that provincial and district managers have a responsibility to ensure that all implementing staff members are aware of new policies. It also shows that policy translation goes beyond written instructions and can be done through active interchanges between staff.

Impact of management capacity on the SHP implementation

Managerial capacity emerged as another important factor that influenced the implementation of national policy. This case study revealed significant weakness in national, provincial and district management and leadership capacity. At national level the post of school health co-ordinator had been vacant for two years at the time of these interviews. Managers charged with the interim responsibility of overseeing the SHP implementation did not have the capacity to do so.

> *They see me as someone who should be supporting them, someone who should be providing some guidelines and they also see me as someone who should provide technical support, or if they employ a new person, someone who would provide direction* (Middle manager, with responsibility for school health, National Department of Health)

This manager indicated that her role is primarily chasing quarterly progress reports from provinces, and little else. Yet national managers, despite being aware of the problems of poor coverage and inadequate routine data, have done little to improve the situation.

> *The truth of the matter is we did not meet that target of 100% of school health. If you say 100% of the 52 districts have got school health, if I go to any one of the schools within the districts, am I going to find school health? I don't think so* (Senior Manager, National Department of Health)

They cite lack of capacity as their primary reason for failure.

> *Given that our capacity is myself and X, we are actually so thinly spread that we do little bits and pieces here and there. So the reality is that something like School Health, we have spent very little time on it* (Child Health Specialist, National Department of Health)

District managers are identified as the next important group of managers in the implementation of the SHS.

> *All provinces have a School Health Co-ordinator but that co-ordinator has no staff or budget. The influence of this program manager is essentially through persuasion and if they can't persuade the District Managers, it's not going to happen* (Senior manager, Western Cape)

Four groups of district managers have been identified as influential role players in the implementation of the SHS. The management groups are: health facility managers who are directly in charge of nurses; programme managers at district level who look after PHC programmes; and sub-district and district managers. Each district has slightly different management. District managers control resources, allocate staff to specific services and are responsible for staff training and support. Yet district-level management capacity, as evidenced by the lack of training and support of school health nurses, was inadequate. The appropriate training and support of staff when there is a policy change is crucial (Green, 1992). The transition of the SHS from a vertical to an integrated SHS required that both new and existing school health nurses and their managers had to be adequately prepared for the changes in their work

responsibilities. As indicated in the previous section, no formal process for translating the national policy took place and district managers were not formally prepared for adding the SHP to their responsibilities.

The majority of district managers acknowledged their responsibility in implementing the national SHP, but indicated that implementation was a huge challenge. There are a number of reasons for this. Managers had different degrees of understanding of what the national SHP entailed. Some managers had almost no knowledge of the national policy that they were responsible for.

> *The school health policy, I am not sure which one they are using. The ladies (nurses) they are going to show you, the policy that they are using. I am not quite clear of the policies that they are using* (MCWH Manager, Rural district, Eastern Cape)

Others had strong commitment to making the policy work. A Free State district manager tried alternative ways of implementing the SHP, since the national implementation guidelines did not work well in her area. She was determined to 'make it work'. The majority of managers were midway between these extremes. They knew of the policy, felt some commitment to ensuring its implementation, made some attempts in this regard, but mostly were constrained by their circumstances. However, the general lack of understanding of the SHP rendered managers incapable of supporting the SHP implementation, both in terms of staff and resource support. Managers had many explanations for their failures. They cited nurse shortages as one of the main difficulties.

> *Now, even if we to make it a number one priority, the work force to really do it on the ground is quite limited* (Provincial manager, Free State)

A key contributor to managerial problems in the SHP implementation is inadequate communication between managers and front-line staff at all levels. At district level it results in a lack of clarity on the part of nurses about the management structures of the SHS. In a rural area of Eastern Cape, managers confidently indicated that the working conditions of the school health nurses were good. However, the

nurses who had been in their positions for a year already asked the researcher to tell them who was in charge of school health in their district and what their reporting lines were. Similarly, the provincial school health co-ordinators, intended to be the interface between national and district managers for the SHP implementation, are unknown to front-line staff in the Eastern or Western Cape. Free State nurses knew the school health co-ordinator, but had little contact with her. District managers also do not interact with provincial school health co-ordinators. Similarly poorly-structured reporting and communication lines exist between the national- and provincial school health co-ordinators.

> *Maybe I should start with some of the* challenges *in the Provinces. When a post is vacant, nobody tells you that the post that was occupied by Mrs X is vacant now. You don't get that kind of communiqué from the provinces. You only find out yourself when you are looking for that focal person. It might be a couple of months. So in the case of Province Y, the new appointee , she didn't get any form of induction in her new job* (Middle manager, with responsibility for school health, National Department of Health)

In mitigation of their inadequate managerial performance, district managers spoke of the difficulties of multiple health-service demands within tight budgetary constraints. Consequently they took many shortcuts and sometimes, as with the SHS, simply did not deliver the service. Competing priorities and the non-urgent nature of the SHS relegated it to the bottom of the priority list. The responsibility for the SHP implementation thus rested with nurses.

Management support and training for school health nurses

Despite their significant responsibility for the implementation of the SHP, new nurse recruits across research sites received little training for their new jobs.

> *There was no training, I don't want to lie . . . the policy was just read through. There's a lot that I don't understand in this book (referring to the SHP). We are just giving the service to the children otherwise . . . we didn't go deep on this policy, I don't like to lie really, we didn't go deep* (Nurse, Eastern Cape, Rural district)

> *It's like you've been thrown in the deep end and you have to swim. I am swimming and I'm not a swimmer* (Nurse, Urban sub-district Western Cape)

Aside from training, managers also provided little supervision and support.

> *Really there is nobody to supervise and to help us, to empower us. We don't know in fact even if we are doing the right thing* (School Health Nurse, rural district, Eastern Cape)

Nurses cited managers' lack of understanding of the SHS as the reason for their frequent recall to clinics to deliver curative services when staff shortages occurred. While school health nurses acknowledged that they had to assist with other clinic services, they felt that it compromised their primary responsibility to school health, since the community-based nature of the service requires that they spend their time largely in schools and not in health facilities. This created tension between nurses who provided school health and those who were clinic-based. School health nurses felt that their nursing colleagues also did not understand and respect their work.

> *I'm in the centre, but in some of the things we're not quite being part of them. They are working inside .and they don't know what you are doing. Even our manager they don't know . . . Most of them they didn't know why am I driving the car to where ever I go . . . at some stage I felt like leaving this place because I didn't know where I am fitting. At school I don't fit because I am not a teacher, here I'm a nurse and yet I'm not fitting anywhere and don't feel part of the team fully* (School health nurse, Western Cape, Urban district)

The urban district of the Western Cape was the exception in the matter of staff training. School health nurses formed 'policy networks' (Sabatier, 2007) that became 'action arenas' for peer-support and training. Nurses from the previous vertical SHS conducted training for their new counterparts. This arrangement tended to be informal and inconsistent.

Organisational structures influencing child health

Service delivery arrangements within districts

Interviewees identified the fledgling nature of the district health system (DHS) as a major obstacle in the implementation of the SHP and child health policies in general. The SHS as a primary level community-based service is greatly affected by this. Interviewees indicated that in recent district restructuring efforts, services were divided into facility-based and community-based. However, the community-based component, under which the SHS fell, was still underdeveloped. The delayed enactment of the National Health Act intended to provide the framework for all health system structures, delayed the development of the DHS. Stronger provinces such as the Western Cape succeeded in initiating a DHS, whilst most other provinces lag behind. As shown in Chapter 5, individual districts and sub-districts, depending on their respective capacities, implemented the SHS differently.

> *We don't have the same thing happening in every District. Where you have management that has insight and knowledge, you will find a successful school health service. I know the director of the SP sub-district is very pro-preventative health care and that manager did everything to get all the schools covered in all of the time* (Nurse, Urban sub-district, Western Cape)

This poorly-sequenced development of the district health system and the implication for implementing new services is aptly described by a senior manager.

> *The SHP is supposed to be delivered in terms of the District Health System. The official policy of this province, to implement and formalise the District Health System, has not been fully implemented . . . It was only in 2005 that we had the legislative framework to say we could implement the District Health System. So the School Health Services in this province was a vertical health service, which was integrated into a decentralised health service that was not properly organised as a District Health System* (Senior manager, Western Cape)

This next section examines two district-level factors that were identified by interviewees as critical to the SHP implementation: staff and money.

Staff

Numbers

The staffing requirements of the SHS, compounded by the endemic shortage of nursing staff throughout the health system, unsurprisingly emerged from interviews as the largest obstacle in the delivery of a SHS of satisfactory coverage and quality. In keeping with the findings from other research (Wadee & Khan, 2007; Hagopian, 2004), interviewees cited the brain drain of nurses from rural to urban, public to private sector, and emigration to other countries as the dominant reasons for the nursing shortage. This increased the work-pressure on front-line staff.

> *I think it's expected from the facilities to just work harder* (Nurse, Rural sub-district, Western Cape)

With school health in particular, some nurses who were dissatisfied with the integration of the SHS had left nursing altogether. They were not willing to learn new activities after delivering only the vertical SHS.

> *We kept on losing the nurses especially the very ones that were doing school health. Staff shortage is basically what stopped the service* (Facility managers, Free State, rural sub-district)

Staff shortages are a particular challenge for community-based activities such as the SHS. School health nurses are frequently recalled to clinics, since the needs of patients requiring curative care are more acute than the preventative health care needs of children who are off-site.

> *We are doing a lot of prevention and it's not always seen as important* (Nurse, Urban area, Western Cape).

Mobility

In addition to staff shortages, high staff mobility, particularly amongst managerial staff within the Department of Health, results in poor continuity of management and service delivery. The next quote underpins the difficulties with attracting and retaining staff in public sector health facilities.

> *You come today and you know that you have people who are very strong in implementation and you even write to a Minister's report and say we are*

> *doing fine. Then three months later, one has gone to the UK, one has resigned, one has died, one has been promoted. That is another concept. Promotion is linked with moving from implementation to a higher office* (Policy task team member, National Department of Health)

Interviewees in management positions had not been in their posts for more than a year or two, and had held several different posts in recent years. The longest-serving manager had been in her post for five years. This poses a particular problem for seeing policies through from development to implementation, especially in the face of poor hand-over mechanisms, as described in Chapter 4. The researcher experienced this first-hand when officials contacted her to ask for an electronic copy of the SHP, because no-one in the National Department of Health knew where to find this important document. Front-line health workers were more stable and moved less within the Department of Health. They tended to move outside of the public health sector or out of the country altogether.

The money

Interviewees cited the absence of a ring-fenced budget for the SHS as a key contributor to the implementation difficulties.

> *No, there's no budget. The budget is expected out of the primary health care budget, but so far it was never served for the SHS* (School health co-ordinator, urban sub-district, Free State)

District managers are responsible for allocating the budget to primary level services.

> *The people who control how the money is spent are the District people* (Senior manager, Western Cape)

They must allocate funds for the delivery of the SHS out of their overall district budget, even though the budgetary allocation did not increase with the release of a new SHP. This is despite the SHP being the only child health policy that provided decision-makers with 5-year cost projections for its implementation. Consequently district managers find it difficult to provide staffing, transport and equipment from their limited money supply. Nurses, who served in the previous vertical service and

had the luxury of ring-fenced resources for school health, were particularly vocal on this matter.

> *When we had a vertical service, we had our own budget. But now the budget comes out from primary healthcare and we need some equipment. The actual budget it's a big challenge. It seems that more emphasis is placed on other primary healthcare activities* (School health co-ordinator, non-case-study province)

The national policy position of integrated service delivery discourages the notion of service-specific budgets. Yet some district managers indicated that even though the SHP favoured integration they were required in practice to handle it as a vertical programme. School health posts were advertised by provincial offices, with no budgetary adjustments.

> *They changed an integral part of PHC then after the school health Policy was approved then they went back to the past. Now when the school health was brought to us it came as a vertical program, it had to have its own personnel. You see I do have school health nursing posts* (District Manager, rural area, Free State)

A few of the district managers intimated that they are obliged to fund the SHS and will do everything they can to ensure that this happens. Others, who find it difficult to fund all services from their allocated budgets, relegate the less-urgent services such as the SHS to the bottom of the pile. In some instances provinces did earmark money for the SHS, but bureaucratic delays in appointments and too few applicants for the school health posts resulted in the money being reallocated.

The effects of other district-level support systems such as the referral system, transport and health information have been discussed in Chapter 5. It suffices to mention here that a well-functioning district health system requires all elements to be in place, including support systems, for effective provision of services.

Impact of systemic policies on districts: Example of the Occupation Specific Dispensation policy

Systemic national policies, in particular the OSD policy which was introduced shortly before the research commenced**,** impacted significantly on district budgets and staff. The OSD is a human resource policy introduced in 2007, intended to retain public sector health workers by differentially compensating them depending on their location and job. Most nurse interviewees spontaneously raised the matter of the Occupational Specific Dispensation (OSD) and the impact it has on their working environment. The criteria for the allocation of the OSD were not clear and the policy had not been applied as expected, as evidenced by widespread protests by doctors and nurses on this point (http:/www.news24.com/SouthAfrica/News/Sama-to-strike-over-OSD-errors:28/2/2010). Nurses gave accounts of the OSD having negative consequences for those engaged in community-based preventative activities such as the SHS, since the OSD seem to be allocated primarily to those engaged in curative care.

> *If you are a school health nurse, they say you don't qualify for that salary level because you are only a school health nurse. Now people are reluctant to do School Health Services. ., they all want to be in primary health care because they sit in clinics, they assess and they assist in primary diagnosis* (Middle manager, DOH)

A nurse manager who works for a municipality in Eastern Cape indicates that their staff members, unlike those who work for the Provincial Health Department, do not qualify for the OSD, even though they work alongside one another.

> *Not all PHC services like the municipalities, we are not on the OSD level. We are not entitled. That has disrupted the services, if I may say, it has really disrupted the service* (Nurse manager, Eastern Cape)

In a minority of research sites school health nurses did not feel disadvantaged by the OSD policy. Unfortunately the researcher could not definitively determine the extent to which the OSD influenced nurses' decisions to opt out of the SHS.

Interestingly, financial compensation such as the OSD did not hold the allure in all instances that policy makers had intended.

> *. . . now one thing I want to tell you Doctor and this is what I told my staff, money don't make people deliver . . . Money don't have an effect and change on the attitudes and the delivery of service in the health. It's your attitude, it's who you are. I was so amazed some of them got 100% and they say sister the work is too much and the work load didn't change and they got 100% increase . . . So money is not always the answer for better service delivery* (Manager, rural sub-district, Western Cape)

This illustrates the complexity of the inter-relationship between the "hard elements" such as money and the "soft elements" such as staff attitude, as a healthy mix of both ultimately determine the quality of service delivery.

The "soft elements" of individual passions, perceptions, and practices

The 'soft' elements of individual capacities, perceptions and attitudes influence the way relationships between levels of the health system are negotiated and experienced. The researcher elicited nurses' and managers' feelings, perceptions and experiences with the SHS. Nurses from the old vertical service were asked about their experience with the new integrated service. New recruits who had not delivered SHS before were asked how they were prepared for their new roles. Managers were asked how they prepared themselves and their staff for the delivery of the SHP. National and provincial interviewees cited the importance of individual personalities in the fostering of national-provincial relationships.

> *It depends on personalities. Some of us in the National department can phone anyone in the provinces and say 'what's going on'. Others will say 'write me a note'. I can walk into any of the provinces at any time without saying I am coming. With other officials they say 'write me a note to say you are coming and I will tell you if it's convenient'. So there are a lot of personality issues* (Senior Manager, National Department of Health)

Perceptions and personalities are in turn linked to the perceived value of interacting with the national department.

> *. . . depending on how valuable they see your interventions, are you going to make any difference with your visit or are you just coming to waste their time?* (Senior Manager, National Department of Health)

This also influences provincial confidence in national decision making as shown in the case of the vaccine policy.

> *I go to National meetings but I don't have confidence in the ability of the National Department* (Senior Manager, Western Cape)

There were similar perceptions and feelings among the nurses across the research sites. Nurses who were newly allocated to the SHS indicated that they did not have a choice in this. The SHS had to be delivered and they simply had to do it. The possession of a valid driving license commonly determined which nurses were allocated to the transport-dependent SHS. When questioned as to whether they would choose differently if given the chance, nurses invariably indicated that they developed a passion for their job and would not change, despite the challenges.

> *I would have done it again. It is interesting; it's nice to work with children* (School Health Nurse, Rural district, Eastern Cape)

> *People first and the Constitution of South Africa say we are servants, so that's why we still like this service* (Nurse, Rural sub-district, Western Cape)

In the Eastern Cape, managers gave accounts of nurses walking to schools or taking public transport, and using on their own money to do so. This is indicative of their commitment to service delivery.

These positive sentiments were common amongst nurses regardless of their previous relationship to the SHS. However, whilst the nurses displayed passion for their work and especially for working with children, unhappiness and frustration with their work circumstances at times overshadow these positive sentiments. Some nurses wept when they spoke about the obstacles that they face in trying to deliver a service of good quality.

> *. . . sometimes I feel it's so heavy on my heart, because I'm thinking I have to move onto another school and I don't see how I can move to another school if I don't feel satisfied. I cannot leave the school and the work is not properly done . . .* (Nurse, Western Cape, Urban sub-district)

Nurses who had not delivered the SHS before spoke of their attitudes to the SHS before they became part of it and confirmed that clinic-based nurses do have misperceptions of the SHS.

> *. . . I was not aware what they were doing there, but I was just looking at the people who just take out the car and get out of the facility and then come back. I thought they were enjoying themselves somewhere. I thought negatively about them, but when I came to do the SHS, hey, it's something else* (School health nurse, Western Cape, Urban district)

Many managers also encountered resistance in getting nurses involved in SHS delivery.

> *We experienced a lot of resistance - "no we can't do that!" . . . School health was just another thing that needs to be implemented. There was very much negativity at the beginning. At the end of the day they didn't have a choice, they just have to do it and they've done it* (Sub-district manager, Western Cape, rural district)

How some characteristics of the SHS influenced its implementation

Conceptual tensions on health service issues that were key to the SHS delivery contributed to the challenges with the SHP implementation.

Conceptual tensions: Prevention versus Cure

One set of conceptual tensions relates to the competition for scarce resources between the more urgent curative services and the preventative services that are often community-based. Interviewees spoke of the pressures of having to deliver highly-pressured curative services, which in recent years have been exacerbated by the burgeoning HIV epidemic, alongside preventative services, both within facilities as well as in community sites such as schools. They spoke of preventative services taking the back stage.

> *Everybody, every person that are working there they're more concentrating on curing . . . They think you are doing nothing by preventing . . . they concentrating on the patients in the Day Hospital that are sick. Preventing*

> *patients not to get sick is not important to them. . I don't know how to get that into their heads* (Nurse, Western Cape, urban district)

In general facility-based preventative services fared better than those based in community sites.

> *EPI, family planning, IMCI, those you definitely do, because you just can't not do them* (Primary care nurses, Rural district, Free State)

Nonetheless, long-standing preventative services are also affected, as evidenced by decreasing immunisation rates in one of the largest urban research sites.

> *I was just compiling a report now. My immunisation coverage has dropped to 69%. We have been at 85 and 90%* (District program manager, Free State)

These same nurses, when asked whether they will initiate a SHS in their area, exclaimed, "*No chance!! As it is they are aware we are so understaffed"*.

Conceptual tension of "vertical" vs "integrated" service provision

Another conceptual tension exists between 'integration' and 'verticalisation'. The abolition of vertical services such as the SHS in favour of integration of all primary level services was a key post-apartheid policy shift and one of the more challenging. Aside from the difficulties of applying it in the delivery of the SHS as illustrated in Chapter 5, other health system challenges such as the scale and seriousness of the HIV pandemic compound this. Exceptions to 'verticalisation' are made in the case of high priority services such as HIV-related services. This contradicts the spirit of integrated service delivery because there is no cross-subsidisation from HIV services to other child health services.

> *HIV is lying there with a huge budget but when IMCI (a child health programme) at sub-district says they are running out of training funds can you help, they are told "no, no, no, this money is HIV/AIDS" But who is affected with HIV/AIDS? It's the same child that you are gunning out. I usually tell them think of this budget as a budget for children, whether the child is coughing, or hair falling out or hungry, whatever. Because once you think of it as the budget for this, then there will be a lot of missed opportunities* (Middle manager, National)

> *I was in the strongest vertical health program you could possibly think of, which is HIV/AIDS . . . HIV/AIDS has a very strong influence on service delivery, especially if you only want to build a parallel health system within a health system to do only HIV/AIDS and it doesn't actually do the other things. Now you can have short term gains . . . but I strongly believe verticalisation in a system like that deters from that system's ability to give a comprehensive service* (Senior manager, Provincial Head Office, Western Cape)

Discussion

This chapter identified three distinct but interrelated sets of factors that provide possible explanations for the poor SHP implementation. The factors explored in this chapter build on the explanations already described in Chapter 4 and that relate specifically to the policy process.

The first set of factors, relating to institutional arrangements, is described in its various forms. The most dominant of these is the South African 'federal' government system with its three spheres of governance. The rules that govern the federal system are defined in the Constitution for the country as a whole and in the National Health Act for the health sector specifically. A 2010 review of the health legislation and policy context for health (Rispel & Moolman, 2010, p127) suggests that "there is an enabling legal, policy and fiscal environment that facilitates the achievement of the MDG's in South Africa. However, there is potential overlap, fragmentation and lack of co-ordination of the various laws and policy initiatives." The researcher shares this perception, especially when considering the contradictory legal statements of the National Health Act and the consequent perceptions about the roles and responsibilities of the national and provincial Departments of Health.

The legal framework governing national oversight and provincial autonomy in particular was not clearly and uniformly understood by health officials. The leeway for provinces to ignore national policy when it conflicted with provincial conditions caused particular confusion and conflict between the national and provincial Departments of Health. This decision to deviate from national policy seem to take two forms: overt defiance, where the provincial stance is clearly and publicly articulated, as in the case of the vaccine and PMTCT policies in the Western Cape; or covertly,

where policy is simply not implemented, as is the case in most provinces in relation to the national SHP. Whilst both situations are deviations from national policy, they have fundamentally different bases. In the overt approach of the Western Cape, clearly articulated reasons were offered for their contrary policy stances on the vaccine and PMTCT policies, and in both instances it concerned matters of principle. The covert approach, using the SHP as an example, is more related to provincial inabilities to implement national policy, rather than fundamental objections to national policy.

Provincial autonomy can have good or deleterious effects for child health. In the case of the PMTCT policy in the Western Cape, the lives of many babies were saved through this intervention (Coetzee et al., 2005). Alternatively, there may have been possible ill effects in the case of the vaccine policy, again in the Western Cape. Deviation from national policy, where provincial lack of competence is the main underlying reason, invariably denies children much-needed health care services, with consequent poor service coverage and expected poorer health outcomes. Of interest is that this strong Department of Health, with a good performance track record in the Western Cape, seems to facilitate their ability to deviate from national policy, without necessarily compromising the health of children.

The findings documented in this chapter also demonstrate that it is not sufficient to have a set of written rules, such as the SHP with its accompanying implementation guidelines, and expect implementation to be successful. The organisational structures through which the rules must be executed may pose obstacles to good service provision. In particular, this chapter shows that where central oversight is weak the deviation from the intended policy goals is significant, as there are inadequate monitoring mechanisms to ameliorate weak or non-existent performance. In the instance of the national SHP, each province, district, facility and individual had the relative autonomy to execute the policy according to their own interpretation. With varied resource capacity (including human and managerial) across provinces and districts, this resulted in non-implementation or poor implementation at best. This

individualism compounds the challenges brought by the federal system of governance, where confusion about roles and responsibilities interferes with good co-ordination and support between different levels of the health system.

However, federalism in itself is not the root of some of the difficulties witnessed in the South African health context. Countries such as Germany have federal governance systems that do not necessarily compromise health care performance. It is the architecture and construction of the federal system and how this applies to the activities across the national and provincial Departments of Health that creates the difficulty in ensuring uniformity of standards in the delivery of health services. This research shows that the exercise of appropriate oversight by the National Department of Health will require strong internal capacity, including skilled staff and robust health and management information systems. It also requires a clear understanding of what the rules do and don't allow. National child health managers had weak capacity. In addition, as regards their mandates on the implementation of national child health policies, provinces have different understandings of what autonomy means. In the context of significant inequity, common national goals might have to supersede individual provincial, or district requirements. These issues are compounded by the weak leadership and strategic direction provided by the National Department of Health. Where clear and decisive direction was required in some key areas of child health policy, only weak broad policy guidelines came forth. These broad guidelines were insufficient to assist provinces, who already struggled with weak capacity, to further develop provincial child health policies and implementation plans for these key areas of child health.

The legislative arrangements, in particular the matter of provincial autonomy and whether it works for South Africa or not, are currently receiving much attention. A recent report outlines a 'roadmap' for the health system of South Africa (Development Bank of South Africa, 2008). A key recommendation of this report was a review of the relationship and relative power between national and provincial Departments of Health (ibid). This recommendation is based precisely on the kind of

experiences associated with the SHP and other similar interventions. However, the challenges with the current system of governance go beyond the Department of Health. A 2011 diagnostic review conducted by the National Planning Commission in the Presidency (Republic of South Africa, 2011) makes recommendations for the country as a whole. Shorty after the release of this 2011 review, and for the first time in the post-apartheid period, national government displayed strong oversight by placing several departments in four debt- and corruption-ridden provinces under 'judicial' administration and took control of their management (http://www.pmg.org.za/report/20120209-national-government-interventions-gauteng-free-state-and-limpopo-mini).

Notwithstanding this concern with the governance system, poor structures, relationships and communications between the national, provincial and district levels of the health system were an even greater concern. A senior national manager explains the shortcomings of the National Department of Health in executing their service mandate, despite the current contestations of constitutional provisions for national and provincial departments:

> *There are some people who believe that, notwithstanding the Constitution, there a number of things that National Department can and should be doing but is not doing, in terms of intervening and providing direct support to service delivery needs* (Senior manager, National Department of Health)

This research highlights a further challenge to successful child health policy implementation, namely the constantly developing and evolving health system. As described in this chapter, provincial and district health system structures are still in their infancy and already additional changes are being contemplated. Consequently the health managers and service providers are constantly chasing moving targets, which hampers the ability of the health system to "settle down". This change process is compounded by the large volume of new policies and programs that the National Department of Health had developed in the post-apartheid period. Regardless of the merits of these policies, there is little elasticity at district level to absorb yet another new policy, as is demonstrated in the case of the SHP. As indicated in Chapter 4, a

second wave of major policy reform is already underway, including the development of a National Health Insurance system, as well as new developments with the SHP.

The failure of the SHP, aside from the shortcomings in the policy development process, can be ascribed to a number of additional factors: the lack of a policy translation process; the lack of the special requirements of the SHS as a community-based service; and the lack of proper guidelines on how the SHS had to be integrated in different district contexts. For policies such as the SHP that have special inherent requirements, such as having to be delivered in community sites and being particularly dependent on good inter-sectoral relationships, special support and consideration must be given to achieve these conditions, since the requirement of inter-sectoral collaboration does not otherwise fall within the normal ambit of PHC services. Special effort must be made to facilitate this. Similarly, the service is completely transport-dependent. Again, special effort is required to provide this basic essential resource for the service. As indicated by Schierhout and Fonn (1999), sometimes a degree of 'verticalistion' is helpful to get the service off the ground.

In addition, other policies that have system-wide influence, such as the OSD, particularly affected preventative community-based services, as this remuneration framework favoured specific categories of staff delivering curative services. All of these aspects point to a policy reform process in South Africa that was fragmented, and where systemic developments and micro-policies such as the SHP were not properly aligned. Absence of strong leadership and good central capacity resulted in a lost opportunity to develop an overarching policy framework to guide and support the delivery of the good quality child health services, in particular those at the primary level.

As shown with the policy development process in Chapter 4, the passion and power of individuals also impacted on the SHP implementation. Front-line service providers and districts managers in particular are deemed 'street-level bureaucrats' by the researcher, as denoted by Lipsky (1980) in his street-level bureaucracy theory. The researcher extended the definition of street-level bureaucrats beyond service

providers and included district managers, as they have a direct influence on front-line implementers and a direct bearing on the implementation of services. The SHP case showed that the power of street-level bureaucrats can be used to good or ill effect. In the case of the SHP nurses, despite their dissatisfactions, this group did not deviate from their commitment to deliver the best service they could under the circumstances. Their facility-based nursing colleagues and managers, however, used their dissatisfaction with the staff shortages to thwart the efforts of school health nurses and were the most powerful obstacles to the SHS provision. District managers exercised their decision-making power and ignored this national policy when they were unable to fit the SHS into their resource base. They met with few repercussions from their senior managers. Similarly, transport managers, who might otherwise be overlooked as important street-level bureaucrats, have a powerful impact on the SHS delivery. Their discretion over vehicle allocation gives them this power and as shown in the case of the rural nurses in the Eastern Cape, in some instances their decisions were guided by personal favouritism rather than by service needs. In the case of the SHP and other child health policies where equity is a dominant policy goal and where central direction and oversight is weak in all levels of the health system, such power of individuals at the level of service implementation may have dire consequences for service delivery.

The powerful influence of street-level bureaucracy is also apparent in other policy implementation experiences in South Africa (Erasmus & Gilson, 2009; Scott in Gilson et al., 2006; Walker & Gilson, 2004). In particular Walker and Gilson examined the experience of nurses with the implementation of the Free Health Care policy for children. In their paper, "We are bitter but satisfied", nurses expressed their feelings about their exclusion from the policy process and the burden of having to deliver services with these feelings of disgruntlement and inadequate resources. Yet, from the researcher's knowledge, these soft factors receive little attention in national and provincial Departments of Health. In a presentation on the development of the district health system in Western Cape, a senior manager acknowledged that,

following much effort in getting structures and systems in place, the next phase will involve staff development and support and will focus on quality of health care provision (Cloete, 2011).

Finally, a fundamental weakness in the current functioning of the South African 'federal' system is that it inadvertently thwarts, rather than promotes, equity. In a strong and well-functioning system, variations in commitment, competence and resources can be compensated for, but in a weakly-functioning system, as is the current case with the DHS, poorly-performing provinces and districts are not adequately supported and brought up to an acceptable level of delivery. This is addressed in detail in the next chapter.

Chapter 7: How equity manifested in child health policy development and implementation

Introduction

This chapter speaks to whether, and how, equity is addressed in South African child health policy development and implementation. The reduction of inequity in various facets of health service provision and health outcomes is a key policy goal of the South African health sector. It also features as a prominent goal in other sectors of South African society. In fact, equity is an issue of key concern in all health system reform processes, in rich, middle-income and low-income countries. The concept of equity and its application is also a key research theme throughout this thesis. It therefore merits a separate chapter for exploration of the concept and of application of equity in child health policy reform.

This chapter builds on the conclusion drawn by the researcher from the documentary analysis of the overarching health sector reform policy documents, that "the context for child health policy reform was predominantly favourable and held great promise for the development of equity-orientated, redistributive child health policies". It explores whether the child health policy reform process capitalised on this favourable context and whether, and how, child health policies integrated equity in their development, content and subsequent implementation. It does so by examining the expressed aspirations on equity in the overarching policy documents, and how these overarching goals were followed through in child health policies. It goes further by linking the expressions on equity in child health policies to the SHP implementation findings, where lack of progress in achieving a more equitable SHS provision is shown clearly in Chapter 5. The chapter then deepens the exploration of

how the various factors that influenced implementation also affected the achievement of equity in child health service provision. In particular it looks at the federal system of governance in South Africa and its impact on addressing widespread and significant health sector inequities. All these issues are located in the prevailing discourse on equity in health and health care. In particular, the issues from this research are linked to three important concepts that feature in the literature on equity in health and health care: conceptual definitions of equity; the parameters of equity; and notions of vertical and horizontal equity. The chapter concludes by identifying factors for further consideration in the development of pro-equity child health policies.

The concept of equity

Equity in its manifold manifestations is considered one of the most fundamental features of a just society. It is a complex concept however, and definition, dimensions, measurement and amelioration of equity are an ongoing concern, as evidenced by the many and varied writings on the subject. Attainment of equity remains elusive across all countries. Wilkinson and Pickett (2005), in their seminal volume *The Spirit level: Why equality is better for everyone*, view inequity (or inequality as they term it) as a human rights violation, resulting in the systematic "genocide" of individuals living in deprivation in one form or another.

Health is one of the fundamental human rights, as promulgated by the International Covenant on Economic, Social and Cultural Rights (United Nations, 1966). Consequently, the pursuit of equity in health and health care has been on the international agenda for a number of decades. South African children are accorded the "right to basic health care" (Republic of South Africa, 1996) and the "right to the highest attainable standard of health" (United Nations, 1989, Article 24, 1), making child health a rights-based obligation of the state. But Chapter 1 also outlines a situation of large margins of inequity in health outcomes amongst children that

directly contradicts their stipulated health rights. These inequities arise from the varied economic and social conditions in which children are born, and live. The parameters, interlinked with one another, that contribute to these inequities are race,[51] socioeconomic situations of households, and geography. The majority of children who are poor are also racially classified as black and live in rural areas (in particular those which coincide with previous homelands), on the fringes of large cities, or in poor over-crowded neighbourhoods. These three parameters of difference also determine the kinds of health services children have access to and, as in the case of the SHS, this varies significantly in quantity and quality.

Linking definitions of equity to the aspirations of South African health care reform

The first conceptual issue that needs to be clarified is the distinction between equity and equality, since the researcher noted that the two terms are often used interchangeably in the South African health policy documents. Inequality refers to differences in patterns of health "whether applied to individual differences, social variations or socially structured inequalities (Graham, 2007, p 4). Simply "describing what it is, makes no moral judgements on what should be" (ibid, p10). For example, differences in health patterns between older and younger persons are not of necessity unfair or unacceptable, but are merely due to age-related biomedical factors. In contrast, inequity has moral implications, and refers to health inequalities which are "politically, socially and economically unacceptable" (Declaration of Alma-Ata, 1978, p1). Inequity reflects systematic, avoidable and undesirable differences brought about by unfairness, injustice and skewed resource distribution (Graham, 2007; Petticrew & Whitehead, 2004). The distinction between inequality and inequity is thus more than just semantic, and has fundamentally different implications for policy and health service development.

[51] As defined in the apartheid era. Definition provided in Chapter 1.

How was 'equity' articulated and conceptualised in South African health policy documents?

According to Braveman, equity-orientated policies reflect their intentions in the kinds of information sourced during the policy analysis, in the actors that participate in the process, and in the content of policies (Braveman, 1998). This section specifically examines how equity manifested in the content of health policy documents.

Achieving equity was a commonly expressed reform aspiration; the terms *equity* and *equality*, *inequity* and *inequality* (also referred to as *disparities*) feature no fewer than 102 times in the overarching health policy documents.[52] For example:

> At the heart of the Government of National Unity is a commitment to effectively address the problems of poverty and the gross inequality evident in almost all aspects of South African society . . . (Preamble, White Paper on Reconstruction and Development, 1994)
>
> The health sector must play its part in promoting equity by developing a single, unified health system; Health care financing and resource allocation policies should promote equity of access to health care services among all South Africans, between urban and rural areas, between rich and poor people, and between the public and private sectors . . . Financial resources should be allocated equitably . . . Physical resources should be distributed equitably. (White Paper on the Transformation of the Health Care System, 1995)

Notwithstanding the numerous reiterations on the importance of equity, none of the documents clearly and consistently indicate what equity in health care reform means in South Africa. In the researcher's judgement, the interchangeable use in the documents of the terms equality (inequality) and equity (inequity) reflects mere impreciseness on the part of the policy makers rather than any intentional conceptual distinctions. The policy documents all make consistent reference to the political, economic and resource distribution injustices of the past as an explanation for the health 'inequities' or 'inequalities', with the implication that fundamental changes in

[52] The word count for "equity" was done on the electronically available documents only and excludes the MCWH Policy and PHC Package.

political, economic and social structures are required in society as a whole and in the health sector specifically to eliminate inequity. This statement from the foreword of ANC Health Plan exemplifies the policymakers' position that inequity stems from moral and social injustices:

> The challenge facing South Africans is to design a comprehensive programme to redress social and economic injustices . . . In the health sector this will involve the complete transformation of the national health care delivery system and all relevant institutions. (Foreword, ANC Health Plan, 1994)

The most commonly expressed equity goal across these documents is "equity in health service provision". Although not explicitly stated in documents, the researcher infers that the availability, accessibility and quality of health services should not be different for citizens according to their race, socioeconomic status, ability to pay for health services, or geographical location. In the documents, the PHC approach is advocated as the philosophy which should underpin the drive towards increasing access and addressing inequities in health care provision:

> . . . reduce disparities and inequities in health service delivery and increase access to improved and integrated services, based on primary health care principles. (White Paper on the Transformation of the Health Care System, 1995)

This aspiration in the White Paper also addresses equity of service provision and advocates for a 'vertical equity' approach, described in a later section, to prioritise those who are most disadvantaged socio-economically.

> Priority will be given to the most underserved areas and the intention is to bring the provision of PHC services for the poorer two-thirds of the population up to the level of that for the better off one-third by the year 2000. (ibid)

The first exclusive policy for women and children, the MCWH policy, also addresses the health of the most vulnerable sections of the population. In this policy document equity is a central focus, as articulated in its stated principles:

> Equity is the first priority and the most vulnerable must be focused on first. Health services will give priority to those groups, populations and regions,

> which have been the most seriously affected in the past and therefore have the highest mortality rates and other evidence of deprivation.
>
> . . . planning of service delivery to achieve equity in relation to population and needs . . . (Draft Maternal, Child and Woman's Health Policy, 1995)

The focus on equity continues in the National Health Act, which was the last of the six overarching documents to be released, in 2003. In the Act, equity appears as the first of 11 principles to guide the development of the District Health System.[53] This made equity more than just a political aspiration, but a legally-binding requirement in health care reform. The Act requires that the health ministry:

> . . . establish a health system based on decentralised management, principles of equity, efficiency, sound governance . . . (National Health Act, 2003)

The documents make it clear that closing the inequity gap through equity-sensitive health policies was a key priority. While not fully defined, the main parameters of equity expressed in the overarching policy documents are those of health service provision and access, and the need to focus on the most deprived groups in society. The challenge for micro-level[54] policies such as child health policies was to translate these broad statements of intent into tangible policies and plans. As stated in the White Paper on Reconstruction and Development:

> policies cannot be piecemeal and uncoordinated. (Republic of South Africa, 1994a)

Like the overarching policy documents, all child health policy documents contain statements that cite equity as an important goal of child health service reform. Statements on equity feature primarily in the introductory sections of child health

---

[53] The District Health System is defined by the WHO as "the structural and organisational arrangement of the health system at community/or primary level through which health services that are aligned with the Primary Health Care approach would be delivered"

[54] Micro-policy is defined as policy which only affects particular sectors, districts, neighbourhoods or groups. Policy for children falls under this definition. It is distinct from ***macro policy*** which affects the whole country and is concerned with monetary, fiscal, trade and exchange rate conditions as well as with economic growth, inflation and national employment levels. Source: http://www.greenfacts.org/glossary/mno/macro-policy.htm

policy documents where principles and visions are outlined and in the sections where the policy issue is characterised.

> Inequity that existed within the service during the apartheid years and which still persists . . . (Introduction section, National School Health Policy and Implementation Guidelines, 2003)
>
> Tackling Inequality and Poverty (Guiding Principles of the Policy Guidelines for the Implementation of the PMTCT Programme, 2008)
>
> Interventions that aim to improve infant and young child feeding should be comprehensive, integrated and equitably distributed. (Guiding principles, Infant and Young Child Feeding Policy, 2007)

Some documents do not use the specific terms *equity* or *inequality*, but imply them in statements such as these:

> . . . ensure that services are easily accessible, available and affordable to the majority of the population of children and adolescents. . . (Executive summary of the Policy guidelines for Child and Adolescent Mental Health, 2003)

These statements plainly indicate that policy makers perceived the importance of striving for equity through child health service reform, but the documents contain few specifics on what they mean by equity and how they propose that it be achieved. Unlike the overarching policy documents that contain broad statements of intent, one would expect micro-policies intended to give clearer policy direction on the structuring and delivery of child health services to contain more detailed proposals on equity. Yet while the child health policy documents' content fail to detail or clarify what their framers mean by equity, the underlying intentions of these policies nonetheless reveal interesting interpretations and approaches to promoting equity. This is elaborated on in later sections.

The parameters of equity

The second conceptual issue relates to the parameters of equity that require change. From his vantage point as a philosopher and development economist, Amartya Sen asks the question "what needs to be equally distributed to make a

society just?" (Graham 2007, p11). Sen further suggests that "the real work begins with the specification of what needs to be equalized' (ibid, p12). The potential outcomes of equity-focused interventions are manifold and form a continuum. At one end of the continuum Sen, in his *capability* approach, suggests that the ultimate attainment of equity is when each individual, within their particular context, can fully reach their personal capabilities unhindered by structures and circumstances (ibid, p13). What this means in practice for social services such as health is still under debate. At the other end of the continuum, Rawls defines equity as the "equitable provision of primary social goods" (ibid, p12). Primary social goods he defines as the "minimum set of rights and resources that individuals need to participate as equals" (ibid). Whilst there is some contestation of what constitutes primary social goods, Daniels (ibid, page13) extending Rawls' concept of primary goods, suggests that providing access to health resources can be defined as a primary social good. However, a counter-argument to Daniels is that simply providing a basket of primary social goods does not automatically guarantee access, since this is dependent on many other factors (ibid). The researcher, like Daniels, views the provision of health services as an important intervention in the pursuit of equity – hence the detailed exploration in this research of how child health services fared with provision and coverage.

In the health care environment the question of "what needs to be equalised" is complex. On the one hand there is "equalisation" of health outcomes and on the other there is "equalisation" of health services (Whitehead & Dahlgren, 2006). Equalising health outcomes is complex and dependent on multiple variables, as shown in the ecological framework in Figure 1. This is acknowledged in the foreword of the ANC Health Plan and in the other overarching policy documents, where statements intimate that interventions across many sectors are required to ameliorate health outcomes. "Equalising" health services is more manageable for health policy makers and managers, as it is directly under the control of the health sector. However, health service equity is also complex and multi-dimensional. It has three main axes, which

the researcher has slightly modified from Whitehead's "Concepts and principles of equity and health" (Whitehead, 1992): equity of provision; equity of access; and equity of quality.

Promoting equitable health services is expressed as a goal in various sections of the ANC Health Plan: "equity of access in health care"; "equity in distribution of independent practitioners"; "equity in health service provision". However, these are not all the same thing, and, again, neither the Plan nor other policy documents specify clearly which health service dimensions "must be equalised". Ensuring equity of access in health care, for example, is partly under the control of the health sector and partly dictated by factors outside of the health domain. And while health services may be available, additional factors such as financial circumstances of users, transport availability and cost, distance from health facilities, and cultural factors also determine access. Some of these factors such as transport lack have been shown to determine whether children are able to access health services (Leatt et al, 2006). On the other hand, the provision of equitable health services is relatively uncluttered by external factors, since the responsibility for this rests squarely with the health sector.

This thesis regarded child health services provision as a measure of whether equity had been achieved.[55] While the SHP did not explicitly state what the equitable provision of the SHS means, the researcher, through her intimate knowledge of the SHP process and the interviews conducted, understands this to mean that both the quantity (meaning the SHS coverage) and the quality of the service will be comparable between schools, regardless of the geographic location and socioeconomic status of the school population. Results in Table 9 indicate that the SHS coverage is low throughout the country and range from infrequently provided to non-existent in many of the research areas. In this context of such overall poor implementation, differences in coverage between research sites were not as stark as anticipated. However, the quantity and quality of the service, as measured by the

[55] In Chapter 1, provision of health services means that "health services have been put in place by the Department of Health and are available to communities for their use".

nurse/school ratios, by the frequency of service provision, by referral service availability, and by quality of the service as defined by nurses, did differ between rural and urban areas, between the high and two lower-income case-study provinces, and between sub-districts with different deprivation indices.

Interestingly, since the Western Cape had the best SHS provision across all nine provinces, it displayed the kinds of inequities that the researcher expected to find more clearly throughout all research sites. The Western Cape results typified the anticipated differences along socioeconomic and geographic axes. The urban district of this province fared better than its three rural counterparts. The urban district had also retained a large number of school health nurses from the previous vertical service, thus making the SHS implementation easier. Rural districts did not have this advantage, and delivered the SHS from pressured clinics and through teams which had a range of other responsibilities. Rural districts also did not receive any additional resources or support to bring their service to the same standard as that of their urban counterpart. Further differences emerged in the urban district between sub-district areas. Schools in the largely black and poorest areas have fewer nurses with lower nurse/school ratios. Nurses in these areas also tended to be less experienced, with no training and little managerial support. Nurses also commented on differences in SHS access for children at school in typical middle-class schools in wealthier suburbs and those at school in poorer areas. Some of the wealthier schools have a SHS exclusively for their own use. Those which did not, were assumed by nurses to have access to private health care services. The majority of children, however, are dependent on the poorly-provided public sector SHS.

Horizontal and vertical equity

The third set of equity concepts, relating to 'horizontal' and 'vertical' equity, (Whitehead, 1992; Whitehead & Dahlgren, 2006), has its origins in economics. Horizontal equity implies that resources will be shared equally amongst recipients with the same needs (http://www.economicshelp.org/blog/935/economics/horizontal-and-vertical-equity). This is akin to a universal approach where different needs and

capacities are disregarded and everyone gets an "equal slice of the cake". Vertical equity implies that differences are taken into account and resource distribution is differential according to different need (ibid) and is akin to a targeted approach. Vertical equity implies that a degree of inequality is purposively created in order to get everyone on the same footing.

South African society is familiar with this concept of "fair discrimination" as it is embodied in a number of laws and policies beyond the health sector. Employment equity is one example, where previously disadvantaged groups are given greater opportunities and preference in the workplace, until a situation is reached where all groups are capable of competing equally for jobs (Republic of South Africa, 1998). The purpose statement in the Act refers to "implementing affirmative action measures to redress the disadvantages in employment experienced by designated groups" (ibid). Allocation of provincial budgets (from central Treasury) according to an "Equitable Share" formula is another example, which redresses income across provinces taking account of provincial population size and select indicators, from different social sectors, that reflect need, including health needs. Provinces with larger populations and greater social needs get a proportionally greater share of the budget until a situation of equilibrium is reached (Ajam et al., 2009; Rao & Khumalo, n.d.). There is no national prescribed formula for how provinces spend their allocation. At provincial level, however, different sectors have to 'fight' for their share of the formula, and the proportion that goes to provincial health varies between provinces, resulting in variations in per capita expenditure on health (McIntyre, 1995). So, while the equitable share is weighted towards addressing inter-provincial inequities, provincial allocations to different social sectors might not necessarily be based on an equity agenda.

Did child health policies promote horizontal or vertical equity?

The "Free Health Care" policy that emerged from proposals in the ANC Health Plan and the RDP White Paper best exemplifies an equity-orientated child health policy (Republic of South Africa, 1994b). When compared to the other eight policies,

this policy has a clear redistributive agenda, as it proposes universal free access to health care for children in their most vulnerable years. It interestingly combines the concepts of vertical and horizontal equity in a single policy, thereby attempting to address inequities within and between subgroups of the population. The policy promotes "vertical equity" by focusing on children and pregnant women as two vulnerable groups requiring special consideration for health service access, thus advantaging them above other sections of the population. It simultaneously promotes "horizontal equity" by requiring universal[56] provisioning of free health care to all individuals in these subgroups. The later incremental extension of free health care to all citizens who use public sector primary level services expanded horizontal equity. The extension of free hospital care to children older than six with moderate and severe disabilities further promotes vertical equity by prioritising a particularly vulnerable subgroup of children.

In the School Health, Youth and Adolescent Health, and Child and Adolescent Mental Health policies, one might argue that the focus on older children and previously neglected subgroups of children, such as those with disabilities and children with mental health problems, uses a vertical equity approach to bring these children to the centre of policy reform. The parameter of "equalisation" for health service provision is their specific health conditions, where they now have access to services similar to their peers with different health conditions, or none. Whilst this is the intention in these policies (with the exception of the SHP), policy documents provide little guidance on how resources should be redistributed to reach these subgroups of children and what exact service reforms are required to improve provision and access. So while the policy intentions on equity are laudable, the inadequacy of explicit equity meanings and pro-equity strategies in micro-policy documents does not help to advance equity in practice.

[56] Universal, with the caveat of it not being available to privately insured families and those earning above a certain income threshold – but this threshold was set very high so the possibility of excluding those who live in poverty and low-income earners was nil.

A glaring oversight in child health policy documents is that children who fall in the bottom deciles of the Index of Multiple Deprivation (Barnes et al., 2007) receive no explicit attention in the policy content. This is despite the many aspirations expressed in policy documents of reaching the most deprived sections of the population. The Free Health Care policy, for all its laudable intent, also fails to indicate how health service provision for these children would be addressed. In an evaluation of this policy done one year after implementation, the researchers could not determine whether the most disadvantaged children benefited from free health care provision (McCoy, 1996). This bears out the concern raised by Braveman that unless you specifically consider equity it might not automatically occur. In addition, it will not be easy to measure equity progress in retrospect, as the appropriate data might not be available (Braveman, 1998). The lack of consideration of children who are most socio-economically deprived in policy proposals holds true for all of the other eight policies. The task of translating the in-principle national policy commitments to equity into tangible pro-equity implementation plans is consequently left to provinces and districts.

Although the SHP is the one policy that explicitly mentions prioritisation of disadvantaged groups in its implementation guidelines, thereby addressing vertical equity, consideration of equity in the SHP process goes no further than that. In the only part of the SHP where it instructs provinces to prioritise the most disadvantaged schools, the wording "should consider doing it" is tentative and makes it sound optional. In the SHP development process policy makers did not adequately contemplate equity. When interviewees were asked whether and how they considered equity during the SHP development their responses were vague and generalised. This suggests that promoting equity as a key policy goal was really an afterthought, not specifically considered during the policy development. The most definitive statement came from the head of the task team, who said that "the policy allowed for the conceptual understanding that resources will not be equal amongst provinces". She acknowledged however that the eventual resources and support did not match this

understanding, as no specific funding was allocated to districts for the SHP implementation. She did indicate that without high level support equity could not be achieved.

> *Policies are developed at national level, and honestly, if there is no paradigm shift from cabinet, equity is just a buzz word. It will never happen.* (National Policy Task Team member)

Despite the lack of policy guidance, front-line nurses lent their own interpretation to vertical equity and often used phrases such as "providing resources according to need", "prioritising struggling areas" and avoiding a "one size fits all" approach. In their positions as "street-level bureaucrats" (Lipsky, 1980), they found definite ways to exercise their own brand of justice and "right the wrongs of the past". Even though they do not specifically articulate their actions within an equity framework, the intention and results promote the tenets of equity within PHC services. Nurses invariably skipped the Model C[57] schools which serve chiefly white and middle-class black children. Their rationale was that some of these schools had their own private school health nurses, and children in these schools could also afford to get the SHS elements (such as vision testing and corrective lenses) through private providers. They preferred to focus their limited resources on public sector schools in more disadvantaged areas. So the SHS performed an interesting about turn and applied a vertical equity approach where, unlike the apartheid era, 'white' schools were neglected in the pursuit of fairness.

Health officials' perspectives on equity

The failure to give meaning and content to the concept of equity in child health policy documents prompted the researcher to explore the views of health officials. Fifteen years into the reform process, it was important to ascertain whether it was lack

[57] A Model C school is a public sector fee-paying school, located in white middle- or upper-class residential areas that were occupied by whites during the apartheid years. With the abolition of apartheid, these schools opened their doors to black children who could afford the fees, thereby making the schools elite and reserved largely for white and middle-class black children

of conceptual understanding of equity that might have contributed to these omissions from policy documents. Quite to the contrary, it emerged that the concept was indeed important to health officials, as more than half of the interviewees raised the question of equity themselves without any prompting. This suggests that equity is constantly on the agenda of health officials and that they grapple with the concept in their daily activities. Not unexpectedly, policy makers, managers and service providers provided different definitions when asked for their understanding of equity. Nonetheless, commonalities across responses emerged that are in keeping with contemporary definitions from the literature.

Most interviewees alluded to the complexity of the term and its application, and how it means "different things to different people". Most interviewees also associated inequity with the oppressive policies of apartheid and saw it as a human rights and social justice issue. Responses from interviews traversed the continuum of approaches to equity. At one end of the continuum, this definition by a policy task team member echoes Sen's capabilities approach:

> *So equity at the time was, can we give them the same opportunity of being healthy on the same level* (National Policy Task team member)

Another task team member defined equity along parameters of access, as influenced by socioeconomic differences.

> *At the end of the day what we wanted to achieve for each of the provinces was that for a child living in the Eastern Cape having the same access to health care and having their health needs met as a child living in a more resourced area* (National Policy Task team member)

Interviewees recognised the difficulty of achieving equity in health outcomes as opposed to equity in health service provision and access, much in line with Daniels's concept of equity as a set of primary social goods.

> *You can either look at equitable access to services to make sure that everyone gets the same services, and that's probably what we aiming for at the moment. Equitable outcomes we will worry about in the future* (Senior Manager, National Department of Health)

A senior manager who was part of the health reform process from the outset also made the distinction between vertical and horizontal equity.

> *The first five years we took the issue of horizontal equity seriously. Because of the history. We couldn't do things differently in different areas, because "what was good for urban areas must be good for rural areas". That was the basis for all policies in government . . . it soon became clear that the absorbtive capacity of rural areas was different to the absorbtive capacity of urban areas . . . we needed to move from, not move from horizontal to vertical equity, but also focus on vertical equity* (Senior manager, National Department of Health)

This statement suggests that any equity strategy had to be carefully contemplated for the particular time and context. In particular the equity intentions of health system reforms in areas with differing capacities had to be considered.

Impact of federalism on the equity agenda

The researcher specifically considered the link between federalism and equity, since federalism is an important explanatory factor for poor child health policy performance. The oversight role of the National Department of Health is particularly important for the achievement of equity because there are wide disparities in the capacity of provinces and districts, yet national officials felt powerless and incapable of intervening to support struggling provinces. This is partly due to the autonomy of provinces and partly due to weak capacity in the national child health directorate. The researcher argues that in the face of such a dominant equity agenda strong leadership and central oversight is required to help "equalise" health care interventions. Therefore the current status quo where individual provinces, districts, managers and individual service providers interpret and apply policy differently destroys, rather than promotes, an equity agenda. The researcher suggests that this is why, six years after the implementation of the SHP, equity in SHS provision still seems out of reach, and why little has changed between the pre- and post-policy periods.

Discussion

Despite the strong explicit political emphasis on equity as a reform goal, this research found only a superficial application of this goal in child health policy development. In South Africa the legislative competency and the assigned role of the National Department of Health is policy development and oversight. It is here where the responsibility lies for the development of equity-orientated policies. Yet although policy makers and planners were cognisant of the need to address equity and had a reasonably good understanding of the concept, this did not manifest in equity-orientated policy content, implementation plans, or resource distribution. Aside from the redistributive Free Health Care policy, the other eight policies have no substantive content that promotes an equity agenda. Absence of specific policy direction on how to achieve equity in health service provision is, in the opinion of the researcher, a key contributory factor in failure to achieving equity in health care for children. This in turn contributes to the still inequitable child health outcomes.

Yet equity is not an easy concept to address and seems to be consistently so across contexts (Braveman, 1998; Whitehead, 1992; Vitora et al., 2003; Gilson et al., 2006; Sander & Chopra, 2006; Graham, 2007; Moreno & Maurecio, 2009; Nkonki et al., 2011). As early as 1989, Gilson (1989) noted the challenge of making health policy more equity-orientated. She argued that a differential and unequal allocation of health care is required to meet people's differing needs – in other words a vertical equity approach – but commented that very few policies pursued this approach. In a more recent review of 391 policy analyses from lower- and middle-income countries around the globe, of which 164 were methodologically sound enough for inclusion, the authors report that "only 15 articles explicitly considered the influence of a policy's equity focus over the policy process" (Gilson & Raphaely, 2008, p299). This suggests that equity considerations are still not high on the agenda of policy researchers in low- and middle-income countries. It also partly reflects inexplicit focus on equity in policies and policy processes themselves, since analysts clearly did not pick this up as an important goal of policies that they reviewed.

Despite the challenges with the concept and its application, equity is still a dominant agenda item for both developed and developing countries. In two well-known reports on equity in health care in the United Kingdom, those of Black[58] and Acheson,[59] inequalities were identified as an important public health challenge and recommendations were made for their remediation. Yet several decades after the release of the Black Report, the situation is evidently unchanged (Exworthy et al., 2003). Exworthy et al. (2003) do concede that the matter of health inequalities does at least now feature on the UK health agenda. A paediatrician who has managerial oversight of one of London's foremost hospitals for children indicated that inequity in infant mortality rates and immunisation coverage rates still exists between children who live in wealthier London suburbs and those who live in suburbs populated by poorer, mainly immigrant families (Personal communication, Professor Peter Lachmann, 2010). While the margins of the child health inequities in London pale into insignificance when compared to those in counties such as South Africa, it nonetheless poses important considerations for planners of child health services in London. In a presentation of a new London health care plan for children, the second principle in the plan reads: "A focus on health inequalities and diversity" (Mitchell, 2010). In a subsequent integrated plan entitled "Healthy Child Programme", the need to address inequalities features prominently throughout (Department for Children, Schools and Families, 2009). Further afield, a substantial body of literature from the

[58] Black Report entitled "Inequalities in Health", 1980. The Black Report (1980) on health inequalities was commissioned by the Labour government in 1977. It identified four possible explanations of health inequalities: artefact, natural selection, cultural, and structural, but saw no role for health care in reducing health inequalities (Mackenbach Stronks, and Kunst 1989). The report was rejected by the Conservative government (then in power) because the proposals were too costly and because of their political antipathy to the issue. Thus for more than a decade the Black Report had little or no impact on policy (Berridge and Blume 2003; Davey-Smith, Bartley, and Blane 1990).

[59] Acheson Report entitled "Independent Inquiry into Inequalities in Health", 1998. The inquiry was asked to "moderate a review of the latest available information on inequalities in health" and "to identify priority areas for future policy development." The Acheson Report (Acheson 1998a) concluded that the "weight of scientific evidence supports a socio-economic explanation of health inequalities." It supported a model that was composed of different layers including individual lifestyles and the socioeconomic environment (Dahlgreen and Whitehead 1991). Addressing social determinants, the report considered poverty, education, employment, housing, transport, nutrition, the life-course, ethnicity, gender, and health care. The report made 39 recommendations, three of which were claimed to be "crucial".

United States highlights inequity in health outcomes and health service access as one of the most critical features in the health care challenges of that country (Byrd & Clayton, 2003; Smedley et al., 2003; Skinner & Mayer, 2007; Berdahl, et al., 2010). Similarly, in an analysis of public health policy for children in Australia the author expresses concern about inequalities should the policies not be implemented appropriately (Leggat, 2004).

Developing countries face even greater challenges in addressing equity. Brazil is a country comparable to South Africa in history, income status and health problems. Like South Africa, it is cited as one of the most unequal societies in the world according to its location in the Gini coefficient rankings. At the turn of the century significant progress has been recorded for the diminishing of child deaths and disease in Brazil (Vitora et al., 2000). Yet, despite these advances, inequities remain (Vitora et al, 2003). In Brazil an interesting "inverse equity hypothesis" was applied to the analysis of mortality and morbidity trends in children. The hypothesis proves that, in Brazil, health improves for richer children first, thereby initially widening the inequality gap. Thereafter, if appropriate targeted interventions are available, health of the poorer children will improve (Vitora et al, 2000). This is clearly demonstrated for the SHP where the relatively wealthier urban district of the Western Cape, the province with the best health resources, most successfully implemented the SHS, while the rural Western Cape districts and the other eight provinces lagged behind. As described in Chapter 1, child health mortality indicators show that inequalities have widened between groups, most likely due to the inverse equity hypothesis. This is supported in an analysis of the extent of, and the determinants for, child mortality in three sites of different socioeconomic status in rural and peri-urban South Africa (Nkonki et al., 2011). The authors demonstrate the inverse hypothesis very well, in that wealthier children had greater access to health care and shouldered the least share of the health burden for children.

In Brazil, overall improvements in the health of poorer children were due to improvements in socioeconomic conditions, but also to policies that specifically

targeted the most vulnerable children. The Brazilian approach, by considering the "inverse equity hypothesis", brought the health status of poor children closer to that of their wealthier peers. This is in contrast to the predominantly universal child health policies in South Africa, where there is no explicit and consistent targeted approach for poorer children. For the first time in the post-apartheid period, a more targeted approach was adopted nationally in 2009 to try and improve child and maternal health in South Africa for the poorest sections of the population. This initiative was launched just before the commencement of this research and a senior manager recounted it to the researcher:

> *We identified 18 districts in the country . . . we identified two indicators on the child's side, for accelerated attention and intervention, as one way to reach some of the MDGs, especially four and five. We came up with a basket of services that we think we needed to reinforce. Nothing new. Not new programs, new emphasis and additional support to districts to ensure that they do it* (Senior manager, National Department of Health)

This initiative specifically aims at "closing the gap", whilst trying to improve overall health status of children. The success of this initiative is not yet known, but it is a step in the direction of purposively identifying inequities and putting vertical equity initiatives in place to "narrow the gap".

In examining the role and contribution of child health policy the researcher notes that in South Africa the notion is often expressed that "policies are good, but implementation is poor". In a broad analysis of "Challenges in achieving health for all" and why inequities in South Africa persist, the authors assert that government policies (assuming this includes child health policies) have explicit pro-equity objectives and that it is largely macro-economic and fiscal constraints that have resulted in the failure of these policies to meet their objectives (Sanders & Chopra, 2006). In a later historical analysis of South African progress with health care, this viewpoint is reiterated.

> The Ministry of Health's role in providing overall guidance on activities that contribute to improving levels of health in South Africa has generally been characterised by good policies, but without equivalent emphasis on the

> implementation, monitoring, and assessments of these policies throughout the system. (Coovadia et al., 2009)

The researcher contests these assumptions about child health policies and concludes from the evidence in this thesis that child health policies are neither pro-equity nor uniformly good, and that the many deficiencies in the design and development of child health policies contribute to the current challenges in child health service provision and ultimately poor child health outcomes. South African child health policies superficially subscribed to the pursuit of equity without specifically indicating or giving guidance to provinces on how to achieve it. The importance of the link between policies and equity is one of the three "crucial" recommendations in the Acheson Report, which states that "All policies likely to have an impact on health should be evaluated in terms of their impact on health inequalities" (Exworthy et al., 2003).

In a health system where the National Department of Health is responsible for policy guidance and implementation oversight over nine autonomous provinces with significant inter-provincial disparities, strong guidance is required on how to achieve equity on a national scale. In their call for the application of an equity lens to child health, Vitora et al (2003) indicate that " equity must be a priority in the design of child survival interventions and delivery strategies, and mechanisms to ensure accountability at national and international level must be developed" (Vitora et al., 2003). As already stated, in the largely universal approach in South African child health policies, with consequent inadequate attention to vertical equity, little thought is given to the health needs of the most deprived children. The case of the Free Health Care policy clearly illustrates this, where one year after its implementation overall utilisation of primary level services increased, but no information exists on whether utilisation for the most disadvantaged children improved (McCoy, 1997). More recent research shows that urban dwellers use free health care more often than their rural counterparts and that "the free health care provided to pregnant women and children under 6 years of age is less vertically effective in rural areas" (Nkonki et al., 2011). It bears out Braveman's point in her framework for equity-orientated policies that the

kind of information that can measure and inform redress of inequity must be identified upfront, because it will not be possible to obtain it in retrospect. Earlier in this chapter the Western Cape case shows that the better the implementation and the data, the better you can explore the performance in terms of equity in service provision. Western Cape exhibited the kinds of inequities that the researcher expected to find in all provinces, but in the Free State and Eastern Cape generally poor implementation and poor data quality masked the disparities.

The research found that all interviewees had a fairly good conceptual grasp of equity. Yet the interpretations of equity varied, emphasising the importance of reaching a common agreement on "what needs to be equalised' (Graham, 2007). It also highlights the difficulty of translating equity aspirations into tangible interventions in the absence of a consensus understanding.

Considering the absence of a clear conceptual framework for child health reform on how to address equity, absence of equity considerations in the design and implementation of child health policies is not surprising. Would it have helped if child health policy makers drew on existing policy analysis frameworks to guide their policy efforts? As indicated in Chapter 4, child health policies were not developed using a priori policy analysis frameworks. The examination of several policy analysis frameworks found that none of these frameworks provided any specific guidance on how to address equity in the design and development of policies (Sabatier, 2007; Dye, 2007; Fischer et al., 2007; Moran et al., 2008; Walt & Gilson, 1994). So even if child health policy makers did draw on current policy frameworks, it might not have enhanced the equity aspect within policies. The researcher feels that this theoretical and conceptual gap in existing policy models/theories might partly explain the general lack of equity considerations by policy makers.

Let us briefly return to the Braveman framework where she considers eight steps in the development of equity-orientated policies. Did child health policies fare well in any of these steps? Child health policies were not guided by a strategic framework, nor were they developed based on adequate information on inequities in

child health status or in child health service provision. In the case of the SHP and most of the other eight policies, key actors who are directly affected by the policies were not involved in policy decisions. Lastly, data to develop indicators whereby progress with equity could be measured is largely absent. Perhaps the next wave of child health policy reform would benefit from the guidance provided by the Braveman approach.

In conclusion, South Africa does not lack in political and macro-policy aspirations to equity. The devil remains in the detail. Micro-policies for child health, while containing pro-equity principles and aspirations, offer little that can promote the translation of these policy principles into clear pro-equity policy proposals and then into equity-orientated implementation plans. It demonstrates that despite the comprehensive consideration of child health challenges in child health policy development, "comprehensiveness is no substitute for coherence" (Wise, 2010, p286). This means that absolute coherence is required throughout all processes and structures, where equity runs as an explicit and well-considered strand – otherwise it will remain an elusive goal.

Chapter 8: Conclusion

Introduction

The South African political transition in 1994 presented a massive window of opportunity for the reform of all social sectors, thereby creating more equitable social services provision and access for all South Africans. The Department of Health seized this opportunity and commenced a health policy reform process of unprecedented scale. This included child health policy reform, which forms the subject of this thesis.

Chapter one shows that during this period children were accorded high political priority. In the health care reform process they were consistently recognised as a vulnerable group deserving of special attention. Aspirations of the National Department of Health for child health, as expressed in the 1999–2004 Health Sector Strategic Framework, were as follows: reduction of infant and child mortality; reduction of child malnutrition; amelioration of adolescent health issues such as teenage pregnancy and substance abuse; and improved management of common serious childhood illnesses (Department of Health, 1999b). Nine key national child health policies and a number of focused programmes and clinical interventions were developed by the National Department of Health to address these aspirations.

Despite efforts to address these child health challenges, child health indicators have remained largely unchanged and in some instances, such as for infant and under-5 mortality rates, have worsened (Bradshaw et al., 2003; Bradshaw & Nannan, 2006; Every Death Counts Writing Group, 2008; Chopra et al., 2009; Nkonki, et al., 2011). South Africa is one of only 12 countries which are regressing in terms of Millennium Development Goal (MDG) 4, the goal of reducing infant and child mortality by two-thirds before 2015 (Every Death Counts Writing Group, 2008; Chopra et al., 2009; Lozano et al., 2011). It is outstripped in performance by other countries of a similar middle-income status and in some instances by low-income countries.

This research applied a retrospective policy analysis method to examine child health policy reform over a 15-year period and to find explanations for the poor policy

performance. There are numerous determinants of child health as shown in Figure 1 and postulated by several other child health analysts (Sanders & Werner, 1997: Chopra & Sanders, 2004; Thangcharoensathien et al., 2007; Exworthy, 2008; Agarwal & Srivastava, 2009). The focus on policy in this research is based on the premise that, among these determinants, child health policies themselves are a possible explanation for the lack of satisfactory progress with child health status and child health service indicators. The ecological framework in Figure 1 shows how child health policies are important instruments in shaping child health services and how child health services in turn contribute to child health outcomes. This warrants an examination of the specific role and contributions of child health policies within a health reform process of the scale and magnitude that was seen in immediate post-apartheid South Africa. This present research on child health policy also questions the commonly encountered assertion in South Africa that "policies are good and implementation is bad" (Sanders & Chopra, 2006: Coovadia et al., 2009). The researcher set out to examine if this was the case for child health policy, or whether some of the blame for poor health indicators could be apportioned to poor policies.

The research focused on the policy development and policy implementation processes of key national child health policies, which in turn is located in the broader context of national health policy reform. The policy development and implementation processes for child health are examined through the example of the National School Health Policy (SHP), which has many characteristics that make it ideal for a case study. Inferences that are applicable to child health policies more broadly are drawn from this case study. In particular the research focuses on: whether and how child health policies addressed the dominant South African reform goal of equity; what the main explanations for poor policy implementation are; and how gaps and challenges in policy processes influenced implementation.

Many deficiencies in child health policy development are brought to light in Chapter 4, despite some evident good practices in South African child health policy reform. Findings in chapter 5 on the implementation of the SHP reflect the

predominantly poor coverage and quality of the school health service (SHS), and make it apparent that inequities in SHS provision persist unchanged from the pre-policy period. Key explanations for these failures in the SHS provision, and in child health services more broadly, emerge from the findings in Chapter 6. These are shortcomings in the policy development process; and general health system deficiencies. In Chapter 7 the identification of gaps in the conceptualisation and application of equity helps to account for some of the failure in achieve equity goals for child health. This concluding chapter gives attention to future possibilities with the new 2012 National SHP, which is an advance, but also has persistent challenges, when compared with the 2003 National SHP. Some analytic reflections from the research are also highlighted.

Overall performance of South African child health policy reform

An assessment was made of child health policy processes, and in particular of whether South African child health policies merit the common assumption that they are indeed 'good'. The researcher's 'reflective practice' as a policy researcher for 10 years, coupled with reflections by other policy analysts on what constitutes good public policies informed this assessment(Walt & Gilson, 1994; Curtain, 2000; Buse et al, 2007; Sabatier, 2007; Gilson & Raphaely, 2008),

A window of opportunity afforded by the South African reform process, as depicted in the multiple streams model (Kingdon, 2003), allowed for the development of appropriate, equity-orientated child health policies. This happened through the convergence of three streams in the context of child health. These streams are: the significant problem of poor child health status and service indicators; the political priority granted to children; and the favourable health policy reform process in which children were identified as a vulnerable group deserving of special attention.

The research findings show that child health policy makers only partly capitalised on this window of opportunity. On the positive side, a prolific number of new child health policies, nine in all, were developed in the decade immediately

following the end of apartheid. These nine key policies were complemented by the adoption of a number of specific child health interventions, such as vitamin A supplementation programmes and new vaccine initiatives to name just two (Shung-King et al., 2000; Saloojee & Bamford, 2006). The Free Health Care policy, the first of the nine policies to be developed, typifies the concept of punctuated equilibrium in policy development (Baumgartner and Jones, 2003), characterised by "large scale departures from the past" (True et al., 2007, p155). This generally only happens in a time of peak political opportunity and change, as was the case with the fall of apartheid. The new child health policies also brought into focus groups of children who are frequently overlooked in policy debates and health services – specifically older children and those with disabilities and mental health problems.

Child health policy development processes displayed some good practices, such as systematic and consistent steps in policy development, similar to those of the stages framework. Some policies, such as the Prevention of Mother-to-Child Transmission (PMTCT)- and the Infant and Young Child Nutrition policy, have good evidence bases, as is commonly expected of government policies these days (Chaskin & Rosenfeldt, 2008). The SHP and PMTCT policies have accompanying implementation guidelines, indicating acknowledgement of the important link between policy formulation and implementation commonly accepted by policy analysts (Lasswell, 1970; Hill & Hupe, 2002; Gilson et al., 2003; Gilson et al., 2006; Fischer et al., 2007; Dye, 2007; Sabatier, 2007). The SHP task team also consulted widely in an attempt to minimise a purely top-down policy development process and involve policy actors beyond the policy elite.

Yet, the South African child health policy reform process as shown in Chapter 4, reveals many flaws and deficiencies. The initial strong momentum for child health policy reform was not sustained. Policy processes were bedevilled by prolonged delays of five to ten years between policy initiation and policy finalisation. Though considered typical by policy analysts (Sabatier, 2007), this resulted in the unacceptable delay of a number of urgently-needed child health services, such as the

PMTCT programme. Furthermore, a relative de-prioritisation of children's issues in the upper echelons of the Department of Health resulted in important policies, such as the overarching MCWH policy, the policy on Chronic Diseases for Children, and the Health Promoting Schools policy, remaining as 'draft' policies, without official endorsement. The neglect of the Maternal, Child and Women's Health policy (Department of Health. 1995) is particularly unfortunate, as it was designed to provide direction to all subsequent child health service and policy reform.

The health promoting schools and the chronic disease policies have been dormant for more than ten years, in the sense that the national child health and health promotion managers were unable to steer the completed policies to the point of final official adoption. The policy guidelines on Youth and Adolescent Health and Child and Adolescent Mental Health are so broad and unfocused that provinces have been unable to convert these into more specific policy interventions. The Youth and Adolescent Health policy is currently being redrafted to make it more focused and specific. The PMTCT policy was significantly delayed through inappropriate use of obstructive political power, explained later in this chapter. Important policy gaps persist, such as for trauma and violence-related injuries in children – now the number one cause of death in children older than four. The lack of a neonatal health care policy means that no national policy guidance exists for this important group of children, whose deaths constitute 30% of infant mortality totals.

Relative neglect seems to be the eventual fate of child health in other countries also when political impetus wanes and other priorities occur. Even in highly developed contexts, policy analysts now bemoan the lack of attention to children's issues in health care reform processes, and anticipate that children will not feature on the agendas of health policy makers in the future either (Wise, 2010, Dowd, 2011). This includes the current reform of the National Health System in the United Kingdom and the relative lack of consideration of children's issues for the past three decades in the United States.

> Despite the range of child health policies and strategies within individual government departments and ministries . . . there is still no sufficiently detailed cross government strategy for improving children and young people's health." (Dowd, 2011)
>
> There is a real sense that the government has not paid sufficient attention to child health as part of its NHS reforms. This cannot go on and there is a risk that we will not do the right thing for our children (ibid)

Unlike in these contexts, child health challenges in South Africa are still urgent and pressing, considering the numbers of preventable child deaths that occur each year (Bradshaw, 2003; Bradshaw & Nannan, 2006; Nkonki et al, 2011). Child health must therefore remain a priority on government's agenda.

Similar to policy development internationally, child health policy development in South Africa, despite concerted efforts at wider consultation, is mainly the domain of the policy elite in the National Department of Health (Exworthy, 2003; Gilson et al., 2003; Dye, 2007; Gilson & Raphaely, 2008; Russ et al., 2010; Wise, 2010). The consequence of this for the SHP was that, despite extensive consultation efforts, district level health service providers and managers still felt excluded. The long time span between policy consultations and the implementation of the policy required a 'policy translation' process, the purpose of which would be to develop a common understanding and common vision for SHP implementation among all frontline health officials and providers. This did not happen. The inadequate understanding of the SHP and lack of commitment from district managers resulted in its reduced priority and patchy implementation.

Many of these deficiencies stemmed from an absence of strategic direction and leadership in child health policy reform. As previously noted, for at least four years during the initial reform period the post of national child health director remained unfilled. Without strategic leadership guidance, the development of policies was inappropriately sequenced throughout the reform process and policy gaps persisted. Policy makers need to have policy-making skills, and from the researcher's

observations during her tenure as SHP task team member, all too often they lacked those skills. They were unable, for example, to draw on policy analysis theories/frameworks which could have had utility for them in policy formation. The policy triangle (Walt & Gilson, 1994), which is now a commonly used tool in policy analysis in low- and middle-income countries (Gilson & Raphaely, 2008), was not utilised in the development of South African child health policy. Consequently 'context' and implementation context in particular, received inadequate consideration during the policy development phase. Poor co-ordination between national child policy makers, where each person focused only on the requirements of their policy, compounded the inattention to context and put undue pressure on frontline service providers. As one overburdened nurse reflected, "I think it's expected from the facilities to just work harder."

Quite often the policy documents themselves are poorly composed and poorly presented. Inconsistencies are present in the documents not just in the format and structure, but also in the intentions set out in them. The policy document for child and adolescent health, for example, is editorially poor, with many spelling errors, sometimes missing pages, and little credible evidence to back up policy proposals, pointing to a lack of any quality control before a major national policy document is made public. Some of the documents, such as the SHP and PMTCT policy documents provide very clear and specific guidance, while others, labelled as guidelines, are left broad and unfocused. Poor capacity at provincial level means that vague and unfocused policy documents are not developed into provincial implementation plans. The key Primary Health Care (PHC) goals form the nucleus of overall health care reform aspirations but there are often inconsistencies in the way they are promoted in policy proposals. Most policies, for example, prescribe the delivery of facility-based services, which poor children, especially in rural areas, find difficult to access. With the exception of the SHP, policies did not actively promote community-based services. Nor, again with the exception of the SHP, do policies actively promote inter-sectoral co-ordination, despite the crucial impact of social determinants on child

health (Sanders & Werner, 1997; Chopra & Sanders, 2004; Thangcharoensathien et al., 2007; Exworthy, 2008; Agarwal & Srivastava, 2009; Victorino, 2009).

Equity, which is a pivotal reform goal, is poorly addressed in policy proposals. Policies primarily promote universal health services, and consequently pay little attention to health service improvements for children who live in poor socio-economic conditions or in localities with historically poor health service infrastructure. Aside from broad expressions on the importance of equity, none of the policies include adequate pro-equity proposals on how health services provision could be targeted to benefit such children who have disproportionately greater health needs. This lack of equity considerations was apparent in the SHP process where key actors, that are considered crucial to the discussions about equity (Braveman, 1998), were left out of the SHP consultations. In the case of the SHP these included policy recipients and also district managers, who have significant influence over how health resource distribution within districts.

Training of policy makers on strategic thinking in policy development, as well as on policy analysis skills is important. This is more so in a period of significant policy reform and "grand policy making" as was the case in South Africa (Dryor, 2008). From the researcher's personal experience with the policy makers, she concludes that a lack of formal policy analysis skills on the part of child health policy makers, rather than any dissenting ideological positions on equity, explains some of the deficiencies in the policy process. In addition policy makers also cited many competing priorities, along with a lack of support for child health from the most senior national health managers, as reasons for some of the policy shortcomings. Perhaps the commonly expressed adage, that "policies are good, but implementation is bad", should instead read that "child health policies are *not* good and neither is their implementation".

Implications of policy development gaps and deficiencies

Deficiencies in child policy development processes do not only result in poorly framed policy documents, they also handicap the provision of much-needed child

health services. For policies that remain incomplete or too broad, the corresponding child health services remain underdeveloped or are non-existent. School health co-ordinators confirmed in interviews that provinces had not been able to develop more specific policies and implementation plans for youth and adolescent health services. In the case of the child and adolescent mental health policy, Cluver and Gardner (2007) confirm that mental health of children across age groups who are infected or affected by HIV and AIDS goes largely untreated due to the absence of suitable services.

The SHP implementation discussed in Chapter 5 shows that this predominantly preventative community-based service received little attention and support from health managers at all levels of the health system. As a quintessential Primary Health Care (PHC) programme, it should have fared especially well in a health system where the PHC philosophy occupies centre stage. Yet it floundered to the point of non-existence in many localities.

Coverage of the SHS is largely poor across the country, with the exception of the Western Cape urban district, two of the four rural Western Cape districts, and pockets of good implementation in the other provinces. Nurses who provide the SHS are largely dissatisfied with the quality of the service that they provide. Important components of the Grade 1 assessment cannot be delivered because of poor classroom infrastructure and classrooms are the only space that the nurses have available to them. Essential operational support systems such as transport, referral services and the health information system, are inadequate and distributed unevenly across implementation sites. Transport and referral services are particularly deficient in rural areas of the poorest Eastern Cape Province. Furthermore, routine monitoring of SHS provision is inconsistent and inaccurate and progress in SHS coverage cannot therefore be measured. The model of provision of the SHS package is also not standardised across implementation sites. Even though the SHP allows for some components such as staffing models to be tailored to local circumstances, the essential elements of the SHS package must be provided uniformly across the country.

The additive effect of all of these challenges means that achieving equity in SHS provision across different geographies and socio-economic environments is still a long way off. Equity in child health service provision should have fared well in the favourable political climate of the early reform period – when it was explicitly inscribed as a goal in all the overarching and micro-policy documents reviewed in this research. However, the devil lay in the detail. Policies seldom got beyond aspirations and were short on detailed proposals about: what equity would mean in practice; what aspects of child health needed to be equalised; and how child health service providers would address equity in service provision. The notion of vertical equity simply did not feature, either in detailed policy proposals or in implementation plans. A predominately universal approach to service provision precluded the prioritisation of any particular group, least of all those who live in poverty. Unless equity and all its dimensions are adequately defined upfront in policy processes, and properly contemplated in implementation plans, it will remain an elusive goal. This statement from a national manager puts it into perspective.

> *Policies are developed at National level, and honestly, if there is no paradigm shift from cabinet, equity is just a buzz word, it will never happen. And how do I, in my position – I just mention it and say, this thing is big, it needs to start from cabinet?* (Middle manager, National Department of Health)

For inequity to be reduced it must be considered in all levels of decision-making, all levels of the health system and all processes and instruments that ultimately impact on service provision for children. If one component fails, the rest will struggle to achieve this important policy goal. As noted by Dowd (2011) in his commentary on the UK health reform process:

> Major reform does offer important opportunities to improve care but only if all the organisations involved—especially the new ones—are clear on how they will interact together. Currently, we simply do not have that clarity. (Dowd, 2011)

The integration of the previously vertical SHS into primary level services was also not straightforward. It also requires a clear definition of integration, what its intention is

and what successful integration practically requires. This kind of guidance was not provided in any of the provinces.

Examples from the research clearly illustrate that SHP process deficiencies impacted on policy implementation. A successful SHS required the following elements to be in place: good collaboration with the Department of Education; co-ordination between the School Health Service and the broader Health Promoting Schools programme; an implementation environment that is supportive of preventative services; support structures and resources to facilitate delivery of a community-based services such as the SHS; and a conceptual framework to guide the integration of a previously vertical service alongside other primary level services. These requirements had to be met in both the policy development and implementation phases. The policy process had many deficiencies that disenabled the achievement of these requirements. Child health policy makers failed to secure the active participation of education officials of sufficiently high level to enable the health-education collaboration. Consequently poor provincial and district health-education relationships persisted. This had logistic implications in many of the implementation sites, where education officials, due to ignorance of the SHS, sometimes obstructed nurses from delivering the service in schools. An evaluation of the SHS in two Western Cape schools confirmed this, (Ramma, 2010) by showing that teachers have no or little knowledge of the SHP or SHS.

Failure to secure the active participation of health promotion officials in the SHP development process resulted in a consistently poor relationship between these programmes through all levels of the health system. Whilst this is indicative of managerial weaknesses in both programmes, it also reflects the lack of support of middle management policy makers by senior health managers in securing these crucial relationships. Senior managers, as the direct line managers of school health and health promotion managers, had the power and jurisdiction to forge such relationships.

Two features inherent to the SHS, namely its preventative nature and its community-based focus, should have received attention through a policy translation process. Failure to develop plans, on how to secure the rightful place of a community-based service in a largely curative and pressured service environment, led nurses to dub it as "the stepchild of PHC programmes".

The inability to deliver all of the functions required by the SHS package at a level and quality that they felt comfortable with, caused great frustration for frontline nurses. Very importantly, the screening component of the Grade 1 assessments in the SHS relies on the availability of good referral services. In terms of international standards, it is unethical to screen without being able to respond to the conditions that are detected via the screening (Wilson & Junger, 1968; Andermann et al., 2008). In rural sites especially nurses indicated that referral services are simply not available and this significantly compromises the ethical status of the SHS. In this case, the root of the problem may be traced back to the poor consideration of 'context' during the policy development phase. Had it been adequately done, the implementation of the screening elements of SHP might have been appropriately postponed, until the required referral services had been secured.

Health system explanations for child health policy failures

Chapter 6 explores a range of factors beyond the policy process that are likely to compromise SHP performance. These include: confusing and duplicating organisational structures for child health; poor managerial capacity at all levels of the health system; inadequate resources (insufficient numbers of nurses especially); and inadequate training and support of nurses who are responsible for the integration and the delivery of this community-based service. Most of these are problems could be ascribed to teething problems in a relatively new and still immature district health system. However, two other problem factors need to be highlighted – 'federalism', which came up repeatedly in the interviews, and the phenomenon of 'street-level bureaucracy'.

Street level bureaucracy puts a spotlight on the way that individualism in service provision (instanced in individual district managers and frontline workers each approaching the SHP very differently) can impact substantially on national policy goals. Especially where central oversight is poor, as is currently the case in the 'federally structured' health system.

Federalism is a complex and currently contested area nationally and this thesis touches on it insofar as it impinges on the evolution of child health policy. Underpinning federalism is complex legislation, a different set of literature, and a range of debates that extend beyond the scope of this thesis. Federalism in South African health care means that the national, provincial and district levels each have a designated set of roles and responsibilities. Importantly, the national level provides implementation oversight and support, which is particularly important in a context of poor provincial capacities and widespread inequities. The SHP example clearly shows that this oversight did not happen. National officials were hamstrung by a lack of clearly prescribed roles and insufficient capacity. Similarly, provinces did not intervene in cases of poor district SHS provision, thus perpetuating 'individualism' and inequities.

This situation is compounded by the strong manifestation of street-level bureaucracy (Lipsky, 1980). The SHP shows that individual district managers, facility managers, school health nurses and transport managers all interpreted the SHP in their own way and made individual decisions on whether to implement it or not. It leads the researcher to conclude that in the face of poor policy development and translation, and poor central oversight, such unchecked individualism runs the risk of widening rather than narrowing health system inequities. The inverse equity hypothesis (Vitora et al, 2000; Vitora et al, 2003) postulates that new policies usually benefit wealthier areas first, since these areas are able to implement policies faster. This is clearly so in the case of the SHP, where the richer Western Cape urban district had the best SHS coverage. Also, enthusiastic and passionate district managers and nurses made great efforts to implement the SHS. Poorer areas and areas where staff motivation is lacking

inevitably lag behind, unless strong central oversight brings about the necessary support for implementation.

Currently the South African system of federalism is under debate with strong political opinions being expressed on whether the provincial level of government should be dismantled or retained. The implications of this for child health are not issues that are peculiar to South Africa. Much of the literature on child health reform in the United States touches upon the federal direction for health reform and its implications for how child health is dealt with at individual state level (Perdahl et al, 2010; Russ et al, 2010; Wise, 2010). As suggested here, federal level health policies should consider carefully what the implications are for child health and whether the various state capacities might worsen or improve inequities for children. Chapter 6 explores the challenges that the national government has in exercising its oversight and support role to provinces. As a result of poor performance and financial mismanagement in four provinces, including provincial departments of health, national government in 2011 placed four provinces under its administration. The fact that these provinces had to be put under administration is indicative of the failure of national government in exercising adequate oversight and support and of poor provincial capacity and performance.

The cyclical interplay between politics, power, policy making and performance never ceases. Indeed, the South African health care reform process requires a much more coherent and integrated approach directed by a clear overall strategic plan. In their assessment of how to meet children's basic health needs, Russ (2010) use the metaphor of moving from a 'patchwork' approach to a more seamless, holistic and integrated 'tapestry' approach. This metaphor beautifully characterises the child health reform process as described in Chapters 4, 5, 6 and 7. Child health policies were developed piecemeal and not integrated with one another. Their content was also not necessarily aligned with overarching reform goals and with one another, and proper co-ordination between different components of child health services did not occur. This patchwork approach signals a need for integration across a wide range of

dimensions. As recommended by Russ et al. for US health reform efforts (p1162), "this new tapestry of comprehensive children's services, integrated across sectors, could set children on optimal health trajectories for life. Meeting children's basic health needs could be a major component of the transformative change the nation is seeking".

What are the analytical and methodological lessons from this research?

This section provides some personal reflections of the researcher and some analytical lessons from the research.

An important conclusion from this research is that there is no single policy analysis framework that can adequately address all the dimensions of policy development and implementation as these are varied, complex and messy at the best of times. The researcher had to consider frameworks and theories additional to the ones chosen at the outset. Perhaps the most difficult aspect was that none of the frameworks presented her with a neat paradigm for studying equity manifestations in policy development and implementation. The Braveman framework focuses on which information to collect and which actors to involve, but does not look at other dimensions of the policy process. The EquiForm framework only published in December 2011 could not inform this analysis. This useful framework focuses on the health and human rights and the health service implications for people with disabilities and will require adaptation for use in child health policy research. The development of a further framework that combines the principles of these two and modifies for more generic use, will enable a more comprehensive analysis of equity in policy making process itself.

The research also suffered some of the challenges of retrospective policy analysis, so many years after the actual policy experience. People have moved on, forgotten, changed sides and changed perspectives. Poor handover mechanisms

resulted in lost and misplaced documents thereby diminishing the documentary materials that were available to the researcher.

After such a lengthy period the policy process might have entered new and different phases as was indeed the case with the SHP. Renewed energy was injected into the SHP by the new Minister of Health just over a year after the fieldwork was completed. This brought about an unexpected opportunity for the researcher to reflect on whether the new policy process had addressed some of the challenges of the previous policy process and whether this new SHP had a better chance of succeeding.

The question remains whether a case study approach, such as the one employed here, adequately allowed for extrapolations about the situation with other child health policies. The answer is an unequivocal 'yes'. Whilst the SHP was the focal point of the interviews, interviewees had sufficiently wide knowledge and experiences to commentate on issues affecting child health in general. Examples from several other child health policies emerged from this research. The range of issues raised through the SHP experience are sufficiently wide, but also sufficiently specific to school health, to satisfy both agendas – that of interrogating the case of the SHP and that of understanding issues for child health policy development and implementation more broadly. In retrospect, it might have been helpful to also examine a policy with a curative focus in more detail, as this might have yielded additional and complementary perspectives about child health service provision in South Africa.

A limitation of this research is that there is no data from Department of Education officials and recipients of the SHS recipients. Their perspectives would have enhanced the understanding of how the SHP affected policy actors outside of the health sector and what its impact was on the intended policy beneficiaries. It is worth considering further research into this. Research on the health challenges among school children and how these are altered through the SHS would enhance the understanding of the SHP performance and benefits. It might also provide a clearer picture of the link between the SHP and eventual child health outcomes.

The researcher also has some personal reflections of her research journey. Chapter 4 shows that policy actors must sometimes fulfil many and varied roles in the policy process. Aside from her multiple roles during the SHP development process, she also assumed different roles before and during this research. She considers herself an "outside commentator" on child health issues in South Africa, as a citizen and as a previous child health policy researcher at the University of Cape Town. During this research she was an objective researcher. Despite her integral involvement in the SHP development process, her time away from South Africa and the long time period between her involvement in the SHP and this research helped to maintain her objectivity. Nonetheless, her previous role as a policy task team member in the national SHP process at times threatened to blur her objectivity. As a result she was frequently tempted into making strong normative and unsubstantiated statements, yet was constantly reminded of the need for empiricism.

This was the first experience for the researcher with qualitative research and a full-scale policy analysis. This experience substantially raised her level of understanding of these methodologies. For its analytical framework the thesis drew on various policy analysis frameworks to examine a complex set of policy activities. This helped to structure her enquiry, but also served as a constant reminder of the enormity of such a task. This research focused on certain aspects of post-apartheid child health policy reform to the exclusion of others. Some of these may form the subject of further post-doctoral research.

This research process also gave the researcher the benefit of engaging with all the phases of policy development: from the initial agenda setting of the SHP to its final evaluation. With some new developments on the SHP, she has already been able to bring some of her research findings to bear on the new policy process and might yet again be drawn into the second 'cycle' of the SHP development.

Do new developments with the national SHP have a better chance at success?

The new Minister of Health has launched proposals for rescuing the flailing SHS. Many of the new proposals directly address the deficiencies highlighted in this research. The researcher wished to gain: a better understanding of what the new changes to the SHP involve; what the reasoning behind some of these changes is; and how district level staff members are being supported in the implementation of yet another new policy. Consequently four email exchanges and one telephonic conversation were held in March 2012 with five national health officials who have knowledge of the new SHP process. Despite repeated attempts the researcher failed to secure an interview with the Minister of Health.

The renewed focus on the SHP by the Minister of Health occurs at a time when three major new policy proposals have been adopted by the national Department of Health. These are a policy for a National Health Insurance system, a strategy for the revitalisation of the ailing primary health care system (referring to primary level care at a district level), and a new human resource strategy for health. These health system proposals are poised to improve PHC delivery, access and financing, human resource capacity, and management. At the same time national efforts are afoot to improve the structure and functioning of the current federal system.

As part of this "second wave of policy reform" many existing policies are being revised. In particular, 18 of the most disadvantaged districts have been singled out for a renewed focus on basic maternal and child health services. The next few years will show if this targeted approach for improving child health can bear fruit. The researcher believes that this will be the case if it is done properly and adequately sustained. As was the case in Brazil which has a similar history, socio-economic situation, and burden of inequities, there is real potential to reverse the 'inverse equity hypothesis' (Vitora et al, 2000).

The strengthening of the SHS is one of only four themes adopted in the national ministerial strategy for the "Revitalisation of Primary Health Care" (Schneider & Barron, 2008; Naledi et al., 2011). This means that the implementation of the new

SHP has the benefit of many concurrent systemic efforts that will strengthen district health services and thus increase the chance of success.

The new SHP (soon to be released as the second official SHP document) similarly focuses on those most disadvantaged, thereby moving away from a universal approach to a more targeted intervention. The Grade 1 assessment element of the SHS is focused solely on schools in the two socio-economically poorest quintiles one and two in order to bring the level of service in these schools on par with those in better-resourced areas. However, areas in other parts of the country such as the Free State, that largely fall in quintiles three and four, and which arguably had a SHS that was worse than in some parts of the Eastern Cape, might lag behind unless they received significant support from their provincial Department of Health. This is a concern in redistributive efforts that favour the most poor, as those that fall just beyond the absolute poverty line are excluded from special attention and are often at risk of becoming worse off than the most poor.

The 2012 SHP offers the following advances on its predecessor: a new integrated service plan for the SHS; a formalised relationship with the Department of Education; and concrete efforts to address resource constraints. An effort to recruit retired school health nurses back into active service has elicited the interest of close to 500 nurses, 48 of whom have already been appointed in the Eastern Cape. The appointment of a national school health co-ordinator after a two-year vacancy in this post has further improved national capacity. Interestingly, the filling of this position was also one of the "tipping points" in the previous SHS process that helped to bring it onto the national agenda. In addition to staffing, attention has also been focused on transport needs. This led to the purchase of well-equipped mobile health service units that can deliver comprehensive school health and referral services to these disadvantaged areas. These mobile units are to serve the ten most disadvantaged districts first and may later be expanded to serve additional areas.

In the new process, some fundamental challenges are addressed that had been flagged as particularly obstructive in the old SHP process. A formal collaboration now

exists with the Department of Basic Education and both Ministers are signatories to the new SHP document. This again demonstrates the endless possibilities for advancing the cause of child health when persons with sufficient power are sufficiently interested and committed to do so. The education officials who formed part of the new SHP task team are actively engaged in the process - similarly so for the health promoting schools officials. The resource and referral challenges of the 2003 SHP are now addressed through a significant injection of resources, exclusively channelled to the SHS. Retired school health nurses are being appointed to boost staff numbers. Already, as noted, 48 such nurses have been appointed in the Eastern Cape, which had the most severe staff shortages of the three case study provinces. National Treasury has allocated additional money to strengthen the implementation of maternal and child health services (school health included) in the most disadvantaged districts.

In the opinion of the researcher, the strong emphasis on school health in these new reforms may lead to the 're-verticalisation' of a service that, almost a decade ago, was dismantled in its vertical form for full integration into PHC services. However, all five health official interviewees uniformly indicated that the service will remain integrated, in the sense that it will be managed with all other PHC services by a single district management team. However, there is a greater emphasis on supporting the SHS and injecting into it the kind of resources that will allow it to become established and perform competently. This fits in with the general international preference for an integrated service delivery approach which still leaves room for strategic prioritisation of essential services (WHO, 1996; Schierhout & Fonn, 1999). At times this might require the 'verticalisation' of elements of a service as is now the case for the SHS.

The content of the policy has changed incrementally. It proposes a wider spectrum of services for the SHS, which requires the involvement of a larger number of programmes and organisations at implementation level. The incremental leap between the old and the new package of the SHS is significant, with many additional service requirements. It remains to be seen if the strained district health system can cope with these new requirements. The capacity of the current implementation

infrastructure is perhaps again overestimated. This suggests that while policy learning seems to have occurred for some elements of the new SHP, in other crucial decisions the same mistakes are repeated.

The case of the SHP clearly exemplifies the cyclical nature of policy development and the justifiable assertion that phases of old and new policy processes may well overlap and are seldom linear. In this case, whilst the old SHP implementation still falters on, new efforts and initiatives are being reviewed and absorbed by district health teams and service providers. It shows yet again what is possible in a favourable political environment and where powerful individuals direct their passions to good effect. As to how it will fare, in the words of one of the interviewed officials and as must so often be said of policy outcomes, "time will tell."

In conclusion:

This research shows unequivocally that deficiencies in the policy development process had a significant bearing on the content of policy proposals and their eventual implementation. This confirms the original hypothesis of the researcher that despite the many social determinants of health, and despite the many other health system explanations for poor child health policy performance, policy deficiencies contribute to poor child health services and by inference poor child health outcomes. In a health reform process on the scale that took place in South Africa, it is crucial for the policy process itself to be evaluated and not just its manifestations. Lessons drawn from such evaluations could inform future policy reform and avoid the repetition of past deficiencies.

The research further suggests that there are compelling reasons to give child health priority in policy processes. The strong rights-based framework for children that exists in South Africa makes it is a legal obligation of the state (United Nations, 1989; Republic of South Africa, 1994) to "put children first" and "in all matters concerning the child, to consider what is best for the child". An important consideration is the narrower time margin for addressing serious child health conditions, thus requiring faster throughput of policies for children (Osmond, 1998;

Kozinets, 2001; Sabatier, 2007). Lastly, child health indicators reflect the socio-economic status and health service performance of a country. Thus to meet the MDGs for child health and so be on par with other middle-income countries, the poor showing of current South African child health indicators requires swift and decisive policy and implementation action. There are examples to suggest that if provinces prioritise child health issues appropriately and place a stronger focus on child health, much can be achieved. The Western Cape's implementation, against all odds, of the PMTCT policy bears this out. A pertinent question that needs asking is, if not in a period so favourable for child health reform, when else would child health be appropriately prioritised?

It is worth reiterating the all-important impact of politics, power and passion that reverberates through all aspects of child health policy reform. Macro-politics have been shown to have both positive and obstructive effects on child health policy development and implementation. The power of policy elite in getting key child health issues onto the national agenda is shown in the example of the SHP in Chapter 4. Chapter 5 highlighted the power of frontline service providers and managers in facilitating, or hampering, the manner and extent of child health service implementation. Through all of these, that often neglected phenomenon in policy discourses (Gottweis, 2007), passion, shapes the highs and lows and the successes and failures of reform. Whether in the context of frontline nurses who sometimes against all odds provided a service of unexpected excellence, or whether in the context of the new Minister of Health who, driven by his personal motivation, is determined to see the SHP succeed, passion is tangible and ever-present.

It seems fitting to conclude this thesis with some words of advice from a wise paediatrician and child health policy analyst in the United States:

> We are entering a period of unprecedented technical capacity to improve the health of children. However, it will also be a period of growing instability in the traditional policy underpinnings of our commitment to provide this capacity to all children in need. The erosion of child health policy as a field has resulted in a cacophony of programmatic pleas and extensive directories of recommendations and requests, an advocacy by lists. However,

comprehensiveness is no substitute for coherence. As during other critical moments in the history of child health, we are in a period that demands not only the generation of new knowledge, but also a critical assessment of this knowledge's implications for a collective professional identity and integrated societal action, a mandate that once was-and must be again-the purpose of child health policy. (Wise, 2010)

REFERENCES

Abbott, S., Shaw, S. and Elston, J.. (2004). Comparative analysis of health policy implementation. *Policy. Studies.* 25(4). pp.259-266.

Abrahams, E. and Shung-King, M.. (2001a). *Report on the Nine Provincial School health Policy Workshops.* Cape Town: Child Health Policy Institute.

Abrahams, E. and Shung-King, M.. (2001b). *Report on the National School Health Policy Guidelines Workshop.* Cape Town*:* Child Health Policy Institute

Abrahams, E., Wigton, and A. de Jong, R. (1997a). *Workshop on an Integrated Policy for School Health. Discussion Document.* Cape Town: Child Health Policy Institute.

Abrahams, E. and Wigton, A.. (1997b). *Key readings on School Health. Compiled for Participants at the Workshop on an Integrated Policy for School Health.* Cape Town: Child Health Policy Institute.

Abrahams, E. and Wigton, A.. (1997c). *Workshop on an Integrated Policy for School Health. Proceedings.* Cape Town: Child Health Policy Institute.

Actuarial Society of South Africa (2005) *ASSA2003 Aids and Demographic Model*. Available at:<http:// www.assa.org.za> [Accessed 9 May 2007].

African National Congress (1956). *The Freedom Charter*. Available at: http:// www.anc.org.za/ancdocs/history/charter.html [Accessed 19 May 2007].

African National Congress. (1994). *A National Health Plan for South Africa.* Johannesburg: African National Congress.

Agarwal, S. and Srivastava, A.. (2009). Social Determinants of Children's Health in Urban Areas in India. *Journal of Health Care for the Poor and Underserved*, 20, 4, pp. 68-89

Ajam, T., Khumalo, B., Mabugu, R. and Setai, B.. (2009). *Technical Report: Annual submission on the division of revenue 2010/11*. Pretoria: Financial and Fiscal Commission

Amin, M., MacLachlan,M., Mannan, H., El Tayeb,S., (2011).Equiframe: A framework for the inclusion of human rights and vulnerable groups health policies. *Health and Human Rights*, 13,2.

Andermann, A., Blancquaert, I., Beauchamp, S. and Dery, V.. (2008). Revisiting Wilson and Junger in the genomic age: a review of screening criteria over the past 40 years. Bulletin of the World Health Organsiation. 86:2008, 241-320.

Appleton, J.V. and Cowley, S.. (1997). Analysing Clinical Practice Guidelines. A method of documentary analysis. *Journal of Advanced Nursing*. 25 (1008-1017).

Barnes, H., Noble, M., Wright, G. and Dawes, A.. (2007). *The South African Multiple Deprivation Index for Children*: Census 2001 Cape Town: HSRC Press.

Barron, P., Day, C., Monicelli, F., Vermaak, K. et al.. (2006a). *The District Health Barometer. Year 2005/6*. Durban: Health Systems Trust.

Barron, P.. (2006b). Input Indicators. In: Barron, P., Day, C., Monticelli, F. Eds.2006. *District Health Barometer - Year 2006/07*. Durban: Health Systems Trust.

Bazeley, P., (2007), *Qualitative data analysis with NVivo*. London: Sage Publications Ltd.

Berdahl, T., Owens, P.L., Dogherty, D., McCormick, M.C. (2010). Annual Report on Health Care for Children and Youth in the United States: Racial/Ethnic and Socioeconomic Disparities in Children's Health Care Quality. *Academic Paediatrics, 10, pp95-118.*

Bosch, A., Rossouw, J., Claaasens, T. and du Plessis, B.. (2010). *A Second look at measuring inequality in South Africa: A modified Gini coefficient.* School of Development Studies. s.n.

Bradshaw, D., Bourne, D., and Nannan, N.. (2003) *What are the leading causes of death among South African children? MRC policy brief No. 3*, Cape Town: Medical Research Council.

Bradshaw, D., and Nannan, N.. (2006). Mortality and Morbidity among women and children. *In:* Ijumba, P. Padarath, A. (eds) *South African Health Review 2006*. Durban: Health Systems Trust.

Braveman, P., (1998). *Monitoring Equity in Health. A Policy-orientated approach in low-and middle income countries*. Geneva: World Health Organization.

Brewer, Garry., (1974). The Policy Sciences Emerge: To Nurture and Structure a Discipline. *Policy Sciences*, 5(3):239-244.

Burgard, S.A., and Treiman, D.J.. (2006). Trends and racial differences in infant mortality in South Africa. *Social Science and Medicine*. 62 (5),pp1126-1137.

Buse, K., Mays, N. and Walt, G., (2007). *Understanding Public Health: Making Health Policy*. New York: Two Penn Plaza

Byrd, W.M., Clayton, L.A.,(2003) Racial and Ethnic Disparities in Healthcare: A Background and History. In: Smedley, B.D., Stith, A.Y., Nelson, A.R., eds. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington D.C.: National Academy Press.

Chaskin, R.J. and Rosenfeld, J.M. eds.,(2008). *Research for Action: Cross-National Perspectives on Connecting Knowledge, Policy and Practice for Children.* New York: Oxford University Press Inc.

Children's Institute., (2006). *Abantwana Babalulekile: Children Count. A*vailable at <http://www.childrencount.ci.org.za> [Accessed 9 May 2007].

Children's Institute., (2010). *Abantwana Babalulekile: Children Count. A*vailable at <http://www.childrencount.ci.org.za> [Accessed 23 March 2012].

Chopra, M. and Sanders, D., (2004). *Child Health and Poverty*. *CHIP report no. 10*. London: Childhood poverty research and policy centre.

Chopra, M., Lawn, J., Sanders, D., Barron, P. et al., (2009).Achieving the health Millenium Development goals for South Africa: Achievements and Challenges. *The Lancet,* 374 *[e-journal]*. Available at <*http://www.lancet.com*>.[Accessed 25 August 2009].

Claeson, M., Wang, H. & Hu, S. (2004) A critical review of Public Health in China. Washington D.C., World Bank.

Cloete, K., (2011). Implementing Health Systems Change: The Western Cape experience. *Oliver Tambo Fellowship Programme*. University of Cape Town, unpublished.

Cluver, L. and Gardner, F., (2007). Risk and Protective factors for psychological well-being of children orphaned by AIDS in Cape Town: a qualitative study of children caregivers' perspectives. Aids Care, 19(3): 318-325.

Coetzee, D., Hilderbrand, K., Boulle, A. ,and Draper, B. et al. (2005). Effectiveness of the first district-wide programme for the prevention of mother-to-child transmission of HIV in South Africa. Bull World Health Organ v.83 n.7 Geneva.

Coovadia, H. J,ewkes, R., Barron, P., Sanders, D. and McIntyre, D. (2009). The Health and Health System of South Africa: Historical roots of current Public Health Challenges. *The Lancet*, 374 *[e-journal]*. Available at http://www.thelancet.com [Accessed 5 September 2009].

Declaration of Alma-Ata. (1978). *International Conference on Primary Health Care*. Alma-Ata:s.n.

Deleon, P. (2007). The Stages Approach to the Policy Process: What Has It Done? Where Is It Going?. In: Sabatier, P, ed.(1999). *Theories of the Policy Process*. Colorado: Westview Press.

Denzin, N.K., Lincoln, YS. (2005). *The Sage Handbook of Qualitative Research.* 3rd ed. Thousands Oak: Sage Publication Inc.

Department for Children, Schools and Families. (2009). *Healthy Child Programme*: Pregnancy and the first five years of life. London: Crown.

Department of Health. (1995). *Maternal Child and Women's Health policy (draft)*. Pretoria.

Department of Health. (1997). *White paper for the transformation of the health system in South Africa*. Pretoria: Government Printer.

Department of Health. (1998a) *South African Health and Demographic Survey*. Pretoria: Government Printer.

Department of Health. (1998b). *Integrated Nutrition Programme for South Africa: Broad guidelines for implementation:* Pretoria. Government Printer.

Department of Health. (1999a). *Baby Friendly Hospital Initiative.* Department of Health, WHO and UNICEF: Pretoria: Government Printer.

Department of Health. (1999b). *Health Sector Strategic Framework 1999 – 2004*: Pretoria: Government Printer.

Department of Health. (2000a). Vitamin A supplementation policy: Pretoria: Government Printer.

Department of Health. (2000b). *The Development of Health Promoting Schools/sites in South Africa. National Guidelines. Draft 3 14 April 2000*: Pretoria: Government Printer.

Department of Health. (2000c). *Child and Youth Mental health services, National Policy guideline*s. Pretoria: Government Printer.

Department of Health. (2000d). *The Primary Health Care service package for South Africa-a set of norms and standards*. Pretoria: Government Printer.

Department of Health. (2000e). *South African Breastfeeding Guidelines for health workers.* Pretoria: Government Printer.

Department of Health. (2001a). *Policy Guidelines for the management and prevention of Genetic Disorders Birth defects and Disabilities*. Pretoria: Government Printer.

Department of Health. (2001b). *Policy Guidelines for Youth and Adolescent Health.* Pretoria: Government Printer.

Department of Health. (2001c). *Research Findings and Policy Implications of the Review of Highly Specialised Services in the Public Hospital Sector.* Pretoria: Government Printer.

Department of Health. (2002). *The Policy Framework for Non-communicable Chronic Conditions in children* (Draft). Pretoria.

Department of Health. (2003a). *The National School Health Policy and Implementation Guideline*s: Pretoria: Government Printer.

Department of Health. (2006). *Annual report 2006/7*: Pretoria: Government Printer.

Department of Health. (2007a). *Annual report 2007/8*: Pretoria: Government Printer.

Department of Health. (2007b). *Infant and Young Child Feeding Policy*. Pretoria: Government Printer.

Department of Health. (2008). *Policy and Guidelines for the Implementation of the PMTCT Programme.* Pretoria: Government Printer.

Development Bank of South Africa. (2008). A Roadmap for the Reform of the South African Health System. Johannesburg: Development Bank of South Africa

Dicocco-Bloom B., and Crabtree, B.F. (2006). The Qualitative Interview. *Medical Education* 2006. 40, pp. 314–321.

Draper, C.E., Lund, C., Kleintjes, S., Funk, M. et al. (2009). Mental Health Policy in South Africa: development, process and content. *Health Policy and Planning.* 24, pp.342-356.

Dror, Y. (2008). Training for Policy Makers. In: Moran,M. Rein, M. and Goodin, R.E., eds. *The Oxford Handbook of Public Policy*. Oxford: Oxford University Press.Ch.4.

Dye, T. (2008) *Understanding Public Policy*. 11th ed. New Jersey: Pearson Education Inc.

Ebrahim, H., 1999. Public Participation. In *The Soul of a Nation: Constitution-making in South Africa.* USA: Oxford University Press.

Elmore, R.F. (1979). Backward mapping: Implementation research and policy decisions. *Political Science Quarterly*, 94(4), Winter, pp. 601-616.

Elston, J. and Fullop, N. (2002). Perceptions of partnership. A documentary analysis of Health Improvement Programmes. *Public Health*. 116(4),pp207-13.

Erasmus, E., Gilson, L. How to start thinking about investigating power in the organizational settings of policy implementation. *Health Policy and Planning*, 23, 5, pp361-368.

Every Death Counts Writing Group, (2008). Use of mortality audit data for decision making to save the lives of mothers, babies, and children in South Africa. *Lancet*, 371, 9620, pp1294-1304.

Exworthy, M., Blane, D. and Marmot, M. (2003). Tackling heath inequalities in the United Kingdom. The progress and pitfalls of policy. *Health Services research*, 38(6), Part II,pp1905-1921.

Exworthy, M. (2008). Policy to tackle the social determinants of health: using conceptual models to understand the policy process. *Health Policy and Planning*, 23, pp318-327.

Fischer, F., Miller, G.J. and Sidney, M.S. eds. (2007). *Handbook of Public Policy Analysis. Theories, Politics and Methods*. Boca Raton: CRC Press.

Fischer, P.J., Strobino, D.M., Pinckney,C.A. (1984) Utilization of child health clinics following introduction of a copayment. *Am J Public Health,* 74**,** pp1401-3.

Geva-May, I., (2004) Riding the wave of opportunity: Termination in Public Policy. J Public Adm Res Theory , 14, 3, pp309-333.

Gilson, L. (1989). What is the future for equity within health policy? *Health Policy and Planning*, 4, pp323-327.

Gilson, L., Doherty, J., Lake, S., Mcintyre, D. et al. (2003). The SAZA study: Implementing health financing reform in South Africa and Zambia. *Health Policy and Planning*, 18(1)pp31–46.

Gilson, L. and Raphaely, N., (2008) The terrain of health policy analysis in low and middle-income countries: a review of published literature 1994-2007. *Health Policy and Planning*, 23, pp294-307.

Gilson, L., and McIntyre, D., (2004). Removing user fees for primary care: necessary but not enough by itself: *EQUINET*.2.

Gilson, L. and Thomas, S., (2006). *Informing Policy and Practice: Developing a Policy Analysis Framework for Evaluation of Health System Change*. Johannes burg: Centre for Health Policy.

Gilson, L., Erasmus, E., Kamuzora, P., Mathews, P.et al (2006). *Applying Policy Analysis in Tackling Health-equity Related Implementation Gaps. Discussion Paper no. 28*. Regional Network for Equity in Health in East and Southern Africa. Durban: Ideas Studio.

Goodin, R.E., Rein, M., Moran, M. (2008). The Public and its Policies. In: Moran, M., Rein, M., Goodin, R.E.,eds.*The Oxford Handbook of Public Policy* (2008).Oxford: Oxford University Press.

Gottweis, H. (2007). Rhetoric in Policy Making: Between Logos, Ethos and Pathos. In: Fischer, F. Miller, G.J. and Sidney, M.S. eds. (2007). *Handbook of Public Policy Analysis. Theories, Politics and Methods*. Boca Raton: CRC Press.

Graham, H. (2007). *Unequal Lives. Health and Socioeconomic Inequalities*. Maidenhead: Open University Press.

Grandin, W., Westwood, A., Lagerdien, K. and Shung-King, M. (2005). *Deaths at the Red Cross War Memorial Children's Hospital, Cape Town 1999-2003: A study of death notification forms*. Cape Town: Children's Institute.

Green, A. (1999). *An Introduction to Health Planning in Developing Countries*. Oxford; Oxford University Press.

Guay, L.A., Musoke, P., Fleming, T., Bagenda, D. et al. (1999). Intrapartum and neonatal single-dose nevirapine compared with zidovudine for prevention of mother-to-child transmission of HIV-1 in Kampala, Uganda: HIVNET 012 randomised trial. *Lancet,* 354, pp795-802.

Hagopian, A. **,** Thompson**,** *M.J.*, Fordyce, *M.*, Johnson, K.E. et al., (2004). *Human Resources for Health,* 2, 1.7

Harrison, D. (2009). *An Overview of Health and Health care in South Africa 1994 – 2010: Priorities, Progress and Prospects for New Gains*. A Discussion Document Commissioned by the Henry J. Kaiser Family Foundation to Help Inform the National Health Leaders' Retreat Muldersdrift, January 24-26 2010. s.n.

Health Systems Trust (1997). *Health and Health care in Mount Frere. A Situation Analysis. Initiative for sub-district support. Technical report 2c*. Durban: Health Systems Trust.

Hendricks, M., Eley, B. and Bourne, L. (2006) Child Nutrition. In: Ijumba, P.and Padarath, A. Eds. *South African Health Review 2006*. Durban: Health Systems Trust. pp203-220.

Hill, M., Hupe, P. (2006). Analysing policy processes as multiple governance: accountability in social policy. *Policy & Politics,* 34(3), pp 557–73.

Hindle, D. (2003) A comparison of health insurance in Slovenia and Croatia. *Aust Health Rev,* 26**,** 106-15.

Hudson, J., Lowe, S., (2004). Understanding the Policy Process. Analysing welfare policy and practice. Bristol: The Policy Press. Ch 12.

Ingram, H., Schneider, A.L., deLeon, P. (2007). Social Construction and Policy Design. In: Sabatier, P.,ed. *Theories of the Policy Process*. 2nd ed. Colorado: Westview Press.Ch 4.

Jann, W., Wegrich, K. (2007). Theories of the Policy Cycle. In: Fischer, F. Miller, G.J. and Sidney, M.S. eds. (2007). *Handbook of Public Policy Analysis. Theories, Politics and Methods*. Boca Raton: CRC Press.Ch.4.

Jian, W., Chan, K. Y., Reidpath, D. D., Xu, L. (2010) China's rural-urban care gap shrank for chronic disease patients, but inequities persist. *Health Aff (Millwood),* 29**,** 2189-96.

Kautzky, K., Tollman, S.,(2008). A Perspective on Primary Health Care in South Africa. In: Barron, P., Roma-Reardon, J.eds. *South African Health Review* 2008. Durban: Health Systems Trust.

Kingdon, J.W. (1984). Agendas, Alternatives and Public Policy. 1st ed.Crawfordsville:Addison-Wesley Educational Publishers Inc.

Kingdon, J.W. (2003). Agendas, Alternatives and Public Policy.2nd ed. Crawfordsville:Addison-Wesley Educational Publishers Inc.

Kirsten, A. (2004). *The role of social movements in gun control: An international comparison between South Africa, Brazil and Australia*. Durban: Centre for Civil Society Research.

Kozinetz, C.A. (2001). Epidemiology of HIV/AIDS in developing Countries: The Children. *AIDS Patient Care and STDs*, 15(4),pp181-184.

Labradarios, D., Steyn, N.P., Maunder, E., MacIntyre, U. et al. (2000). *The National Food Consumption Survey (NFCS): Children aged 1-9 years.* Pretoria: Department of Health.

Lasswell, H.D. (1956) *The Decision Process: Seven Categories of Functional Analysis*. College Park: University of Maryland Press.

Lasswell, H.D. (1970). The Emerging Conception of the Policy Sciences. *Policy Sciences*, 1, pp3-14.

Leatt, A., Shung-King, M. and Monsoon, J. (2006). Healing inequalities: The free health care policy. In: Monson, J. Hall, K. Smith, C. and Shung-King, M. eds. South African Child Gauge 2006. Cape Town: Children's Institute.pp51-56.

Leggat, S.G. (2004). Healthy children, healthy country: The use of governing instruments in shifting the policy paradigm. *Australia and New Zealand Health Policy*, [online] Available at: http:// www.anzhealthpolicy.com/content/1/1/4 [Accessed 10 June 2010]

Lilleker, D.G. (2003). Interviewing the Political Elite: Navigating a Potential Minefield. *POLITICS*, 23(3).pp207–214.

Lindblom, C.E. (1959). The Science of ''Muddling Through''. *Public Administration Review*. Yale University.

Lipsky, M. (1980). *Street-level bureaucracy: Dilemmas of the individual in public services*. New York: Russel Sage Foundation.

Lozano, R. et al. (2011). Progress on Millenium Development Goals 4 and 5 on maternal and child mortality: An updated systematic analysis. Lancet, 378, pp1139-1365.

May, J.P., and Wildavsky, A., eds.(1978). The Policy Cycle. Beverly Hill, CA: Sage

McCoy, D. (1996) *Free health care for pregnant women and children under six in South Africa. An impact assessment.* Durban: Health Systems Trust.

McCoy, D., Besser, M., Visser, R. and Doherty, T. (2002) *Interim Findings on National PMTCT pilot sites*. Durban: Health Systems Trust.

McIntyre, D. (1995). *Health care finance and expenditure*. Durban: Health Systems Trust.

Meyers, T., Sherman, G., Eley, B., Moultrie, H., Cotton, M. (2006).Management of HIV-infected children. In: Ijumba, P., and Padarath, A., eds. *South African Health Review 2006*. Durban: Health Systems Trust.

Mhlanga, R.E. (2008). Maternal, Newborn, and Child Health: 30 years on. In: Barron, P., Roma-Reardon, J.eds. South African health review 2008. Durban: Health Systems Trust.

Minister of Health and Others vs TAC and Others, 2000(10) BCLR 1033.

Mitchell, A. (2010).*London Health Plan for Children*: Children and Young People's Project, unpublished.

Mkandawire, T. (2001). Social Policy in a Development Context.

Monson, J., Hall, K., Smith, C., Shung-King, M., eds. (2006). *South African Child Gauge 2006*. Cape Town: Children's Institute.

Moran,M. Rein, M. and Goodin, R.E., eds., (2008). *The Oxford Handbook of Public Policy*. Oxford: Oxford University Press.

Moreno, L. and Mauricio, R. (2009). Implementing Social Guarantees: The Regime of Explicit Guarantees in Health in Chile. In: Gacitua-Mario, E. Norton, A., Georgieva, and S.V. eds. (2009). *Building equality and opportunity through social guarantees: New approaches to public policy and the realization of rights*. Washington: World Bank.pp71-110.

Moyo, D. (2009). *Dead Aid. Why Aid is not working and how there is another way for Africa.* London: Penguin Books Ltd.

Naledi, T., Schneider, H., Barron, P. Primary Health Care in SA since 1994 and implications of the new vision for PHC Re-engineering. In: Padarath, A., English, R.,eds. *South African Health Review 2011*. Durban: Health Systems Trust.

National Health Services Commission. (1944). *Report of the National Health Services Commission, 1942-1944*. Pretoria: Government printer.

Nkonki, L., Chopra, M., Doherty, T., Jackson, D. and Robberstad, B. (2011). Explaining household socio-economic related child health inequalities using multiple methods in three diverse settings in South Africa. *International Journal for Equity in Health,* 10(13),pp10-13.

O'Dowd, A. (2011) Child health is under threat from NHS reforms, says report.*BMJ*,343,d8022.

Organisation of African Unity. (1990). *African Charter on the Rights and Welfare of the Child*. Available at: < http://www.africa-union.org/official_documents/Treaties>[Accessed 20 March 2012].

Osmond, D.H. (1998). *The Epidemiology of HIV infection*. San Francisco: University of California. Available at: <http://www.hiv.va.gov> [Accessed 17 December 2009].

Ostrom, E. (2007). Institutional Rational Choice. An assessment of the Institutional Analysis and Development Framework. In: Sabatier, P.,ed. *Theories of the Policy Process*. 2nd ed. Colorado: Westview Press.

Perdahl, T., Owens, P.L., Dogherty, D., McCormick, M.C., Pylypchuck, Y., Simpson, L.A. (2010) Annual Report on Health Care for Children and Youth in the United States: Racial/Ethnic and Socioeconomic Disparities in Children's Health Care Quality. *Academic Pediatrics*, 10, pp95-118.

Pierson, P. (2000). Increasing returns, path dependence and the study of politics. *American Political Science Review*. 94, pp251-268.

Petticrew, M., Whitehead, M., Macintyre, S., Graham, H. and Egan, M. (2004). Evidence for public health policy on inequalities: The reality according to policymakers. *Journal of Epidemiology and Community Health,* 58, pp811-816.

Pillay, Y.G., Bond, P. (1995). Health and Social Policies in the new South Africa. *Int J Health Serv,* 25(4)pp727-43.

Pongpirul, K., Starfield, B., Srivanichakorn, S. & Pannarunothai, S. (2009) Policy characteristics facilitating primary health care in Thailand: A pilot study in transitional country. *Int J Equity Health,* 8**,** 8.

Price, M.,(1986) Health care as an instrument of Apartheid policy in South Africa. Health Policy and Planning, 1(2),pp158-170.

Proudlock, P., Mahery, P. (2010). Children's rights to health. In: Kibel, M.,Lake, L.,Pendlebury,P., and Smith,C. Eds.*South African Child Gauge 2009/2010*. Cape Town: University of Cape Town.pp22-28.

Proudlock, P. and Shung-King, M. (2003). *Submission on the National Health Bill*, Cape Town: Children's Institute.

Pülzl, H. and Treib, O. (2007). Implementing Public Policy. In: Fischer, F., Miller, G.J., and Sidney, M.S., eds. (2007). *Handbook of Public Policy Analysis. Theories, Politics and Methods*. Boca Raton: CRC Press. Ch.7.

Rao, M.G. and Khumalo, B. (undated). *Sharing the cake: A review of Provincial Equitable Formala in South Africa*. Pretoria: Financial and Fiscal Commission, Republic of South Africa and National Institute of Public Finance and Policy, India.

Republic of South Africa. (1994a) *White Paper on Reconstruction and Development, Notice 1954 of 1994*. Pretoria: Government printer.

Republic of South Africa. (1994b) *Free health services for pregnant women and children under the age of 6 years. Notice 657 of 1994.* Pretoria: Government Printer.

Republic of South Africa. (1996) *The Constitution of the Republic of South Africa. Act 108 of 1996*. Pretoria: Government printer.

Republic of South Africa. (1998). *Employment Equity Act, No. 55 of 1998*. Pretoria: Government Printer.

Republic of South Africa. (2003). *National Health Act. No 61 of 2003*. Pretoria: Government printer.

Republic of South Africa. (2005). *Children's Act. No 38 of 2005*. Pretoria: Government printer.

Republic of South Africa. (2011). *Diagnostic Overview*. National Planning Commission.Pretoria: Government printer.

Richards, D. (1996). Elite interviewing: Approaches and Pitfalls. *POLITICS,* 16(3),pp199–204.

Richards, L. (2005) *Handling Qualitative Data. A practical guide*. London: Sage Publications Ltd.

Ridde, V., (2006). User fees and worst off: it's time to find a solution. *J Epidemiol Community Health*, 60, 398 .

Rispel, L. and Moolman, J. (2010). Health Legislation and Policy: Context, Process and Progress.In: Fonn, S., and Padarath, A. Eds. South African Health Review 2010. Ch 14, pp 127-141. Durban: Health Systems Trust

Ritchie, J. and Lewis, J., (2003), Qualitative Research Practice. A Guide for Social Science Students and Researchers. London: Sage Publications Ltd.

Russ, S., Garro, N., Halfon, N.,(2010) Meeting children's basic health needs: From patchwork to tapestry. *Children and Youth Services Review,* 32, pp1149–1164.

Sabatier, P. ed., (1988). An advocacy coalition framework of policy change and the role of policy-oriented learning therein. *Policy Sciences,* 21,pp129-168

Sabatier, P., (2007). *Theories of the Policy Process*. 2nd ed. Colorado: Westview Press.

Sabatier, P. and Weible, C.M. (2007). The Advocacy Coalition Framework; Innovation and Clarifications. In: Sabatier, P.,ed. *Theories of the Policy Process*. 2nd ed. Colorado: Westview Press. Ch.7.

Saloojee, H. and Bamford, L., (2006). Key Child Health Promotion and Prevention Programmes. In: Ijumba, P. and Padarath, A. eds., *South African Health Review 2006*. Durban: Health Systems Trust. pp181-202.

Sanders, D. and Werner, D. eds. with Weston, J. Babb, S., Rodriguez, B., (1997). *Questioning the solution: The Politics of Primary Health Care and Child Survival with an in-depth critique of oral rehydration therapy*. Palo Alto: Healthwrights.

Sanders, D. and Chopra, M. (2006) Key challenges to achieving Health for All in an Inequitable society: The case of South Africa. *American Journal of Public Health,* 96 (1),pp73-78

Sanders, D., and Schaay, N., (2008). International Perspective on Primary Health Care Over the Past 30 Years. In: Barron, P., and Roma Reardon, J., eds., *South African Health Review 2008.*Durban: Health Systems Trust.

Schierhout, G. and Fonn, S. (1999). *The Integration of Primary Health Care Services: A Systematic Literature Review.* Durban: Health Systems Trust.

Schneider, H. and Barron, P. (2008). *Achieving the Millenium development Goals in South Africa through the Revitalisation of Primary Health Care and a strengthened District Health System.* s.n.

Schneider, H. and Stein, J. (2001). Implementing AIDS policy in post-apartheid South Africa. *Social Science and Medicine,* 52, pp723-731.

Semba, R.D., Miotti, P.G., Chiphangwi, J.D., Saah, A.J. et al. (1994). Maternal vitamin A deficiency and mother-to-child transmission of HIV-1. *Lancet,* 342, pp1593-7.

Shaffer, N., Chuachoowong, R., Mock, P.A., Bhadrakom, C. et al. (1999). Short-course zidovudine for perinatal HIV-1 transmission in Bangkok, Thailand: a randomised controlled trial. Bangkok Collaborative Perinatal HIV Transmission Study Group. *Lancet,* 353, pp773-80.

Shung-King, M. et al. (2000) Child Health. In*:* Ntuli A (ed).2000 *South African Health Review 2000*. Durban: Health Systems Trust.

Shung-King, M. and Proudlock, P. (2002). "*Facts about child deaths: An overview of child deaths for decision-makers and service providers in South Africa*. Cape Town: Children's Institute.

Shung-King, M., Michelson, L., Kaime, T., Proudlock, P. et al. (2004) In: Coetzee, E,, and Streak, J. eds. 2004. *Monitoring child socio-economic rights in South Africa: Achievements and challenges*. Cape Town: Institute for Democracy in South Africa.

Shung-King, M., McIntyre, D., Jacobs, M. (2005). Healing Inequality: Targeting health care for children. In: Leatt, A., and Rosa, S.eds.(2005). *Towards a Means to Live: Targeting poverty alleviation to make children's rights real.* Cape Town: Children's Institute.

Shung-King, M. (2006). *The Ebb and Flow of Child health Policy development in South Africa: Three case studies reflecting the role of the Children's Institute at the University of Cape Town in shaping child health policy in South Africa*. Cape Town: Children's Institute.

Shung-King, M., Proudlock, P., Michelson, L. (2008). In: Chaskin, RJ. and Rosenfeld, J.M. eds. *Research for Action: Cross-National Perspectives on Connecting Knowledge, Policy and Practice for Children.* New York: Oxford University Press Inc.

Skinner, A.C. and Mayer, M. L. (2007) Effects of insurance status on children's access to specialty care: a systematic review of the literature. *BMC Health Serv Res,* 7**,** 194.

Smedley, B.D., Stith, A.Y. and Nelson, A.R., eds. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington D.C.: National Academy Press.

Snape, D. and Spencer, L. (2008). The Foundations of Qualitative Research. In: Ritchie, J., and Lewis, J. eds. 2008. *Qualitative Research Practice. A Guide for Social Science Students and Researchers*. London: Sage Publications Ltd.

South African Government (2005). *Statistics South Africa. Mortality and Causes of Deaths in South Africa, 1997-2003*. Pretoria: Government printer.

St John, W. and Johnson, P. (2000). The Pros and Cons of Data Analysis Software for Qualitative Research. *J Nursing Scholarsh*, 32 (4), pp393-397.

Statistics South Africa. (2005). General Household Survey 2005. Pretoria: Statistics South Africa.

Statistics South Africa. (2006). General Household Survey 2006. Pretoria: Statistics South Africa.

Snape, D. and Spencer, L. (2008) In: Ritchie, J., and Lewis, J., Qualitative Research Practice. A Guide for Social Science Students and Researchers. London: Sage Publications Ltd.Ch. 1, p3.

Tanahashi, T. (1978). Health Service Coverage and its Evaluation. *Bulletin of the World Health Organization*, 56(2), pp295-303.

Tellis, W. (1997). Application of a Case Study Methodology. The Qualitative Report: 3(3). Available at:< http://www.nova.edu/ssss/QR/QR-3/tellis2.html> [Accessed 14 September 2009].

Thangcharoensathien, V., Prakongsai, P., Limwattananon, S., Patcharanarumol, W. and Jongudomsuk, P. (2007). *Achieving universal health coverage in Thailand: What lessons do we learn?*. Available at: <http://www.who.int/social_determinants/resources/csdh_media/universal_coverage_thailand_2007_en.pdf> [Accessed 20 March 2012].

Torgerson, D. (2007). Promoting the Policy Orientation: Lasswell in Context. In: Fischer, F., Miller, G.J., and Sidney, M.S., eds. (2007). *Handbook of Public Policy Analysis. Theories, Politics and Methods*. Boca Raton: CRC Press. Ch.2.

True, J.L., Jones, B.D. and Baumgartner, F.R. (2007). Punctuated Equilibrium Theory: Explaining Stability and Change in Public Policymaking. In: Sabatier, P. ed. 2007. *Theories of the Policy Process*. Colorado: Westview Press.

UNESCAP. (2007). Towards universal health care coverage in the Asia-Pacific region. In: Development of Health Systems in the Context of Enhancing Economic Growth towards Achieving the Millennium Development Goals in Asia and the Pacific. Chapter 4. s.l.:UNESCAP.

UNESCO (2004). Creating Heath Promoting Schools: Fostering integrated and coordinated programmes in which children themselves play a full and active part. s.n.

UNICEF., (2006). State of the World's Children: Excluded and Invisible: New York: UNICEF.

United Kingdom Government. (2009). *Healthy Child Programme. From 5-19 years old.* London: Department of children, schools and families.

United Nations. (1989). *Convention on the Rights of the Child, General Assembly resolution 44/25.* Geneva: Office of the High Commissioner for Human Rights, United Nations.

United Nations Development Programme. (1998). *HIV/AIDS and Human Development South Africa*, Geneva: United Nations.

United Nations, Office of the High Commissioner for Human Rights. (1966). *International Covenant on Economic, Social and Cultural Rights : Article 12. General Assembly resolution 2200A (XXI).* Geneva: United Nations.

Uzicanin, A., Eggers, R., Webb, E., Harris, B., et al. (2002).Impact of the 1996–1997 supplementary measles vaccination campaigns in South Africa. *International Journal of Epidemiology*, 31, pp968-976.

Van Niekerk, R. (2009). *Social policy and citizenship in South Africa: The development of inclusive, de-racialised social policies in the periods 1939 - 1961 and 1989 – 1998*. DPhil. Oxford University. Ch 5.

Van Rensburg, H.C., and Harrison, D., (1995). History of Health Policy. In: Harrison, D., and Nielson, M.,eds.,*South African Health Review 1995*.Durban: Health Systems Trust. Ch 4.

Vitora, C.G., Vaughan, J.P., Barros, F.C., Silva, A.C. and Tomasi, E. (2000). Explaining trends in inequities: evidence from Brazilian child health studies. *The Lancet*, 356,pp1093-1098.

Vitora, C.G., Wagstaff, A., Schellenberg, J.A., Gwatkin, D. et al. (2003). Applying an equity lens to child health and mortality: more of the same is not enough. *The Lancet*, 362, pp233-241.

Victorino, C.C. and Gauthier, A. (2009). The social determinants of child health: variations across health outcomes – a population-based cross-sectional analysis. *BMC Pediatrics*, 9, 53.

Wadee, H. and Khan, F. (2007). Human Resources for Health. In: Harrison, S., Bhana, R. and Ntuli, A., eds. *South Africa Health Review 2007*. Durban: Health Systems Trust.

Walker, L. and Gilson, L. (2004*)* We are bitter but we are satisfied: nurses as street-level bureaucrats in South Africa. *Social Science and Medicine,* 59(6), pp1251-1261.

Walt, G. (1994). Health Policy-An Introduction to Process and Power. London: Zed Books.

Walt, G. and Gilson, L. (1994). Reforming the health sector in developing countries-the central role of policy analysis. *Health Policy and Planning,* 9(4) p353-370.

Walt, G., Shiffman, J., Schneider, H., Murray, S.F., et al. (2008). 'Doing health policy analysis: methodological and conceptual reflections and challenges. Health Policy and Planning, 23, 5, pp308-317.

Westwood, A., Shung-King, M. and Lake, L. (2010). Basic Health Care Services for children. In: Kibel, M., Lake, L., Pendlebury, S., Smith, C. eds. *South African Child Gauge 2009/2010*. Cape Town: Children's Institute.

Whitehead, M. (1992). "The concepts and principles of equity and health," *Int J Health Serv* 22/3 (1992), pp. 429-445.

Whitehead, M., Dahlgren, G., (2006). Concepts and Principles for tackling social inequities in health. *Levelling up Part 1*. Copenhagen: WHO.

Wigton, A. (1998) *Firearm-related injuries in Cape Town children and youth 1992 – 1996.* Cape Town: Child Health Policy Institute.

Wilkinson, D., Sach, M.E., and Abdool Karim, S.S. (1997) Examination of attendance patterns before and after the introduction of South Africa's policy of free health care for children under 6 years and pregnant women. *British Medical Journal,* 314(7085), pp940-941.

Wilkinson, R., and Pickett, K. (2009).*The Spirit Level. Why Equality is Better for Everyone.* London: Penguin Books.

Williams, G. (2003). 'Studying Development and Explaining Policies'. *Oxford Development Studies,*31(1), pp.37-58.

Wilson, J.M.G., and Junger, G. (1968). Principles and Practice of screening for disease. Available at: <http://www.who.int/bulleting/volumes/86/4/07-050112BP.pdf>[Accessed 21 October 2011].

Wise, P. (2010) Child health policies. Where are you when we need you?. *Academic Pediatrics*,10, pp285-286.

World Health Organization. (1988) *The Challenge of Implementation: District Health Systems for Primary Health Care*. Geneva: World Health Organisation.

World Health Organization. (1996). *Integration of Health Care Delivery*. Report of a WHO Study Group. Geneva: World Health Organisation.

World Health Organization. (2000). *World Health Report 2000*. *Health systems improving performance*. Geneva: World Health Organisation.

World Health Organization. (2011). <http://www.who.int/immunization_delivery/benefits_of_immunization/en/index.html >[Accessed 6 March 2012]

Wren, C.. (1990). *South Africa to Admit All Races as Patients in Its Public Hospitals*. Special to the New York Times, 17 May.

Yin, R.K.. (1994) *Case Study Research. Design and Methods,* 2nd ed. London: SAGE Publications.

Zwarenstein, M., and Barron, P., (1993). Managing Primary Health Care in South Africa at district level. *S Afr Med J*, 83(8), pp562-4.

Websites:

http://www.cabinetoffice.gov.uk/strategy.aspx

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance:

http://www.doh.gov.za

http://www.economicshelp.org/blog/935/economics/horizontal-and-vertical-equity

(http://www.inet.co.zahttp://www.inet.co.za, 11/27/2008)

http:/www.news24.com/SouthAfrica/News/Sama-to-strike-over-OSD-errors:28/2/2010

http://www.pmg.org.za/report/20120209-national-government-interventions-gauteng-free-state-and-limpopo-mini

http:// www.tac.org.za/community/about

http://www.un.org/millenniumgoals/bkgd.shtml

http://www.who.int/immunization_

http://www.who.int/whr/2002/chapter5/en/index5.html

APPENDIX A: Topic Guide Nat. Dept of Health officials

Officials will include middle/senior managers from deputy director to deputy director general that are responsible for child health programmes or oversee the cluster in which child health programmes are located. If possible the director general will be interviewed.
Depending on who the interviewee is, some additional questions specific to their portfolio might be asked.

GENERAL INFORMATION (FILL IN PRIOR TO INTERVIEW)

a. Date of interview:
b. Name of interviewee:
c. Current position:

COMMENCING THE INTERVIEW

Thank you for agreeing to do this interview. I am Dr. Maylene Shung King, currently a doctoral student at the University of Oxford and a visiting researcher at the University of Cape Town's Children's Institute. This research forms part of my doctoral thesis. The overall research aim examines whether, and how, child health policy in post-apartheid South Africa has addressed equity in its development and implementation. This part of the research project focuses on the development and implementation of the national School Health policy, as an example through which to explore the main research questions. The research is being conducted at all three levels of the health system, that is national, provincial and district. One component of the review involves a country-wide snap-shot of the implementation of the School Health Policy. Three provinces have been selected as case studies for an in-depth evaluation of the policy's development and implementation. This interview forms part of the exploration at a national level and will take at least an hour and a half (Make sure that the interviewee has this chunk of time at their disposal).

The results of the research will be used exclusively for purposes of my research. A full copy of the results will be provided to the national Department of Health and provinces will receive sections of the results relevant to them. Results should be available towards the end of 2009.

If you have any questions for me about the research, now or at the end of the interview, please don't hesitate to ask. In order to make analysis of the interviews easier, I would like to record this interview. All recorded interviews will be destroyed at completion of my thesis. Please indicate if you have any objections to this interview being recorded and I will record the interview by hand instead.

OPENING QUESTION

a. Perhaps we can start with you telling me a about your current role and responsibilities in relation to child health policy?

b. Do you make a distinction between policy, policy guidelines and programmes?

2. RELATIONSHIP BETWEEN NATIONAL AND PROVINCIAL POLICY

Let us now look at the relationship between the different levels of governance and how it relates to policy.

a. What is the process of policy making, as you understand it, between the national and provincial health departments.

If interviewee does not volunteer, ask:

- what the explicit roles are of national and provincial departments in the development of child health policies
- when national policy is made and passed down to provinces, what is the national expectation of provinces with regards to adopting and implementing the policy
- if national policies do not fit in with provincial priorities, how do you as a national department respond when provinces defer/ignore national policy

b. What in your opinion determines how a new child health policy is placed on the national agenda?
    - (Prompt interviewee if necessary to think of individual and systemic factors, external drivers such as new evidence, international factors etc)

3. FOCUS ON THE SCHOOL HEALTH POLICY

Let us focus on the School Health Policy now and explore it in more detail (from here onwards, the questions might differ depending on the interviewee and their specific position. A separate sheet with interviewee-specific questions will be drawn up)

3.1 POLICY PROCESS

a. Following on from the previous question on setting priorities, how did the school health policy land on the national agenda?

If interviewee does not volunteer, ask specifically:

- Did the policy fit in with the overall national child health agenda at the time?
- How was this policy co-ordinated with other complementary policies (if necessary, prompt interviewee to consider the Health Promoting Schools policy as an example)
- Was the policy part of a broader national child health plan, or was it considered as a stand-alone issue?

b. The consultative process for this policy was extensive involving all provinces through individual provincial workshops. How do you think the choice of inclusive process influenced the final product?

c. What, if any, were the trade-offs?
d. The relationship with education is clearly an important one in relation to the school health service. How was this relationship managed at a national level and what opportunities/challenges arose for inter-sectoral cooperation between health and education?

3.2 POLICY CONTENT

Although we will not explore policy content in detail, certain aspects are important to reflect on.

a. Was the ‘’Integrated model’’ proposed in the policy compatible with overall national health system strategy? Ask the interviewee to qualify their answer.

(Do you think there is any room at all in the current system for vertical health programmes such as the previous school health service?)

b. Clearly the policy requires a certain level of resource-availability for its implementation. How does a national policy such as the School Health take account of provincial resource availability/constraints?
c. This policy was funded by USAID and had specific input from UNICEF at various stages of its development. How do you think this influenced the policy process/content?
d. In general, from your experience so far, how is South African child health policy shaped by international agencies such as WHO/UNICEF?
e. From your experience, do you think the evidence-base used to guide the policy direction and content was sufficient?
f. From a national point of view do you think the specific activities proposed in the policy adequately covers the health needs of school-aged children?

3.3 IMPLEMENTATION

The implementation of any policy can highlight both positive benefits and changes for health services, as well as challenges.

a. What were the positive service benefits and/or challenges for child health services from a national point of view?
b. School health services did not receive specific national financial support and its implementation relied on provincial resource provision.

What is the national response when provinces are unable to allocate adequate resources for the implementation of a national policy?

c. There is some anecdotal evidence that suggests that preventative programmes like the SH policy might take the back-burner in favour of curative care. What is your opinion on this?

3.4 EQUITY ISSUES

As stated in the beginning, one of the main areas of interest for me is the extent to which equity has been addressed through the school health policy. We know that prior to the release of the national school health policy school health services differed greatly across the country in their availability and quality. Let us talk about how this policy addressed school health service equity.

a. Perhaps we can start with you sharing your opinion on what ‘’equity’’ means

b. Most policies, including the school health policy have a universal rather than a targeted approach (in other words, they expect the service to be implemented in the same way everywhere). How do you think this approach influences the attainment of equity

c. This policy made some practical suggestions to provinces on how to improve equity. Some of these included focusing on disadvantaged areas first and finding innovative ways to staff the service in areas where nurses are not sufficient. How does the national department support provinces in meeting equity goals? If you have knowledge of it, how did it work in the case of the school health policy?

4. RELATING SCHOOL HEALTH EXPERIENCE TO CHILD HEALTH POLICY IN GENERAL

We have spoken specifically about the national School Health policy until now.

a. Do you think the experience with the school health policy is typical of what happens with child health policy in general?

If interviewee does not volunteer, ask specifically about:

-The federal relationship

-How other policies considered and addressed equity

-The universal versus targeted approach

(If time is running out, focus only on how equity is dealt with in the implementation of other child health policies).

5. CLOSING THE INTERVIEW

d. If person did not ask any questions her/himself, offer them the opportunity to do so.

e. Thank the interviewee for their time and helpful insights. Ask if it will be acceptable to contact them telephonically is one or two additional questions arise. Get the best number to contact them on.

f. Offer to be contacted at any time should questions/concerns arise via the contact details on the consent form

APPENDIX B: Topic Guide Prov. Dept of Health officials

TOPIC GUIDE:

PROVINCIAL DEPARTMENT OF HEALTH OFFICIALS
(Officials will include middle- and senior managers from deputy director to deputy director general levels that are directly responsible for child health programmes or that have child health as one of several areas of responsibility. Where possible the director general (or highest official in each province) will be interviewed.

Depending on the interviewee, some additional questions specific to their portfolio might be asked.

GENERAL INFORMATION (FILL IN PRIOR TO INTERVIEW)

d. Date of interview:

e. Name of interviewee:

f. Current position:

COMMENCING THE INTERVIEW

Thank you for agreeing to do this interview. I am Dr. Maylene Shung King, currently a doctoral student at the University of Oxford and a visiting researcher at the University of Cape Town's Children's Institute. This research forms part of my doctoral thesis. The overall research aim examines whether, and how, child health policy in post-apartheid South Africa has addressed equity in its development and implementation. This part of the research project focuses on the development and implementation of the national School Health policy, as an example through which to explore the main research questions. The research is being conducted at all three levels of the health system, that is national, provincial and district. One component of the review involves a country-wide snap-shot of the implementation of the School Health Policy. Three provinces have been selected as case studies for an in-depth evaluation of the policy's development and implementation. This interview forms part of the exploration at a provincial level and will take about an hour and a half (Make sure that the interviewee has this chunk of time at their disposal).

The results of the research will be used exclusively for purposes of my research. A full copy of the results will be provided to the national Department of Health and provinces will receive sections of the results relevant to them. Results should be available towards the end of 2009. All interviews will be kept confidential and where possible, interviewee anonymity will be preserved. No names will be used in the reporting of results.

If you have any questions for me about the research, now or at the end of the interview, please don't hesitate to ask. In order to make analysis of the interviews easier, I would like to record this interview. All recorded interviews will be destroyed

at completion of my thesis. Please indicate if you have any objections to this interview being recorded and I will record the interview by hand instead.

OPENING QUESTIONS

a. Perhaps we can start with you telling me about your role and responsibilities in relation to school health in particular (child health policy for more senior officials who are less involved with specifics of school health).

2. RELATIONSHIP BETWEEN NATIONAL AND PROVINCIAL POLICY (ASK THIS IF THERE IS TIME AT THE END)

Let us now look at the relationship between the different levels of government and how it relates to policy.

a. What is your provincial role/input in relation to the National policy process?

(If interviewee does not volunteer, ask specifically:

- how often the province is involved in the initiation and development of national policy
- who generally initiates, develops and finally approves policy?
- when national policy is made and passed down to provinces do they adopt it as is, re-write it to make it province-specific
- what happens if national policy does not quite fit in with provincial priorities at the time

b. What in your opinion determines how a new child health policy is placed on the national /provincial agenda?

(Prompt interviewee if necessary to think of individual and systemic factors, external drivers such as new evidence, international factors etc)

3. FOCUS ON THE SCHOOL HEALTH POLICY

Let us focus on the School Health Policy now and explore it in more detail

(From this point the questions might differ depending on the interviewee and their specific position. A separate sheet with interviewee-specific questions will be drawn up)

3.1 POLICY PROCESS

a. Following on from the previous question, how in your opinion did the school health policy land on the national agenda?

b. What has been the provincial role in the development of the national School Health Policy?

If interviewee does not volunteer, ask specifically:

- To what extent was your province involved in the initiation and development of the national policy
- Were provincial needs and priorities reflected in the final policy

- How were district level staff involved in the national and/or provincial policy
- Would you have done it any differently if you had the option?

c. The consultative process for this policy was extensive involving all provinces through individual provincial workshops. How do you think the choice of such an inclusive process influenced the final product?

d. What, if any, were the trade-offs from your point of view?

e. How did senior health managers in this province respond to the release of the National policy? (senior managers are those from chief-director level upwards and make ultimate decisions on what to do with national policy, resource-allocation for specific health interventions etc)

f. How were district level staff and managers involved in the provincial school health policy process?

g. The relationship with education is clearly an important one in relation to the school health service. How is this relationship managed in this province?

h. Who were the other key stake holders in this process and what is your assessment of the extent of involvement in developing the policy?

i. How does the school health service relate to Health Promoting Schools in this province?

3.2 POLICY CONTENT

Although we will not explore policy content in detail, certain aspects are important to reflect on.

a. What was the response in this province to the ‘’integrated model’’ of service delivery proposed in the national SHP?

b. Does/did the policy content in terms of the specific interventions it proposed for Grade 1 screening and health promotion interventions for older children cover the needs of school-aged children in this province? (Ask person to substantiate their assertions).

3.3 IMPLEMENTATION

The implementation of any policy can highlight both positive benefits and changes for health services, as well as challenges.

a. What were the positive benefits and/or challenges when the School Health Policy was implemented here in the Western Cape

If interviewee does not volunteer, ask specifically:

- How does a new policy such as the SHP get prioritized considering that it was one of several policies, programmes and protocols to be implemented in the past 14 years?
- How nurses responded to the integrated service model. If negative, ask how their reactions manifested?
- Did the province allocate any additional resources?(For example, in the WC, the health plan indicated that an additional 22 SHN will be appointed. Where are they likely to be deployed to?)
- What was the effect on staff/facility workload?

b. Were these benefits/challenges the same throughout the province or were they different in each district/region? Can you give one or two examples of areas where the effect was positively/negatively different?

c. There is some anecdotal evidence that suggests that preventative programmes like the SH policy might take a back-seat in favour of curative care. What is your opinion on this?

EQUITY ISSUES

As stated in the beginning, one of the main areas of interest of this study is the extent to which equity has been addressed through the school health policy. We know that prior to the release of the national school health policy school health services differed greatly across the country in their availability and quality. Let us talk about how this policy addressed school health service equity.

a. Perhaps we can start with you sharing your understanding of what ‘’equity’’ in health care means

b. The national policy made some practical suggestions to provinces on how to improve equity. Some of these included focusing on disadvantaged areas first and finding innovative ways to staff the service in areas where nurses are not sufficient.

How did this province go about addressing the issue of equity for school health service delivery?

c. Most policies, including the school health policy have a universal rather than a targeted approach (in other words, they expect the service to be implemented in the same way everywhere). Do you think this approach is the best for the attainment of equity?

d. How are you monitoring the achievement of equity in the provision of school health services, in other words, how do you know whether poorly resourced areas (special nodes) are receiving the same level of service provision compared to better-resourced areas ?

4. RELATING SCHOOL HEALTH EXPERIENCE TO CHILD HEALTH POLICY IN GENERAL

We have spoken specifically about the development and implementation of the national School Health policy until now.

b. Do you think the experience with the school health policy is typical of what happens with child health policy in general? (perhaps ask interviewee to give an example, with reasons, of the best and the worst policy process they have been involved with)

If interviewee does not volunteer, ask specifically about:

-The federal relationship
-Consultation
-Process of developing child health policy
-The issue of equity

(If time is running out, focus only on how equity is dealt with in the implementation of other child health policies).

6. CLOSING THE INTERVIEW

g. If person did not ask any questions her/himself, offer them the opportunity to do so.

h. Thank the interviewee for their time and helpful insights. Ask if it will be acceptable to contact them telephonically is one or two additional questions arise. Get the best contact number.

i. Offer to be contacted at any time should questions/concerns arise via the contact details on the consent form

APPENDIX C: Topic Guide District Level officials

TOPIC GUIDE: DISTRICT LEVEL HEALTH OFFICIALS

(Interviewees at this level include clinic managers, district managers responsible for child health and nurses involved in the delivery of school health services)

Depending on the interviewee, some additional questions might be asked that are specific to their portfolio

GENERAL INFORMATION (FILL IN PRIOR TO INTERVIEW)

a. Date of interview:

b. Name of interviewee:

c. Current position:

COMMENCING THE INTERVIEW

Thank you for agreeing to do this interview. I am Maylene Shung King, currently a doctoral student at the University of Oxford and a visiting researcher at the University of Cape Town's Children's Institute. This research forms part of my doctoral thesis. The overall research aim examines whether, and how, child health policy in post-apartheid South Africa has addressed equity in its development and implementation. This part of the research project focuses on the development and implementation of the national School Health policy, as an example through which to explore the main research questions. The research is being conducted at all three levels of the health system, that is national, provincial and district. One component of the review involves a country-wide snap-shot of the implementation of the School Health Policy. Three provinces have been selected as case studies for an in-depth evaluation of the policy's development and implementation. This interview forms part of the in-depth case study and will take at least an hour and a half (Make sure that the interviewee has this chunk of time at their disposal).

The results of the research will be used exclusively for purposes of my research. A full copy of the results will be provided to the national Department of Health and provinces will receive sections of the results relevant to them. Results should be available towards the end of 2009.

If you have any questions for me about the research, now or at the end of the interview, please don't hesitate to ask. In order to make analysis of the interviews easier, I would like to record this interview. All recorded interviews will be destroyed at completion of my thesis. Please indicate if you have any objections to this interview being recorded and I will record the interview in writing instead.

3. OPENING QUESTIONS

a. Perhaps we could start with you telling me about your role with child health services in general.

b. Now tell me about your role and responsibility with school health services in particular.

4. DISTRICT ROLE IN POLICY PROCESS

Let us move now to talking about the specifics of the School Health policy

a. How was the release of the School Health Policy first communicated to you?

b. What was your role, if any, in shaping the national and provincial SHP?

c. How did your fellow-staff/managers respond to the release of the policy?

5. CO-ORDINATION WITH SCHOOLS/OTHER HEALTH PROGRAMMES

a. How is the relationship between the clinics and schools structured with regards to the school health policy?

b. How is the relationship between school health services and the Health Promoting Schools initiative structured?

c. How are school health services co-ordinated with other child health services?

6. POLICY IMPLEMENTATION

For the most part you are responsible for implementing the school health policy that has been developed by provincial or national officials.

a. Before the new School Health Policy came about how were school health services delivered in your area?
b. What changes came about following the release of the national policy?
c. When exactly did your area start the implementation of the policy?
d. How did you/your facility prepare for the implementation of the policy?
e. To what extent were you involved in deciding how the school health service would be delivered from your clinic?
f. What have been the main opportunities/challenges for your facility/district in implementing this service?

If interviewee does not volunteer, ask specifically about:

- The reaction of nursing staff to the proposed integration of SH with PHC services?
- Staff and facility workload

- Preventative health services such as SH reportedly not enjoying the same priority as curative health services.

- Resource requirements/provision

g. Is your facility planning to implement phase two anytime soon? If yes, how are you preparing to do this?
h. Based on your experience with the policy thus far, would you change anything about it?

7. EQUITY ISSUES

Equity was and still is a very important goal of our transformation process. Lets explore this a bit in relation to SH.

a. Perhaps we can start with you sharing your opinion on what ‘’equity’’ means
b. How did you/staff in your clinic consider achieving equity for the delivery of school health services in your area
c. The national policy specifically suggested that the poorest areas be prioritized first in the implementation of the policy. How did it work in your area?
d. I have heard that the rural regions especially are struggling to implement this policy. As a rural/periurban/ urban area, do you get any extra support from the provincial office to implement this policy? Prompt for a further explanation depending if answer is ‘’yes’’ or ‘’no’’.

MONITORING OF IMPLEMENTATION (This will be asked only of clinic managers/person overseeing school health in the interview district)

The national annual report for 2007/8 reported one hundred percent coverage of SHS for all provinces. What exactly does this mean in your area?

Let us unpack some of the data for your area.

a. How many schools is this facility responsible for?

b. How often do you visit each school? Are schools from poorer areas visited equally to schools from better-off areas?

c. What kind of routine data is kept on school health service coverage?

d. Can you explain if you make any distinction between district coverage, individual school coverage and learner coverage? Do data exist that can confirm this?

e. Are learners that were missed out during the school visit followed-up at another time?

f. How are referrals dealt with?

RELATING SCHOOL HEALTH EXPERIENCE TO CHILD HEALTH POLICY IN GENERAL

We have spoken specifically about the national School Health policy until now.

Do you think the experience with the school health policy is typical of what happens with child health policy in general?

If interviewee does not volunteer, ask specifically about:

-The process for policy devolution and implementation in districts/clinics

-How equity has been considered with other child health policies

(If time is running out, focus only on how equity is dealt with in the implementation of other child health policies).

10. CLOSING THE INTERVIEW

a. If person did not ask any questions her/himself, offer them the opportunity to do so.

b. Thank the interviewee for their time and helpful insights. Ask if it will be acceptable to contact them telephonically is one or two additional questions arise. Get the best number to contact them on.

c. Offer to be contacted at any time should questions/concerns arise via the contact details on the consent form

APPENDIX D: Topic Guide: Prov. Managers and Co-ordinators

TOPIC GUIDE – PROVINCIAL MCWH PROGRAMME MANAGERS AND SCHOOL HEALTH CO-ORDINATORS

(These interviewees are hands-on service providers/managers and therefore more specific questions are being asked of them)

These interviews will be done telephonically, except in the case study provinces where it will be done face-to-face.

GENERAL INFORMATION (FILL IN PRIOR TO INTERVIEW)

d. Date of interview:

e. Name of interviewee:

f. Current position:

COMMENCING THE INTERVIEW

Thank you for agreeing to do this telephonic interview. I am Dr. Maylene Shung King, currently a doctoral student at the University of Oxford and a visiting researcher at the University of Cape Town's Children's Institute. This research forms part of my doctoral thesis. The overall research aim examines whether, and how, child health policy in post-apartheid South Africa has addressed equity in its development and implementation. This part of the research project focuses on the development and implementation of the national School Health policy, as an example through which to explore the main research questions. The research is being conducted at all three levels of the health system, that is national, provincial and district. One component of the review involves a country-wide snap-shot of the implementation of the School Health Policy, and is being done in conjunction with the national MCWH cluster. Three provinces have been selected as case studies for an in-depth evaluation of the policy's development and implementation. This interview forms part of the country-wide review and will take about an hour (Make sure that the interviewee has this chunk of time at their disposal).

The results of the research will be used exclusively for purposes of my research. A full copy of the results will be provided to the national Department of Health and provinces will receive sections of the results relevant to them. Results should be available towards the end of 2009. All interviews will be kept confidential and where possible, interviewee anonymity will be preserved. No names will be used in the reporting of results.

If you have any questions for me about the research, now or at the end of the interview, please don't hesitate to ask. In order to make analysis of the interviews easier, I would like to record this interview. All recorded interviews will be destroyed

at completion of my thesis. Please indicate if you have any objections to this interview being recorded and I will record the interview in writing instead.

1. OPENING QUESTIONS

Perhaps we could start with you telling me about your role with school health services in your province, as well as what your responsibility with school health services involves.

2. FOCUS ON THE SCHOOL HEALTH POLICY

We will now move on to specific questions about the national School Health Policy and its implementation in your province

a. Prior to the release of the national School Health Policy in 2003, how were school health services provided in your province?

b. What role did you, or other members of your school health team in this province play in the initiation and subsequent development of the national School Health Policy?

c. Following the release of the national School Health policy, did your province adopt it as is, or did you adapt it especially for your province?

d. If you did adapt it, please explain how your provincial policy differs from the national one.

e. When exactly did the implementation of the School Health policy start in your province?

f. How did the National School Health policy change the way in which school health services are delivered in your province?

(If interviewee does not volunteer, ask specifically:

- The model (vertical/ integrated) of service provision
- The frequency of school health visits
- The ability to respond to learners' health problems
- The referral system

g. With the implementation of any new policy some new and exciting opportunities may come about, whilst at the same time some challenges may occur. What positive changes/challenges did you experience when moving from the previous service delivery system to the one under the new policy?

(If interviewee does not volunteer, some prompt questions to ask)

- How did the integration of the service with other PHC services work
- The influence on nursing staff (Both those involved with SHS and those working alongside them)

- The functioning of health facilities with the addition of the SHS
- How was resource allocation for school health services handled by the provincial health department?

h. Let's talk about the co-ordination of the SHP with other services/sectors.
   - In particular, tell me about the relationship with Health Promoting Schools

   - What is the relationship between your department and the Department of Education with regards to the School Health service?

i. Do you think the activities/interventions proposed in the School Health Policy adequately addresses the needs of school children? If no, what changes would you propose?

4. FOCUS ON EQUITY

As stated in the beginning, one of the main areas of interest for the study is the extent to which equity has been addressed through the school health policy.

a. Perhaps we can start with you sharing your understanding of what ''equity'' in health care means?

b. Part of the reason for the development of the national School Health Policy was the differential provision of the School Health service between different race groups and different geographic areas. How did your province approach the service gaps that existed?

If interviewee does not volunteer, ask specifically:
- How did your province approach the delivery of SHS in areas where this service was not delivered prior to the national school health policy coming into being?
- If this was not done, what are the plans for addressing gaps in service delivery for the future?
- Whether the service had changed in areas that did not get regular school health services before (Ask the interviewee to give concrete examples)

c. Do you feel that the national policy provided your province with sufficient direction on how to achieve a more equitable school health service?

d. Briefly, how do you consider the issue of equity in the implementation of your other child health policies/services?

5. MONITORING OF THE POLICY

The monitoring of school health service provision is important to assess whether the policy is being implemented as intended. Let us focus now on the data that is available in your area for monitoring school health service provision.

a. What indicators (data items) do the clinics collect on school health service provision?

The recent annual report of the national department of health indicated 100% district coverage throughout the country.

b. What does this mean in your province?

If interviewee does not volunteer, ask specifically:

-if the service is available in each district, but only for some schools
-if the service is provided to every school in the district every year (if not, how often)
-every learner in Grade R/1 that should be screened gets screened (how are absent learners followed up?)

(Ask the interviewee if they will be able to post/fax/email the available data for the last 6 months of 2008 as an example)

11. CLOSING THE INTERVIEW

a. Are there any other comments you would like to make? Changes that you would like to see in SHS, or positive developments/challenges that we did not address in the interview?

b. If person did not ask any questions her/himself, offer them the opportunity to do so.

c. Thank the interviewee for their time and helpful insights. Ask if it will be acceptable to contact them telephonically is one or two additional questions arise. Get the best number to contact them on.

d. Offer to be contacted at any time should questions/concerns arise via the contact details on the consent form