EXPLORING THE ROLE OF THE DEPARTMENT OF SOCIAL DEVELOPMENT ON THE INTEGRATED SCHOOL HEALTH PROGRAMME IN THE BUFFALO CITY MUNICIPALITY

By

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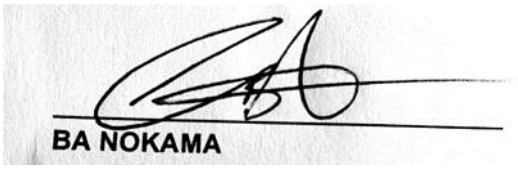
DECLARATION

I, **Busisa Antoinette Nokama (201614958)** do hereby declare that the content of this study is my own original work and never been submitted to any other institution for the attainment of any qualification or degree, either in part or in its entirety.



30 October 2021

DEDICATION

This study is devoted to my grandfather, Tsukumbini “Manethi” Nokama who has been nothing but an inspiration, motivator and confidant – he never really went to school but was committed to my studies more than I was. I dedicate it to my family and friends who supported me throughout, encouraging me in periods of cognitive dissonance.

I also dedicate it to every person within the education, health and social development sector that has served learners with diligence and passion contributing to realization of dreams that seemed impossible. Lastly, I dedicate it to every learner because every child deserves an opportunity to be the best they can be and to reach their full potential regardless of their background.

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This journey would never be fulfilled without my colleagues from three departments. Their perspectives did not only enrich the study but also provided me with great insight that led to personal growth.

I would like to acknowledge Dr. TC Maramura who made the fulfillment of this work possible. This is the result of her persistence, encouragement and professional guidance. Thank you Dr. Maramura for committing to hold my hand till the finish line.

I must mention Dr. Bathathu Peter whom I started this journey with, if it were not for his confidence in me, this journey would not have started.

The support from my family, Nonyameko Evelyn Nokama-Nelani and Khulile Leanord Nelani was remarkable as they had to listen to me trying to ground this work in literature. My mother made referrals that were never followed such as people from the department of education that visited her school.

ACRONYMS

BCM:	"Buffalo City Municipality"
CSTL:	"Care and Support for Teaching and Learning"
DBE/DOBE:	"Department of Basic Education"
DBST:	"District Based Support Team"
DoE:	"Department of Education"
DSD:	"Department of Social Development"
ISHP:	"Integrated School Health Programme/Policy"
NDP:	"National Development Plan"
OVC:	"Orphaned Vulnerable Children"
SBST:	"School Based Support Team"
SHS:	"Social Health Services"
SOP:	"Standard Operation Procedure"
SRHR&SS:	"Sexual Reproductive Health, Right and Social Services"
WHO:	"World Health Organisation"
GiZ:	"Deutsche Gesellschaft für Internationale Zusammenarbeit"
SIAS:	"Screening, Identification, Assessment and Support"
NAYH:	"National Adolescent and Youth Health Policy"

ABSTRACT

If one's health is a state of wellbeing then the role of social development is key in the implementation of the Integrated School Health Programme (ISHP) as it includes treatment and prevention of psychosocial dysfunction. The purpose of the study was to explore the role of the Department of Social Development (DSD) within the ISHP in Buffalo City Municipality. DSD services are complex hence the need active collaboration to ensure delivery of multi-sectoral services. Covid-19 evidently shows the link between physical, emotional and academic success (OECD, 2020). The trauma and challenges faced by learners' manifests through behavioral problems that social workers and counsellors can address more effectively. Social work practice aims to treat and prevent psychosocial dysfunction, thus social workers remain integral in addressing social determinants of health. The challenges in the implementation of ISHP began at policy development, moreover they were exacerbated by poor coordination and management of the ISHP. The legislative framework however affords learners the right to protective care and support. The role of social development is not limited to transportation but has been captured through psychosocial support.

The study suitably employed a qualitative research design to examine how the participants make sense of the Integrated School Health Programme and to provide a comprehensive description of the complex role of the DSD in the provision of psychosocial support. 15 participants from DOH, DoE and DSD were interviewed to capture the perspective of all three (3) departments. The findings indicated how the development of the policy impacts implementation. The DSD is participating in the implementation of ISHP, however the failure of the policy to capture the role of the DSD, hinders the DSD from full participation. The study also found a lack of resourcesto support implementation and often struggle to get learners but implementation varies. Conclusively, the study recommends the need for the departments to develop a Memorandum of Understanding, Terms of reference as well as Integrated Implementation plans in an effort to support and close the gaps identified in the policy. Collaboration was found to be an effective strategy to enhance resource mobilization. Coordination and Management still need to be strengthened, including accountability.

Keywords: *Social Development; Policy Implementation; Wellbeing; ISHP; Buffalo City Metropolitan Municipality*

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CHAPTER ONE: INTRODUCTION AND BACKGROUND OF THE STUDY

1.1 INTRODUCTION

If the health of a child enables better learning, a multi-sectoral collaboration is needed to ensure that the Integrated School Health Policy (ISHP) programme can be effectively implemented to provide a holistic intervention that enables learners the opportunity to access a healthy, reproductive and rehabilitated life. The ISHP envisioned a world where children of school going age enjoy optimal health and development where they live and learn (Department of Health (DoH) & Department of Basic Education 2012). The ISHP provides an opportunity for all children to access equal opportunities and benefits according to their rights. Dibakwane and Peu (2018) further state that, through health promotion the ISHP serves as an intervention to ensure Orphaned-Vulnerable Children (OVCs) have similar access to rights as other children.

This study explored the role of the Department of Social Development (DSD) in light of the policy framework that informs the implementation of the Integrated School Health Programme. The Eastern Cape Department of Education (2016) regards the ISHP as key in the fight against HIV/AIDS, social security and poverty. In addition, a school health programme as described by Peu et al. (2015) is a basket of integrated services that should improve the physical, social and mental facets of a learner. Khoza (2017) advocates that all health-related factors were mandated to be incorporated by the ISHP, thus this study defines concepts such as health and psychosocial support to define a clear understanding of what the programme seeks to achieve.

1.2 BACKGROUND OF THE STUDY

The policy is required to ensure that all identified learners have access to proper services and resources in terms of assessment and treatment, as well as care and support. These services are rendered by three departments, namely Health (DoH), Basic Education (DBE) and Social Development (DSD) including all stakeholders (Department of Health & Department of Basic Education 2012). However, a number of studies view the comprehensive ISHP approach as a challenge due to lack of clear articulation of the roles of the service providers (Keothaile 2016), moreover, focus is often on the role of the DoH within schools, thus the Department of Education (Dibakwane and Peu 2018; Keothaile 2016; Khoza 2017).

According to a study from Lesotho, Tanzania and Zanzibar working with teachers, parents and school pupils, Community-Based Rehabilitation (CBR) workers, community members and health

personnel who are interested and committed, contributes to inclusive education. (Mariga, McConkey and Myezwa 2015). Furthermore, ISHP necessitates the three departments, the School Governing Bodies (SGBs) and other external stakeholders to collaborate in the provision of services and protection methods (Department of Basic Education 2017). In addition, an Annual Review of Public Health suggests that psychological, counselling, social services, family and community engagement are part of the ten interactive components of school health programmes (Kolbe 2019).

Furthermore, the Annual Review of Public Health when referring to a strategy are referring to school health because school health will improve health and education of the public (Kolbe 2019). ISHP responds holistically to the health of learners with the aim of enhancing attendance and ultimately enable learners to obtain quality basic education (Department of Basic Education 2017). This can be achieved if resources are used effectively, and people's needs are responded to. This study is aligned with the principles of Public Administration outlined in Chapter 10 of the Constitution of South Africa 108 of 1996.

1.1. PROBLEM STATEMENT

The general objective of the ISHP is the running of an inclusive and integrated health programme at school (Department of Health & Department of Basic Education 2012). Implementing an ISHP requires commitment from all stakeholders namely the Department of Social Development, Health, Education, and more, to actively collaborate and responsibly ensure its comprehension and sustainability. However, the Eastern Cape DoH conducted an implementation evaluation on ISHP and found that the ISHP is under-resourced and instead, much focus is on Human Papilloma Virus (HPV) and Deworming. Furthermore, coordination is strong between DoH and DoE however in terms of the on-site services and screening, there is a lack of adequate nurses, social workers, psychologists and other professions needed for effective implementation of the ISHP (Dlamini, Merile, and Gixela 2017).

The Standard Operational Procedures (SOPs) for ISHP requires amongst others, a provision of therapeutic services, protective services that respond to children exposed to violence and abuse (Department of Basic Education and Read to Lead 2017). The DSD is needed in relation to childhood development, child care or protective services and to address poverty issues (Department of Basic Education and Read to Lead 2017; Department of Health 2013).

Furthermore, there is a need for collaboration in the identification of vulnerable learners, intervention and support as agreed on the Memorandum of Understanding (MOU) between the three (3) Departments.

The problem is the lack of clear roles and participation requirements by stakeholders, leading to the use of disjointed, uncoordinated and unsustainable approaches when implementing ISHP consequently delayed identification and holistic interventions (Rasesemola, Matshoge, and Ramukumba 2019). Prior this research, there has been no research conducted to assess the implementation of ISHP by the Department of Social Development (DSD), however, most research focused on DoH and DBE. According to Menziwa (2019) there is no proper referral system for vulnerable learners thus they access to appropriate services. The intersectoral and multisectoral collaboration still needs to be improved for effective and efficient implementation of ISHP programmes (Rasesemola et al. 2019). Given this background the study explores the role of social development to address the aforementioned challenges while improving multisectoral collaboration.

1.3 RESEARCH OBJECTIVES

The aim of this study was to explore the role of DSD on the implementation of the Integrated School Health Programme – ISHP in Buffalo City Municipality, Eastern Cape. The sub-objectives of the dissertation were:

a) To explore the role of Menzi Social Development within the Integrated School Health Programme.
b) To investigate the current participation of Social Development in rendering the ISHP.
c) To make recommendations on the delivery of multi-sectoral services in the implementation of the Integrated School Health Programme.

1.4 RESEARCH QUESTIONS

The following questions guided the study:

a) What is the role of Social Development in the Integrated School Health Programme?
b) What is the current participation of Social Development in rendering the ISHP?
c) What are the recommendations to enhance the participation of DSD in the delivery of multi-sectoral services?

1.5 SIGNIFICANCE OF THE STUDY

The study assessed the role of the Department of Social Development in the execution of the ISHP. The study obtained significant knowledge on how psychosocial support proposed by the policy is rendered (ISHP). It also identified what works and does not work in the provision of DSD services, thus enabling effective ways of delivering multi-sectoral services and improving resource utilization (Ijeoma, 2014). The study contributes to the body of knowledge as there is not enough written about this topic, thus reaching new conclusions (Chun Tie, Birks and Francis, 2019). This study contributed to the strategies drafted by all departments to improve both health and education by establishing a comprehensive approach that considers inclusiveness, anti-discrimination frameworks, human rights policies and laws to ensure equity for all learners and to uphold the principle of "No child will be left behind" (OECD, 2020).

1.6 LITERATURE REVIEW

It has been widely recognized that there are aspects that affect one's health and wellbeing. More than just biomedical services, health is also psychosocial (Samuel, Jones and Hamad 2017). Psychosocial support describes a "…wide variety of care and support and protection activities aimed at ensuring the five domains of psychosocial wellbeing (social, spiritual, emotional, physical and mental) of individuals, their families and communities (Department of Social Development and USAID 2016). DSD through its statutory obligations is more likely to provide psychosocial support services to learners. Furthermore, rendering of multi-sectoral services remains the best approach in responding to learner's health needs. This multi-sectoral approach is widely recommended and proposed by the ISHP. The packages of services offered by ISHP are tabulated below as presented by the ISHP policy document. This table highlights the components of the package that motivated the exploration of the role of the Department of Social Development. The potential role of social development cannot be limited to those, but were explored in this study.

Table 1: ISHP Package of Services

Grades/Phases	Health Screening	Onsite services	Health Education
Grade R-3 (Foundation Phase)	Oral health; Vision; Hearing; Speech; Nutritional assessment; Physical assessment (Gross & fine motor); **Mental Health**; Tuberculosis; Chronic illnesses, Psychosocial **Support**	Parasite control; Deworming and bilharzia control (where appropriate); Immunisation; Oral health (where available); Minor ailments	Hand washing; Personal & environmental hygiene; Nutrition; Tuberculosis; Road safety; Poisoning; Know your body; **Abuse (sexual, physical and emotional abuse)**
Grade 4- 6 (Intermediate Phase)	Oral health; Vision; Hearing; Speech; Nutritional assessment; Physical assessment; **Mental Health**; Tuberculosis; Chronic illnesses; **Psychosocial Support**	Deworming; Minor ailments; **Counselling regarding SRH (if indicated), and provision of and referral for services as needed**	Personal & environmental hygiene; Nutrition; Tuberculosis; Medical and Traditional Male circumcision; **Abuse (sexual, physical and emotional abuse including bullying, violence); Puberty (e.g., physical and emotional changes, menstruation & teenage pregnancy); Drug & substance abuse**
Grade 7 – 9 (Senior Phase)	Oral health; Vision; Hearing; Speech; Nutritional assessment; Physical assessment incl. anaemia; Mental **Health**; Tuberculosis; Chronic illnesses; **Psychosocial support**	Minor ailments; **Individual counselling regarding SRH and provision of or referral for services as needed**	Personal & environmental hygiene; Nutrition; Tuberculosis; **Abuse (sexual, physical and emotional abuse including bullying, violence); Sexual & reproductive health; Menstruation; Contraception;** STIs incl. HIV; MMC & Traditional; Teenage pregnancy, CTOP, PMTCT; **HCT & stigma mitigation; Drug and substance abuse; Suicide**
Grade 10 – 12 (Further Education and Training)	Oral health; Vision; Hearing; Speech; Nutritional assessment; Physical assessment incl. anaemia; **Mental Health;** Tuberculosis; Chronic illnesses; **Psychosocial support**	Minor ailments; **Individual counselling regarding SRH needs, and provision of or referral for services as needed**	Personal & environmental hygiene; Nutrition; Tuberculosis; **Abuse (sexual, physical and emotional abuse including bullying, violence); Sexual & reproductive health; Menstruation**; Contraception; STIs incl. HIV; MMC & Traditional; **Teenage pregnancy**, CTOP, PMTCT; **HCT & stigma mitigation; Drug and substance abuse; Suicide**

The package of services recommends the provision of psychosocial support from Grade R to Grade 12. However, it does not define what psychosocial support is. Services that are tabulated include

mental health and counselling which are key services that the Department of Social Development can provide.

1.7 THEORETICAL FRAMEWORK

The study was guided by two (2) theories that enable a comprehensive view of the role of social development. Bronfenbrenner's Ecological Systems theory focused on the quality and context of the child's surroundings (Härkönen, 2007). Both theories strengthen one another because of the emphasis on the importance of behavioral, environmental and individual factors in the learning process.

1.7.1 Bronfenbrenner's Ecological Systems theory

Learners live in different environments, thus have different needs. Interventions that are rendered by the Department of Social Development differ from school to school, therefore it was critical to look at the role of the DSD with the same perspective. This theory is aligned to the research design as it also provides a comprehensive view of the complex role of the Department of Social Development. Key to the study this theory (Ebue *et al.,* 2019) states that amongst a number of intervention approaches used by social workers to mediate clinical and social challenges, interventions occur in the micro, mezzo and macro levels; these are structures of the ecological systems theory. The study examined these systems as the role of social development was investigated at all levels and within and across directorates and departments.

1.7.2 Bandura's Social Cognitive Learning theory

Some of the participants were not from the Department of Social Development but from the Department of Health or the Department of Education, thus they responded to questions based on their observations learnt when working closely to the Department of Social Development. This was supported by the use of this theory as it posits that an individual's learning does not merely occur through one's experience, however through the observation process (Harinie, Sudiro, Rahayu and Fatchan, 2017).

1.8 EMPIRICAL LITERATURE REVIEW

By managing relationships between people and changing social behavior, social workers are often responsible for improving the social needs of learners in an effort to improve their well-being

(Reyneke, 2018). A study from Kenya alluded that in a world where young people are living with HIV and AIDS, policies should focus on providing a safe environment through the support of both physical and psychosocial well-being of learners (Limo, Jelimo & Kipkoech, 2016). Social workers holistically address all the domains of psychosocial support namely emotional, social and behavioral challenges posed and experienced by learners.

The Department of Social Development offer parenting support programmes which aim to create an environment with effective care and protection (Social Development, 2019). Ndlovu (2019) and Reyneke (2018) agree that family is a form of psychosocial support, thus it is important to include parents when assisting a learner with social barriers. Schools ought to promote care and support for teaching and learning hence social workers capacitate teachers on how to identify learners that have social challenges and refer them to the Department of Social Development (Reyneke, 2018). Effective school health services reduce mortality and morbidity through the facilitation of early identification, diagnosis and consequently intervention (Kuponiyi, Amoran and Kuponiyi, 2016). In the Eastern Cape, there are school-based social workers placed in specialschools, thus social workers screen and assess new enrolments in liaison with other social workers, nurses and professionals that are not amongst them (Reyneke, 2018).

1.9 LIMITATIONS OF THE STUDY

The study was conducted in the Eastern Cape and due to Covid-19, virtual and telephonic interviews were conducted through Microsoft Teams and telephonically, however where, permissible interviews were conducted facially. The time factor was a major challenge as it made it difficult for members to participate due to competing priorities and different schedules. It was very difficult to reach the Senior management of the Departments, consequently some could not even participate. However, the selected sample from all departments provided the required knowledge. The sample was represented by personnel at different levels due the formation of the different Departments and the availability of the targeted participants. Some of the participants could not give specific policy related answers but were able to articulate the role of the Department of Social Development as some were indirectly contributing to the ISHP.

1.10 ORGANISATION OF THE STUDY

Table 2: Organisation of the study

The study is organized into five (5) chapters which are outlined below:

CHAPTER	FOCUS
Chapter One	**Introduction and Background**: This chapter provides a brief introduction and background of the study, the problem statement, objectives of the dissertation, research questions and significance of this study.
Chapter Two	**Literature Review**: This chapter describes critical concept of this dissertation including the theoretical framework, empirical review of literature which provides ground to see the "intellectual traditions" that support the exploration of the role of social development within the Integrated School Health Programme and the supporting legislative framework.
Chapter Three	**Research Design and Methodology:** The research methodology and design which guided the process that was followed to achieve the research objectives, data presentation and data collection is outlined in this chapter.
Chapter Four	**Findings and interpretation:** This chapter focused on data analysis and interpretation.
Chapter Five	**Summary, Conclusion and Recommendations:** This chapter focused on discussions from findings and recommendations.

1.11 CONCLUSION

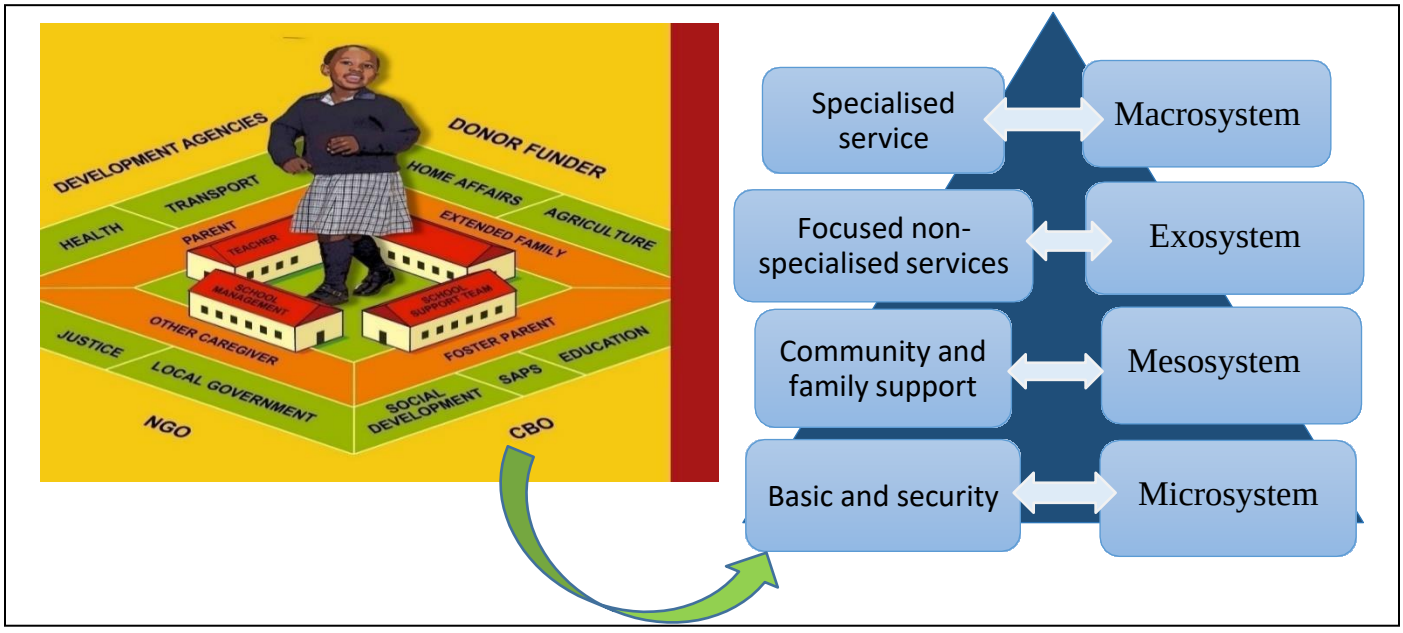
This chapter introduced and provided a background to the study. Furthermore, it summarized the objectives of the research, the problem statement and the importance of the study. The services that should be provided through ISHP were highlighted to strengthen the background of the study; the significance of the study was discussed as well as well as the empirical work that has been conducted regarding the role of social work. The following chapter focuses on the literature that supports the research aim and objectives. It tackles the conceptual framework, the theory that form basis of the study and guides the research design that follows and also discuss the supporting legislative framework.

CHAPTER TWO: LITERATURE REVIEW

2.1 INTRODUCTION

The relationship between psychosocial support and health was examined to understand the role of DSD in the Integrated School Health Programme. Thus, considering the different facets of health and the context in which the programme is implemented, the study questioned how psycho-social support services can be delivered. Social development or social work practice is not rendered in isolation but with several other interventions to enable the provision of multi-sectoral services which are learner centered. DBE has a number of frameworks that enable the provision of a comprehensive support to the needs of learners and the framework as presented below brings everyone including all stakeholders together. The diagrams below postulate provisions of a learner centered approach where the needs of learners are holistically addressed in accordance to the Conceptual Framework of the Care and Support for Teaching and Learning (CSTL) framework. This framework requires the consideration of the ecological systems theory including the levels of psychosocial support where basic and security needs are provided at micro and community level while family support is at meso-level. The components of the picture below are discussed further in the conceptual framework and the theoretical framework.

Figure 1: The Conceptual Framework of the Care and Support for Teaching and Learning (CSTL) Programme and psychosocial support in an ecological system



2.2 CONCEPTUAL FRAMEWORK

In this chapter, important concepts that are key in the role of social development have been considered and a distinction between the topics is outlined. Furthermore, it became crucial to understand the relationship between health and psychosocial support considering that both are interrelated terms that cover a similar scope of practice or what is referred to as "domains" in the case of psychosocial support. The programme is implemented by departments that have various programmes which support and care for learners; these programmes are School Health Programmes and School Mental Health Programmes. The researcher questioned whether there is a difference between the two. Looking at these concepts stated below, the role of social services within the health context was captured including the importance of multi-disciplinary teams.

2.2.1 Understanding Health and Psychosocial support

Health and psychosocial support overlap because health is described as entirely psychosocial. It is a state of physical, social and mental wellbeing (Flatscher and Liem, 2017). The traditional views of health define health as a state where one has no disease whilst the ecological perspective sees it as a concept that is more relative. Furthermore, puts greater emphasis on the interrelationship between the way one's life is in terms of quality and the environment, therefore it is based on how one functions and adapts to the environment. Svalastog, Donev, Kristoffersen and Gajović (2017) states that, modern concepts of health recognize health as the maximum or rather ultimate capacity of one to reach self-realization and self-fulfillment. The definition of health whereby one's ability to function in the environment provides a basis for the theoretical foundation that this study is embedded on. Provision of psychosocial support is inevitable if one takes into consideration the definition of health by WHO as discussed by Flatscher and Liem (2017), defining it as a state of complete physical, mental and social wellbeing.

The DBE (2010) consider psychosocial support as the delivery of care and support in addressing the emotional, mental and social needs of learners and educators. It further highlights how these can manifest in absenteeism, dropout and failure to perform in school amongst other signs such as depression and behavioural difficulties. Poverty and losing a parent through illness, death or absence, results in the need for child psychosocial support. The purpose of psychosocial support

is to ensure that the social, emotional and psychological wellbeing of individuals, their families and communities are taken care of (Phillips, 2015). Social work practice aims to treat and prevent psychosocial dysfunction therefore social workers remain integral in addressing social determinants of health (Ebue, Uche and Agha 2019; Saxe, Msw and Msw 2019). There is a well-known link between physical and behavioral health, thus the need to address all components of an individuals' well-being for a holistic improvement of health (Saxe et al., 2019). To understand health requires the consideration of biomedical and psychological perspectives, hence the policy does not only focus on physical health but psychosocial wellbeing and the need for a multisectoral approach (Stahl, 2012). Evidently, social workers have effectively addressed issues of stigma and access to health services, especially mental health (Saxe et al., 2019). The psychosocial support programmes from the Department of Social Development are targeting school going learners however services these learners through successful referral (Phillips, 2015). The Integrated School Health Programme currently suffers the same disadvantage that was endured by early school health programmes which focused on the prevention of disease and health problems, however due to challenges faced by learners, the focus shifted to all issues pertaining to the health of the public; for example mental health, sexual health, drug and alcohol misuse, Human Immuno-deficiency Virus (HIV) and Acquire Immuno-Deficiency Syndrome (Stewart-Brown, 2006).

2.2.2 Mental Health and School Health Programmes

Inee (2016) argues that mental health and psychosocial support are closely related, however mental health is a term often used by nurses whilst psychosocial support is used by those outside health. The minute one speaks of mental illness, immediately there seems to be a shift to Inclusive Education without realizing that mental health programmes focus on social, emotional and problem solving skills, positive behavior and social inclusion (Fazel et al., 2014). This evidently shows that these programmes address similar psychosocial support dimensions such as the social, spiritual, emotional, physical and mental health. There are a number of unmet mental needs in schools due to insufficient resources to deal with large numbers of learners with psychosocial barriers (Lindsey, 2017). According to Fazel et al. (2014), Social workers, Counsellors, Therapists, Psychologists, Psychiatrist and Occupational Therapists belong to community of mental health experts and should be servicing the programmes.

There is a difference between mental health and education services; including the criteria used for identifying learners that need access to services and how the outcomes are seen (Fazel et al., 2014). The role of the Department of Education is to ensure that educators prioritize curriculums, provide a structured environment where early identification of mental health issues, its prevention, support and early intervention can be facilitated in a timely manner (Kern et al., 2017; Punukollu, Burns and Marques, 2020). Community-partnered mental health services and services that are from outside the school augment existing school health services such as those provided by nurses, Learner Support Agents (LSA) and Social Behaviour Change Agents. Some schools require their partners to offer on-site individual, family and group treatment for identified learners who might be suffering from anxiety, depression, disruptive behaviour disorders and traumatic stress (Fazel et al., 2014).

2.2.3 Social Services within the health context

The ISHP is often seen as a responsibility of the DoH focusing on the physical aspects of health (biomedical) even though researchers such as Parast and Allaii (2014) support that social workers play a critical role in healthcare, especially where patient and family interaction is concerned, including other social problems. The role of social workers in healthcare enabled the role of social development to be understood through the health context. Social Workers are aware of the psychosocial risk factors that experienced by learners, thus are in a position to help learners and their families to navigate through the complex health system especially those learners that are from child headed households or raised by grandparents (Saxe et al., 2019).

Parast and Allaii (2014) highlights standards of Social Workers as expressed in National Association of Social Work in Healthcare as:

1. Ethics and Values
2. Health inequalities
3. Cultural Competence
4. Privacy professionals
5. Knowledge
6. Assessment
7. Intervention and Treatment
8. Leadership in social work

9. File Management
10. Crisis Intervention
11. Empowerment

The Buffalo City Metropolitan Municipality has a significantly smaller percentage 24.9% of children between the ages of 0 to 14 years compared to South Africa (28.8%) (Buffalo City Metropolitan Municipality, 2020). In terms of pregnancy, delivery between 10-19 years in facility rate was 10% and the termination of pregnancy under 20 years rate was 11,3% (Buffalo City Metropolitan Municipality, 2020). Buffalo City Metropolitan Municipality (2020) highlights that, "Trauma and injuries are the leading causes of mortality in the ages 15-24 (74%) among males, while HIV/AIDS and TB are still the leading causes of death for the ages 25-49 years, 40% males and 52 % among females of the same group. Furthermore, the gains on TB are being reversed by the unrelenting social determinants".

The Children and Families Directorate is responsible for rendering psychosocial support. Progress and improvement in school is one of the themes commonly used to measure psychosocial wellbeing (Phillips, 2015). Phillips (2015) highlighted proxy measures which align with ISHP as follows:

- School progress or improvement
- HIV medication adherence
- The child engages in cooperative and kind behaviours considerate of other's feelings Emotional symptoms seems happy
- The child interacts with family and peers
- Peer relationships interaction with other children as opposed to preference for being

According to Moronkola (2010), "A comprehensive school health program is an integrated set of planned, sequential, school-affiliated strategies, activities and services designed to promote the optimal physical, emotional, social and educational development of students. The program involves and is supportive of families and is determined by the local community, based on community needs, resources, standards and requirements. It is coordinated by multidisciplinary teams and is accountable to the community for program quality and effectiveness". Support staff such as psychologists and Social Workers mainly work with students with academic difficulties and might not have training on dealing with some challenges faced by learners such as rape

victims, family reunification services and other complex challenges (Fazel et al., 2014; Lindsey, 2017).

Social Workers are expected to render school-based mental health services and this can also be done with counsellors than psychologists and psychiatrists (Fazel et al., 2014). Social Workers help people regardless of age or social status to improve their social functioning and coping skills, in turn making individuals more resilient (Chukwu et al., 2019). Ebue, Uche and Agha (2019) further described Clinical Social Work Practice as a strategy to improve and maintain how individuals, their families and other small groups function psychosocially. The provision of psychosocial support is one of the key roles that the policy of ISHP seeks to deliver. Teater (2014) states that social workers intervene at the points where people interact with their environment.

2.2.4 **Multi-disciplinary Teams**

School health services are complex, as they are offered across a wide spectrum of age groups, they encompass many different kinds of interventions, and require inter-sectoral collaboration (Shung-king, Orgill, and Slemming, 2013). There is a need for a comprehensive and multisectoral approach to respond holistically to the physical, social and psychological needs of learners, teachers and the community and Keothaile (2016: 25) suggests that successful implementation of the ISHP programme lies in the active involvement of school, family and the community (Dibakwane and Peu, 2018). OECD (2020) refers to a holistic approach to education as one in which learning, social and emotional needs of learners are considered to an extent that all sectors of government partner together with other non-governmental agencies to provide support services which respond to complex needs of vulnerable learners. Rasesemola *et al.*, (2019) recommended that, inter-sectoral and multi-sectoral engagements be strengthened to execute ISHP effectively. There is a need for clear roles of those involved as well as a clear participation. The adoption of the CSTL Framework provides for a multi-sectoral response that must be coordinated through theDBE and target the well-being of learners (Shung-king et al., 2013).

Salunke & Lal (2017) defined the multi-sectoral approach or coordination as intended collaboration amongst several stakeholders and sectors to supportively attain a policy outcome. The European Commission (2017) refers to multi-sectoral approaches as "…the collaboration between organisations in different areas of policy (health, social, environment) and different sectors (public, private, third), as well as communities and people working together to achieve

policy outcomes. This includes partnering with organizations at grass-root level by recognizing the importance of informal education and its providers which often takes place after school or when schools are closed (OECD, 2020). Typically, multi-sectoral approaches involve holistic inter-organisational and inter-agency efforts across key and relevant sectors, to address common and specific goals". In other words, a multi-sectoral approach is the mobilization of all available resources toward holistically achieving certain goals in an integrated manner. This multi-sectoral approach is widely recommended and proposed by ISHP and CSTL as discussed in the legislative framework.

2.3 EMPIRICAL LITERATURE REVIEW

Most studies that have been conducted on the ISHP focus on the role of the DoH and DoE. This section presents an evolution between school health programmes across the world, more specifically in the United States, Sweden, Australia, Nigeria, Kenya and South Africa. Some countries prioritize the importance of social services and psychosocial support, as well as the need to offer health education through school curriculums. Schools are often emphasized as central in the provision of care thus, provision of resources within the school rather than referring outside the school premises. The benefits of early identification and barriers in the implementation which might be resulting from the lack of standard procedures or protocol are described.

2.3.1 School Health Programmes across the world

This section looks at school health programmes in the United States where the focus is on early identification. In Sweden, the programmes became more complex like in Australia, Nigeria, Kenya and South Africa. The Swedish approach also includes psychosocial support which is identified as an integral part of the legislative framework and as required by the Standard Operating Procedures for Sexual Reproductive Health, Right and Social Services in secondary schools. The countries are compared and similarities are noted between Sweden, Australia and South Africa. The need for early identification is emphasized in the United States, thus, is briefly discussed in this section in relation to the benefits of identifying such learners as early as possible, as well as the dangers of late detection. School based intervention, barriers in the implementation, coordination and management of the ISHP are discussed at length.

2.3.1.1 United States

Early identification and early interventions have been buzzing words in modern school health programmes and it has been emphasized that prevention is better than cure. Effective school health services, reduce mortality and morbidity through the facilitation of early identification, diagnosis and consequently intervention (Kuponiyi, Amoran and Kuponiyi, 2016). School health programmes improve the outcomes of health and education. Kolbe (2019) argues that 40% of students in the United States are living in poverty, thus, are in danger of acquiring mental, emotional and/or behavioral disorders which can be addressed through school health programmes. Using a youth-friendly approach in California, a school based center provides care that intervenes for both physical and mental health challenges experienced by learners (Menziwa, 2019).

2.3.1.2 Swedish

School Health care in Sweden started early in 1700s and has grown to a complex and rather demanding programme to suitably respond to the high demands of the society (Persson and Persson, 2016). The Swedish approach is aligned to this study because the focus is on organizations, groups and individuals, and, consists of professionals with medical, psychological, psychosocial and special education expertise (Persson and Persson, 2016). At an organizational level, the school environment is enabled for care and support whilst group level is where the staff are able to identify learners in need of assistance and individual level is where the individual child who needs care can access it (Persson and Persson, 2016)

2.3.1.3 Australia

Different health programmes which include school-based immunization, oral health, nutrition and healthy eating, mental health and well-being, bullying and physical activity programmes, medical and other support for students with disabilities are delivered through intersectoral collaboration (Tooher et al., 2017). Like in Sweden, school health services provided in Western Australia use a population-based approach to detect health issues early and health enrichment (Menziwa, 2019). Focus is more on health education sessions conducted by educators in classrooms and policies advocate for nutrition and physical activity (Keothaile, 2016).

2.3.1.4 Nigeria

In Nigeria, school health programmes involve both health and educational programmes which focus on the health needs of learners as well their future. This is accomplished through support from home, community and government (Menziwa, 2019). Health education programs are implemented to improve knowledge, inspire attitudes and boost healthy behaviors amongst learners (Chidiebere et al., 2016). Various Nigerian studies have found that disabilities and handicaps that are diagnosed very late, are irreversible thus it is recommended that screening be part of the admission process (Kuponiyi *et al.*, 2016). Despite the above, psychosocial support is often abandoned and preference given to material, economic, nutritional and other physical needs.

2.3.1.5 Kenya

A study from Kenya alluded that in a world where youngsters are living with HIV and AIDs, policies should focus on providing a safe environment by supporting both physical and psychosocial well-being of learners (Limo, Jelimo and Kipkoech, 2016). Limo et al. (2016) posits that establishing health promoting programmes is an important component in elevating a child friendly school.

2.3.1.6 South Africa

The Integrated School Health Programmes are focused more on the prevention of Human Immune Deficiency Virus - HIV and Acquired Immunodeficiency Syndrome - AIDS, Sexually Transmitted Infections - STIs and Tuberculosis - TB (Peu et al., 2015). The programme is implemented as guided by the Integrated School Health Policy of 2012 (Keothaile, 2016). According to Khoza, (2017), the goal of the ISHP is, "…to improve the general health of school-going children as well as the environmental conditions in schools and to address health barriers to learning". The programme is comprehensive and complex, thus addresses health, education and social needs, thus requires partnerships between government sectors and non-government organisations (NGOs) to be effectively implemented (Mohlabi, Van Aswegen and Mokoena, 2014; Shung-king et al., 2013).

2.3.2 **Benefits of Early Intervention**

Scott, Mihalopoulos, Erskine, Roberts and Rahman (2016) agree that neglecting learner's psychosocial support needs leads to greater psychological challenges. Furthermore, when there is no proper support, learners' resort to antisocial behaviours that may lead to school dropouts,

consequently these learners may become a threat to the social fabric and may need economic support by the government in the long-term (Scott, Mihalopoulos, Erskine, Roberts and Rahman, 2016). Furthermore, Khoza (2017) argues that the psychological, emotional and physical changes that adolescents experience, influences their behaviour and decisions in regard to sexual activity. The study did not mention the DSD except that ISHP implementation can be improved through the involvement of community-based organisations and other political structures including NGOs. As illustrated in the background, recent research on the compliance of schools to the ISHP found a wide spread of non-compliance and insufficient integration of stakeholders (Rasesemola et al., 2019).

2.3.3 School-based intervention

Covid-19 has reminded the nation of the link between physical, emotional and academic success; and that the core business of schools is to support the wellbeing of learners by improving their academic performance through curriculums (OECD, 2020). Studies such as Mwoma and Pillay, (2015) support the response methods proposed by the policies, learner's needs must be addressed through life skills in the classroom using the curriculum approach and services be provided in school. Mwoma & Pillay (2015) state that behavioral and emotional problems leading to bullying, aggression and low self-esteem do not only disturb learners, but teachers as well. School personnel often request the government to hire professional counsellors, psychologists, and social workers to support Orphans and Vulnerable Children (OVC). Schools are facing challenges caused by emotional and physical trauma and teachers are struggling to provide teaching and learning because of these severe traumas and anxiety (Wood and Goba, 2011).

A survey assessing school readiness administered by the DBE, found that 50% of the School Management Team (SMT) members believe that psychosocial support is needed by both learners and educators (Namome, Winnaar and Arends, 2021). One of the strategies that Mwabo and Pillay (2020) suggested is the training of all teachers in life orientation and basic counselling skills so that educators can identify and refer OVCs to the right services. Taken into consideration, the life skills subject was introduced to address the psychosocial pressures and the impact of HIV and AIDS that young people are faced with through the provision of health education (Keothaile, 2016). On the other hand, Mwoma and Pillay (2015) emphasized the importance of parental support. Hence, increasing positive parent-child interactions by capacitating parents on how to

communicate with their children in an emotional way; using time out to discipline; and most importantly support them in responding to their children's behaviors to improve emotional and behavioral outcomes thus reduce both internalizing and externalizing problems. However, Keothaile (2016) found that parents are not giving consent for children to receive these services and that absenteeism hindered SRH service delivery. According to Stewart-Brown (2006) school-based programmes that promote mental health using the health promoting schools approach, are the most effective. Furthermore, focusing on the well-being of learners goes beyond socio-emotional needs but considers other services that can be provided to learners who are most vulnerable and these include those who might have suffered physical and/or psychological abuse, who are in poverty thus might not have eaten and those experiencing grief from any form of loss (OECD, 2020).

2.3.4 Barriers in the implementation of ISHP

The focus of the integrated school services has been in the psychical health and nutrition more than psychosocial support. Keothaile (2016) states that the programme is implemented differentlyin every school because it lacks standard protocol. Keothaile (2016) on the other hand, conducteda qualitative study on the implementation and outcomes of the school health programmes in Ditsobotla and found that, stakeholders are not adequately involved in the planning of school health programme activities, Sexual Reproductive Health education was rendered by life skills educators who are not trained on the subject whilst Sexual Reproductive Health services were provided by personnel from Non-Governmental Organisations (NGOs) rather than nurses from the Department of Health.

Keothaile (2016) highlighted the importance of proper skills for the delivery of the programme however those skills and knowledge are lacking. Khoza (2017) also found it very disappointing that learners reported that there are no nurses that visit the school. However, in some schools there are unpredictable visits from nurses even though nurses are key drivers of the school health programme.

In addition, Lenkokile (2016) found that both school managers and primary healthcare facility managers are knowledgeable about what role they are supposed to play in ISPH however there is poor communication, lack of collaboration, consultation and resources (Lenkokile, 2016). Transporting learners to where they are referred to for services, remains a challenge including the

entire referral system. The relative paucity of appropriate referral services in the public sector remains an obstacle to the full roll-out of the ISHP (Shung-king et al., 2013). These challenges also result from competing demands as education focuses on teaching and learning, nurses prioritize health services provided in their facilities while social development prioritizes services rendered in the community (Keothaile, 2016). There is a lack of understanding of policies and clear roles of those that should be providing these services (Keothaile, 2016). There is no money that is allocated for school health services in all levels of government (Shung-king et al., 2013).

2.3.5 Management and Coordination of the ISHP

The challenges of the implementation of the programme began in the management and coordination of this programme. Firstly, the policy is signed by the Department of Health and Education but not of Social Development. Secondly, in terms of the relationship between the sectors, the DSD is less involved (Shung-king et al., 2013). Shung-king et al. (2013) emphasizes the importance of involving DSD as an important third partner because of its crucial role in supporting children who experience psychosocial problems. In Nigeria, school health services are provided by teachers, health workers, counsellors and school administrators in conjunction with the families that these learners come from and the communities. Consequently, social and health services are provided to the school community (Olatunya et al., 2015)

Shung-king et al. (2013) highlights that, efforts to establish structures that will support the management and coordination of ISHP have been made at all levels but these structures are not yet fully functional. There is a growing relationship between two sectors, the Department of Healthand of Education that have been noted (Shung-king et al., 2013). This study further notes the importance of the role of Social Development, a sector that has been identified as a third wheel in the policy. Furthermore, Olatunya et al. (2015) suggests that school health services in Nigeria attempt to provide preventive and curative health services, however implementation in public schools is poor because there is a lack of collaboration.

Shung-king et al. (2013) echoes that progress in the establishment of intersectoral structures has been made but there is a need for a high-level political mechanism to ensure that the programme is prioritized and well resourced. Sustainable approaches should be used to improve the implementation of ISHP. Sexual and Reproductive Health (SRH) education is rendered to supplement a programme that has been prioritized, namely the life-skills programme which is

regarded as a behavioral intervention that will be more effective when supported by more holistic youth-empowerment programmes (Scotti, Schaayi, Schneideri and Sandersi, 2017)

In support of the above, this programme should be led by leaders of all the three departments to enhance and improve accountability. This study assumes that executing the ISHP programme through CSTL will enable better integration. This integration needs to be planned carefully following proper guidelines as recommended by Shung-king et al. (2013). It is believed by health professionals, educators and social workers that the provision of sexual reproductive health services are a cost effective way of meeting the health needs of children (Olatunya et al., 2015).

2.4 LEGISLATIVE FRAMEWORKS

The legislative frameworks and policy frameworks act as a guide to interventions that have been tailor-made to support children in South Africa. Thus, this section examines how the policies have highlighted the importance of the provision of care and support for children of school going age. The Integrated School Health Policy and its supporting guidelines are the core of this study as it focuses on its implementation. However, policies that support the implementation of the Integrated School Health Programme have been highlighted.

2.4.1 Children's Rights Framework

Children's need of ongoing psychosocial support is a dire need that should be seen as a right. According to Gumede (2020), the United Nations Convention on Children's Rights obligates state parties to protect children, Article 24 (1); and ensures that children enjoy the highest possible standard of healthcare without discrimination (Article 2). Article 3, highlights that all actions for, protection and care of a child are according to the best interest of the child, and emphasizes how that is necessary for the well-being of the child whilst Article 19 focuses on the protection of children against all forms of physical and mental violence; and Article 37, protects children against torture, cruel, inhumane and degrading treatment or punishment whilst Article 39 states that appropriate measures which promote physical, psychological and social reintegration of the victim of neglect, exploitation or abuse will be taken care of in an environment that fosters the health, self-respect and dignity of the child.

The African Charter on the Rights and Welfare of Children (1990) also highlights the right to enjoy the best attainable state of physical, mental and spiritual health, in other words, advocates for the provision of psychosocial support or rather support that health is not just a state of disease in the

body. Hence, the participation of social development in the Integrated School Health Programme needs to be provided in a holistic manner.

2.4.2 Constitution of South Africa 108 of 1996

The Constitution of South Africa 108 of 1996 affords all South Africans certain "fundamental socio-economic rights such as the right to access health care, housing, sufficient food and water" and furthermore, outlines the rights to basic nutrition, shelter, basic health care services and social services as well as the right to protection from abuse and neglect (Gumede, 2020). Chapter 10 of the Constitution of South Africa 108 of 1996 emphasizes that the needs of the people not only be responded to but also services be delivered fairly, in an equitable manner without bias. Hence, the White Paper enforces schools to become inclusive centers where learners get an opportunity to learn regardless of their challenges, and emphasizes that comprehensive support be available to learners (Babedi, 2013). Section 28 of the Constitution relates more to the rights and protection of children and brings forth the best interests of the child principle as of supreme importance in everything concerning a child as a child is always dependent (Gumede, 2020). Chapter 3 of the Constitution of South Africa (1996) also emphasizes the importance of intergovernmental relations whereby the formation of a structure that facilitates these relations is stressed, and more so the spheres of government are required to coordinate their actions and adhere to procedures agreed upon with one another. This will also be the case for the Integrated School Health Policy. Therefore, the three departments are required by the constitution to provide these integrated services to enable a multi-sectoral response.

2.4.3 Children's Act No 38 of 2005 as Amended

The Children's Act aims at providing results to the rights of children as illustrated in the Constitution of South Africa 1087 of 1996 and to set principles that relate to the care and protection of children (Gumede, 2020). The Children's Act 84 of (1996) further provides a basis wherein the rights of the children stipulated in the constitution, are carried out by setting out principles relating to care and protection of children including provision of measures that protect children in matters concerning health and specifically focus on consent to medical treatment, HIV testing, pre and post HIV counselling, confidentiality of information on HIV status and access to contraceptives (Department of Social Development and USAID, 2016).

2.4.4 An overview of policies and intervention programmes supporting implementation of ISHP.

The policies that support the implementation of the Integrated School Health Programme and this study are outlined below. The overview will start with the Integrated School Health Policy which informs the execution of the Integrated School Health Programme and form part of the research questions. The National Adolescent and Youth Health Policy and Policy on Screening, Identification, Assessment and Support were discussed including the CSTL. The plans that support the implementation such as the NDP and the National Plan of Action.

2.4.5 Integrated School Health Policy

The policy recognizes how ill-health has prevented the learner from benefitting from equal rights to education. Initially the policy required a partnership between two departments, the Department of Health and the Department of Education. However, according to the DOH and DOBE (2012:17), the ideal implementation of ISHP depends on the commitment between the three departments agreeing to work collaboratively. However, the ISHP policy is silent about the role of social development especially when looking at the basic components that the Integrated School Health Programme should provide. However, for assessments targeting the foundation phase focus is on identifying learners that are at risk in terms of health, psychosocial and other problems. Furthermore, for later grades the need for mental health services and sexual reproductive health is emphasized.

The 2012 policy highlights how the referral systems do not always respond to the health needs that are identified and the importance of having a designated employee responsible for school health services (Department of Health and Department of Basic Education, 2012). The definition of health outlined above incudes social development in reference to health needs. The 2003 policy only introduces the provision of mental health assessments based on necessity, but the 2012 version made psychosocial and mental health assessments a requirement including the identification and support of learners with chronic diseases (Shung-king et al., 2013). However, the policy implementation is through the CSTL Programme which requires a comprehensive response to be discussed later in this study. It is integral to highlight that this policy emphasized that all health services should rather occur in school as opposed to screening and referral.

The DSD has been afforded the responsibility to assist learners with finances when they struggle to access services such as the provision of transport to health facilities when necessary. The ISHP Policy of 2012 regulates the three departments to coordinate the ISHP Programme. On the other hand, the Standard Operation Procedures (SOP) for Sexual Reproductive Health, Rights and Social Services (SRHR&SS) for secondary schools of 2019, provide guidance on these services must be rendered and thus require implementing partners to ensure that ongoing psychosocial support is available to all learners who need it and for as long as the learner requires it. The SOP support the DBE National Policy on HIV, STI and TB and the Integrated School Health Policy and Programme (DBE, 2019).

2.4.5.1 The National Adolescent and Youth Health (NAYH) Policy

The Department of Health (2017) highlights how broadening the scope of involvement of the community in health service provision at local level, is the only way that health can be improved. This NAYH policy looked at the factors that shaped the theoretical framework of this study such as structural, familial, systemic and social factors (Department of Health, 2017). Furthermore, the policy shows how health results from issues that occur on individual, societal, community and family levels. The key drivers of poor health outcomes emphasized by this policy include violence, economic vulnerability, social isolation including victimization and harmful gender norms (Department of Health, 2017). Therefore, health interventions or rather health promoting programmes need to focus on delivering a basket of services that respond to individual, societal, community and family challenges in schools, families and communities. The DoE must deliver curriculums that promote healthy behaviour whilst the DSD promotes mental health amongst other positive preventions of HIV-positive adolescents including evidence-based parenting/caregiver programmes with demonstrated effects on adolescent health risk and protective behaviours (Department of Health, 2017).

In support of this study the policy further states that “The DoH will support processes that are led by Social Development, South African Social Security Agency (SASSA) and the DBE, in implementing social protection interventions for 10-24-year-olds, using combined social and economic empowerment strategies” (Department of Health, 2017). This will all be done to achieve the first objective of this policy which is, “…to use innovative, youth-oriented programmes and technologies to promote the health and wellbeing of adolescents and youth”; and the second

objective, “To provide a comprehensive, integrated sexual and reproductive health, and rights services integrated with HIV, AIDS as well as TB” (Department of Health, 2017).

Preventing violence and substance abuse is the responsibility of all sectors of government and society. In order to be effective and sustainable, interventions to detect, treat and reduce violence and substance abuse must be rooted in families, schools and communities (Department of Health, 2017). The commitment and leadership of the DSD and DBE are crucial to prevent violence and substance abuse among youth and adolescents through interventions that foster an understanding and awareness of violence and substance abuse to reduce the appeal and availability of alcohol and drugs to adolescents and youth. This is achievable through the promotion of positive parenting, conflict and anger management, and gender equality (Department of Health, 2017). Schools and community based interventions that provide youth and adolescents with the skills to recognize, avoid and report violence and victimization must be provided (Department of Health, 2017).

2.4.5.2 Policy on Screening, Identification, Assessment and Support (SIAS) 2014

This SIAS policy is aligned to the Integrated School Health Policy and outlines structures from the schools to districts that are responsible for the planning and provision of support. It further guides how the school can further support and make more interventions available through the Careand Support for Teaching and Learning (CSTL) framework. This policy supports the principle thatthe learner must receive support within his or her local community, thus advocating for assistanceto be delivered to the school setting other than being referred to an alternative specialized setting (Department of Basic Education, 2014). One of the organizing principles states that, the child must be viewed within his or her context. The aim is to design support programmes that make schools inclusive centers of learning, care and support. Policy states that support is more efficient and cost-effective when it is based on inter-sectoral collaboration (Department of Basic Education, 2014).

Assessments need to be multi-dimensional or systematic in nature, thus located within a framework of barriers experienced at individual, curriculum, school, family, community and socialcontext levels hence the theoretical framework (Department of Basic Education, 2014). Through the support teams, Education collaborates with Social Services to support learners with psychosocial barriers and in situations where support goes beyond school level. The Department of Social Development’s range of services also include social grants, protective placements, victimsupport and empowerment programmes (Department of Basic Education, 2014)

2.4.5.3 Care and Support for Teaching and Learning (CSTL)

CSTL facilitates an integrated approach in responding to health and social barriers (Department of Basic Education, 2010). This framework or programme provides an opportunity for care and support providers to plan together and have similar plans and reports. This integration of activities works in the interest of learners as it avoids overlapping and duplication of services. The success of CSTL is determined by the extent to which learners are enrolled at, stay in, and successfully complete schools by providing necessary support that enables them to reach their full potential and CSTL provides a guide for addressing all these dimensions including health (Shung-king et al., 2013). One of the minimum requirements of this framework is health promotion whereby the risk and protective factors that impact the wellbeing of educators and learners should be addressed through the Integrated School Health Programmes and the HIV and AIDS Life Skills Education Programme (Department of Basic Education, 2010). Services must be delivered in a coordinated and harmonized manner through the structures that have been set for the programme at all levels. The framework stressed collaboration with the Department of Social Development in six (6) priorities namely, health promotion, safety and protection, psychosocial support, curriculum support, social welfare services and material support.

In terms of safety and protection, DSD and the South African Police Service (SAPS) are to provide an adequate response to ensure that schools are free from all forms of violence, abuse and bullying including psychological and emotional safety of learners and educators. According to the Department of Basic Education (2010), the DSD and DOH are critical to link learners with social workers, psychologists and psychiatrists when it comes to psychosocial support. The Department of Basic Education (2010 and 2017) requires schools to keep a record of learners that have been classified as vulnerable. These leaners are those that are eligible for social assistance and these records will include incidents where child abuse is suspected, including neglect. Furthermore, the actions that were taken must also be recorded even in issues of child labour so that learners can be linked to care, and the DSD can link these learners to services such as social grants, and register some to facilities that provide partial care (Department of Education, 2010 and 2017).

2.4.5.5 Millennium Development Goals (MDG) & Sustainable Development Goals (SDG)

The Millennium Development Goals were adopted in 2000 and were the perfect fit for South Africa as we strived to achieve them through the global development agenda, Sustainable Development Goals and the National Development Plan towards 2030 (Republic of South Africa, 2015). The overarching aim of the plan of action is to reduce poverty and development of the people of South Africa (Republic of South Africa, 2015). The commitment to MDGs targets the previously marginalized and ensures equality for all in terms of opportunities and outcomes, health and education domains (Republic of South Africa, 2015).

This study is aligned to the eight developmental goals specifically those addressing poverty, hunger, education, child mortality, maternal health, communicable diseases including HIV and partnership development. The school health programmes advances health, social, education and economic development through a combination of prevention programmes or services that deal with physical, mental and social well-being of learners (Department of Health and Department of Basic Education, 2012). Nevertheless, according to Republic of South Africa (2015) all social policies are viewed as pro-poor as they always aim to eradicate poverty. The Integrated School Health Policy also addresses this through the provision of nutrition, life skills and the promotion of integration and multi-sectoral services. The Sustainable Development Goals focus on broader objectives of the social, inclusive social development including economic and environmental spectrum, thus human prosperity and peace (Jong and Vijge, 2021; Kumar, Kumar, and Vivekadhish 2016). The difference between MDG and SDG is that the MDG focuses on the most disadvantaged, poorest and average citizens while SDG focuses on the most vulnerable and marginalized groups (Jong and Vijge, 2021). Unlike SDG, the MDG focused on human basic needs rather than the human rights approach. Notably, the MDG perceived poverty as something that can be addressed through economic rather than social and political reform. The ISHP focuses mainly on ten (10) SDG goals namely, no poverty, zero hunger, good health and well-being, quality education, gender equality, clean water and sanitation, reduce inequality, sustainable cities and communities, peace, justice, and strong institutions and partnership for the goals(Kumar et al., 2016).

2.4.5.6 Plans that support the implementation of the ISHP

The South African National Development Plan – 2030 strives "to implement a comprehensive approach to early life by developing and expanding existing child-survival programmes". It aims at "…collaborating with other sectors so that all sectors have policies that consider the importance health". Furthermore, encourage learners to eat healthy and exercise especially at school (Scotti, Schaayi, Schneideri and Sandersi, 2017). A National Plan of Action (NPA) was developed in support of orphans and children who were made vulnerable by AIDS and other circumstances.

The strategic goals of the NPA to children affected by HIV and AIDS are:

a) Strengthen and support the capacity of families to protect and care for OVCs.

b) Mobilise and strengthen community-based responses for the care, support and protection of OVC.

c) Ensure that legislation, policy, strategies, and programmes are in place to protect the most vulnerable children.

d) Ensure access of OVC to essential services.

e) Raise awareness and advocate for the creation of a supportive environment for OVC.

f) Strengthen mechanisms to drive and support the implementation of the NPA.

As aforementioned, the role of social development is key in the provision of psychosocial support in other words the implementation of ISHP. It is not only crucial for the effectiveness of the programme but ensuring that learner's needs are responded to and provided in a holistic manner.

2.5 THEORETICAL FRAMEWORK

In this section, the Ecological System's Theory and the Social Cognitive Theory are discussed as the theories that underpinned this study and later the utilization of these theories is justified also take into consideration how these theories are currently represented within departments such as that of Education and of Social Development. The theories are further linked to psychosocial support which forms a foundation of this study.

2.5.1 **Ecological Systems Theory**

Bronfenbrenner's Ecological Systems theory looks at how the child is developing in the environment which consists of different systems which influence the development of the child paying particular attention to the quality and context of the child's surroundings (Ettekal and Mahoney, 2017; Paquette and Ryan, 2001; Härkönen, 2007)). Ecology is teaching us about how as individuals depend on our surroundings allows us to tackle a number of environmental factors including people from various interacting relationships, roles, processes involved and actions (Härkönen, 2007).

The systems discussed in Bronfenbrenner's Ecological Systems theory are micro, mezzo, exo- and macro systems. The microsystem being closest to the child involves how the activities of the child occur, the roles, the role models and other models that might influence how the belief system of the child is formed or even molds the child's behaviour; this on the other hand is two-fold as the child can influence his or her surroundings (Härkönen 2007). The mesosytem now moves to the connection of the child to the surroundings for example parents and teachers (Härkönen, 2007; Paquette and Ryan, 2001). The exosystem on the other hand, looks at things that are indirectly affecting the child, for example the mother's employment conditions and macrosystems is the broader beliefs, culture and values of the society (Paquette and Ryan, 2001).

Derksen (2010) supports the use of this theory, that ecological view is at the center of the continuing development, understanding and the promotion of the field of care for children and youth. The ecological systems theory's assumption is that development is complex, unpredictable and consists of multiple paths and systems which an individual has to travel through life; ultimately, it is crucial for one's development to fit into the environment (Eriksson, Ghazinour, and Hammarström, 2018). This theory is key to the study as Ebue et al. (2019) states that amongst a number of intervention approaches, Social Worker use occurs in the micro, mezzo and macro levels which are systems of ecological systems theory. These intervention approaches are used to mediate in clinical and social challenges. To understand the role of the DSD, it was important to consider the psychosocial support pyramid and theory that underpins the interventions of the department. Furthermore, beneath the health outcomes lies characteristics individuals portray while interacting with the environment and this is emphasized by the Ecological models (Golden and Earp, 2012).

2.5.2 **Social Cognitive Theory**

The Social Cognitive Theory mainly focuses on improving the information learners know through health education and skills building to change their behaviour (Keothaile, 2016). Bandura's Social Cognitive Learning theory emphasizes the importance of behavioral, environmental and individual factors in the learning process. He further suggests that, the individual learning does not merely occur through one's experience, however through the observation process (Harinie et al., 2017). This means that learning can take place through observation, therefore if the family does not take treatment, the child will follow suite. In essence, this theory builds on learning by imitation. This theory underpins this study as it considers the link between the person, the environment and ones behaviour (Harinie et al., 2017).

This theory also assumes that learning occurs whether the behaviour is changed or not, however the way of thinking (referred to as cognitive strategies) and the way we respond, take place through learning by observation without necessarily being enforced. It is crucial to note that, how we expect one to respond or how we view the consequences of our behaviour ought to be in the future, is based on the now and if our expectations are not met then that influences how we perceive the matter (Nabavi 2014). Keothaile (2016) states that the social cognitive theory suggests that one's individual behavior is influenced by targeting the entire environment, therefore a conducive school environment impacts learners positively. This theory links well with the components of ISHP such as health promotion and education, as individuals are empowered regarding health through education, thus leading to behavioral change (Keothaile, 2016).

2.5.3 **Justification of the theories**

Mwoma and Pollay (2015) state that psychosocial support emphasizes the importance of the close connection between psychological aspects of our subjective experiences (involving personal thoughts, emotions and behaviour) and broader intersubjective social experiences (involving relationships, tradition, and culture) which formed the basis of this theoretical framework. Programmes targeting children of school going age often adopt a socio-ecological framework which is the same framework used by the Department of Social Development in their intervention programmes. This framework ensures execution at individual, social, community, policy and environmental levels. The ecological system was also effective in showing the context of relationships and environment in which learners interact. It was also crucial to note the alignment

of this framework to the psychosocial support intervention approach. There are various health determinants that only come to play when an individuals' health needs are holistically considered (Darlington, Violon and Jourdan, 2018).

If schools are made the inclusive centers of care and support, access to education will be improved and children will start viewing schools as a place of safety and protection. Learners enter the schooling environment affected by different environmental factors at micro, meso, exo and macro levels. Everyone interprets and responds to what happens in the environment differently using what they have learned; consequently, every learner needs different kinds of support (basic services and security, community, and family support, focused non-specialized support and specialized).

In support of the above, if the Department of Social Development brings its services closer to the schooling environment, then the demand of psychosocial support services will be enhanced. Both theories provide a great foundation for the provision of psychosocial support as stipulated in ISHP; as well as the Psychosocial Support Intervention Guidelines for Vulnerable Children and Youth which aims to harmonize the practices and provide guidance to those who deliver psychosocial support services to ensure psychosocial wellbeing of children (Department of Social Development and USAID, 2016).

2.6 CONCLUSION

The literature review shows that there is no health without psychosocial support as the two concepts overlap or somewhat have the same definition. The need for multi-sectoral services is overly emphasized. However, social workers remain integral in the provision of psychosocial support because of the core responsibility to prevent psychosocial dysfunction. To understand health, both biomedical and psychological aspects of health need to be considered hence the policy calls for an integrated approach and both the school health programmes and mental health programmes respond to similar challenges. The role of the Department of Education remains life skills provided through curriculums, furthermore provision for services to be rendered in school to enhance early identification of health issues whether mental, biomedical or physical.

On the other hand, the Social Worker should intervene where the people interact. Social Workers play a fundamental role in assisting learners and their families to navigate the complex health system and learners who are vulnerable require this support, especially those from dysfunctional

families, child headed households, raised by grandparents or have no family support at all. The success of the Integrated School Health Programme lies in the active collaboration of all role players including the family and community of the learners. Consequently, all partners of government are required to work together especially at grassroots level to ensure that the complex needs of beneficiaries are effectively responded to. This is supported by the ecological systems theory and social cognitive theory which teaches about the importance of surroundings in the continual development of a learner. Therefore, the whole environment should be targeted to change one's behaviour and psychosocial support.

To support the above, the legislative frameworks also highlight the strides that the government is taking to ensure that the learners have access to support. The package of psychosocial support services outlined in the Standard Operating Procedure (SOPs) for the provision of SRHR&SS in secondary schools (Department of Basic Education, Read to Lead, and 2030 NDP, 2019) offers protection of children exposed to violence and abuse to a point where the child can be removed from home to protective care. In addition, proposes the implementation of behaviour or change programmes meaning it also acknowledged the link between environment, behaviour and individual.

Therefore, maintaining the well-being of a learner holistically is as important as access to school and health. Holistic measures that effectively respond to the needs of the learners must be based on a whole-school and whole-community approach therefore there is a need for strong partnerships and collaboration between schools and communities which foster ongoing communication between educational staff and families to ensure that the most vulnerable learners are assisted (OECD 2020). Fin Church Aid states that "…Quality education and psychosocial support create conditions for improved learning for children and youth affected by crisis". In my view one of the roles of the DSD is to prepare the environment for a child whether through family reunification or preservation, therefore this theory emphasizes how the child interprets the events that occur in his or her environment and his or her ability or competency to respond to it (Dubow, Huesmann, and Boxer, 2008).

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter provides the research methodology that was employed when the study was conducted. An exploratory research design was employed, thus provided a comprehensive description of the role of DSD (Khan, 2014). Furthermore, the phenomenology approach was used to inform the vision, explain the position, expand the view of the world and to study the experiences of participants in-depth (Qutoshi, 2018). The constructivist paradigm based on the belief that people construct their own reality, suitably aligned with the theoretical framework and the research questions. The role of the DSD is rather complex considering the nature of psychosocial support, therefore a qualitative research design was deemed the most appropriate design to examine how the participants make sense of the programme and also how they interpret the policy requirements (Ijeoma, 2014).

The aim of the study was to explore the role of social development within the Integrated School Health Programme, therefore the three departments; Department of Health, Education and of Social Development; were deliberately selected to understand the perspective of managers from each department as per the policy and programme implementation. The study made use of a non-probability sampling technique to obtain a comprehensive description and understanding of the phenomenon rather than the quantity of understanding (Burger and Silima, 2006). A sample of fifteen (15) participants from the three departments, took part in the study.

In-depth interviews were conducted, they were lengthy in the beginning but were conducted within approximately 60 minutes, thus providing an opportunity for the researcher to gather in-depth information that fully represents the experiences and viewpoints of the participants (Turner, 2010). Covid-19 regulations were adopted thus face to face interviews were prevented through the use of a Microsoft Teams (MS) Virtual Meeting as well as Telephonic interviews as interview platforms, however where permissible, face-to-face interaction was used. Informed consent was sought before the respondent's participation. Ethical clearance was received from the University Research Ethics Committee (UREC), MAR031SMAQ01 and permission to conduct research was requested from the three departments prior data collection. Before signing informed consent forms, participants were informed of the objectives of the study as well as ethical considerations to ensure that their consent is informed.

3.2 RESEARCH DESIGN

According to Menziwa (2019), a research design is chosen based on the research questions and the objectives that the study aims to achieve. The exploratory design was employed thus provided a comprehensive description of the role of DSD (Khan, 2014). Furthermore, the phenomenology approach was used to inform the vision, explain the position, expand the worldview and study experiences of the participants more in-depth (Qutoshi, 2018). This approach has an element of interpreting meaningful social structures and policies looking at the participants perceptions, thus research questions were also drawn in such a manner (Qutoshi, 2018). The research questions and objectives moved from the policy mandate, implementation then recommendation, therefore the qualitative and inductive methods used in phenomenology approach further assisted in gathering the in-depth information and perceptions of the role players (Vos et al., 2011). The research design permitted the exploration through asking why the policy was developed, what is happening on the ground and how it should happen which enabled capturing of the beliefs, attitudes, and processes by which actions were created from the participants' worldview (Menziwa, 2019).

3.3 RESEARCH PARADIGM

The constructivist research paradigm was applied in this study. It aligned to the research question which carries the assumption that "…people construct their own understanding of the world based on how they experienced incidents and reflect on those experiences". Constructivism is also in line with the theoretical framework of this study (Adom and Ankrah, 2016; Mogashoa, 2014). According to Mogashoa (2014) "constructing meaning is learning, there is no other kind of learning other than constructing meaning". The theoretical framework similar to the chosen paradigm, postulates that people learn through their experiences, what they believe, their ideas, events and activities they participated in (Adom and Ankrah, 2016; Mogashoa, 2014).

3.4 RESEARCH METHODOLOGY

Research methodology is often treated as a research design and furthermore provides a map that a researcher should follow when conducting the study (Khoza, 2017). The research methods can also be determined by the approach that data collection and analysis is embedded on (Khoza, 2017). It is important to note that the complexity of the role of DSD and the nature of psychosocial support, made the qualitative research methods appropriate for showing how participants make

sense of the programme and how they interpreted the policy requirements (Ijeoma, 2014). In recent years, a descriptive and observational study was conducted by Olatunya et al. (2015) to assess school health services whilst a cross-sectional survey was conducted by two other researchers (Almalki et al. 2018; Kuponiyi et al. 2016). A qualitative method was used to assess both implementation and barriers in the implementation of ISHP by Dibakwane and Peu (2018); Keothaile (2016); Lenkokile (2016). Therefore, the qualitative approach was selected to describe and provide further understanding about this phenomenon (Ijeoma 2014; Vos et al. 2011).

3.5 TARGET POPULATION

The study targeted the provincial offices of health, education and social development to understand the perspective of managers from each department as per the policy. Participants were selected according to their relevance to the ISHP programme rather than their representativeness (Neuman, 2006). The Directorate School Health and Social Planning is the key directorate in the delivery of ISHP within the Eastern Cape Department of Education and it shares this responsibility with the Nutrition Directorate. The Directorate further established the ISHP Task Team and a task team at district level which include DoH and DSD. There are three (3) Chief Directorates within DSD consequently nine (9) directorates tabulated below that contributed in enhancing understanding of DSD thus ensure a comprehensive dissertation.

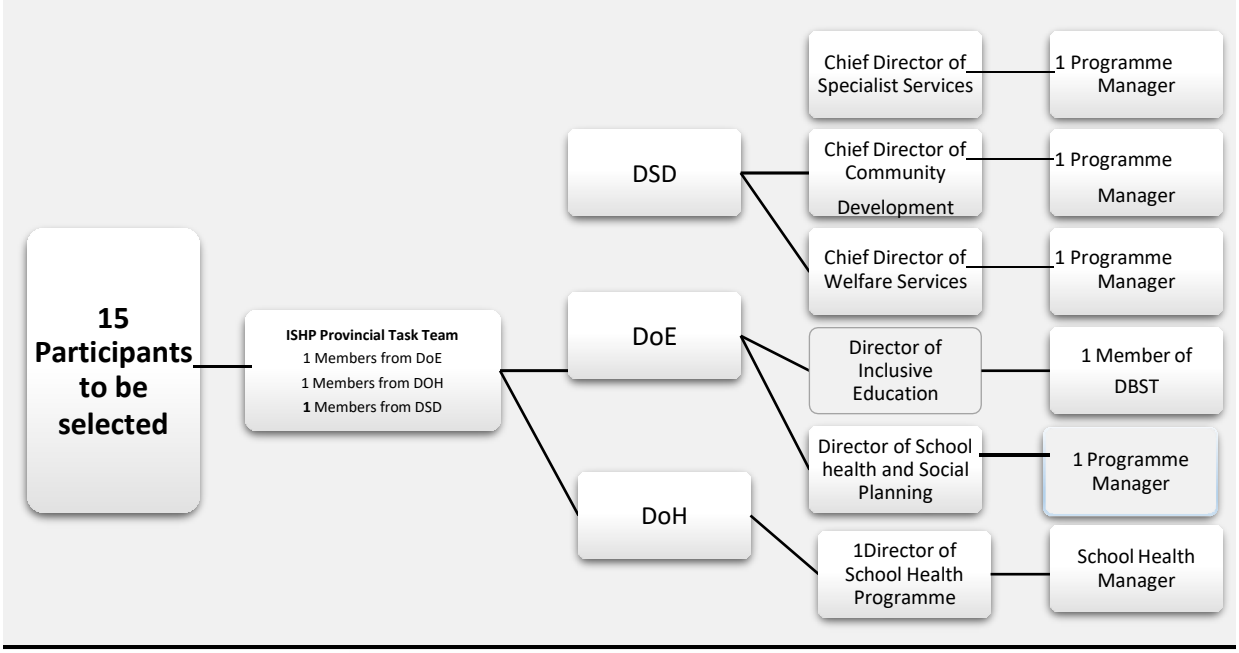
Figure 2: The department of social development's key directorates to the study

Chief Directorate of Specialist Social Service	Chief Directorate of Social Welfare Services	Chief Directorate of Community Development
•Directorate HIV & AIDS •Directorate of Victim Empowerment •Directorate of Crime Prevention and Substance Abuse (Restorative services)	•Directorate of Children and Early Childhood Development •Directorate of Integrated Services to family •Directorate of Child care and support (Foster care, adoption, etc.)	•Directorate of Youth development •Directorate of Sustainable livelihoods and community development •Directorate of Women Development

3.6 SAMPLING TECHNIQUES

The study made use of the non-probability sampling technique to obtain a comprehensive description and understanding of the phenomenon rather than quantity of understanding (Burger and Silima, 2006). The sample design was purposive sampling to enable selection of participants based on participation in the Integrated School Health Programme and/ or provision of psychosocial support. The fact that other participants were also a member of the ISHP Task Teams was an added advantage as these individuals possessed sufficient knowledge to answer the research questions (Chun Tie et al., 2019). DSD had more participants interviewed because the study was based on the role of DSD. The ISHP Task Team was purposely selected by the researcher because it is the structure that brings all departments together. The Provincial ISHP Task Team is a structure where the three departments (DOH, DSD and DoE) meet to ensure effective coordination of the ISHP Programme. Therefore, this structure represents one of the key elements needed to execute ISHP according to the policy. The members of this structure were approached telephonically and requested to participate in the study. Furthermore, the participants were requested to nominate participants that were to provide further understanding to the phenomena. Most of the participants were even alluded to or rather made examples of when the participants were responding to the research questions therefore referral was very easy. It was difficult to get Chief Directors and Directors as some of them were no longer within the directorates but the chief directorates were well represented. thus. A purposive sampling diagram is also depicted below, showing how the sample of 15 participants was selected.

Figure 3: The purposive sample diagram of with 15 participants



However, as aforementioned, all the directors were replaced by junior officials that were within the targeted directorate. Some of the participants were programme managers and also part of the Integrated School Health Programme Provincial or District Task Team. To ensure a true reflection of Buffalo City Municipality, officials from District level who are programme managers were approached in situations where a programme manager from the province was unavailable.

Officials that never participated in the ISHP Programme or any discussion pertaining to ISHP were excluded in the research because the research required knowledge of the ISHP policy, understanding of the background and implementation which informed the recommendation of the study as per the research objectives. A prospective participant that was referenced during the interview and/or recommended base on his or her knowledge and understanding of the ISHP was included in the study.

3.7 DATA COLLECTION METHODS

Interviews provided an opportunity to gather in-depth information that represents the experiences and viewpoints of the participants regarding the role of the Department of Social Development (Turner, 2010). Face to face interviews were the ideal method to explore how DSD is currently participating in the roll-out of ISHP programme consequently provided an opportunity for theoretical interpretation from data analysis to develop (Kolb, 2012). However, due to Covid-19

regulations, a Microsoft Teams (MS) Virtual Meeting and telephonic interviews were used as a platform to interview the participants but where permissible, face-to-face interaction was used. The, interviews were lengthy in the beginning and data collected from interviews became more specific and focused, as a result, data was collected until saturation was reached (Chong and Yeo, 2017; Kolb, 2012).

The meetings were scheduled based on the availability of the participants. The interview procedure followed stages from introduction and entry, asking and recording information and probing (Vos et al. 2011). Documents were reviewed for further understanding of the role of DSD and were evaluated for authenticity, credibility, representativeness and meaning of the document by checking whether there is an author or authorizing body ascribed to it (Vos et al., 2011). The credibility of the document used as evidence, depended on the accuracy of its reference and representation of the phenomena (Vos et al., 2011). The disadvantages of document review included bias of selective survival of information, locating and accessing suitable documents or finding outdated documents (Creswell, 2014; Ijeoma, 2014; Vos et al., 2011). The collected data from this process was backed-up to guarantee credibility.

3.8 **DATA ANALYSIS**

According to Vos et al. (2011), data analysis is an unstructured process that does not consist of a technical procedure to make judgement from information that is empirical about social life. However, it is a non-ending process using open-ended information and develop a concept from informal to formal (Vos et al., 2011). The study employed thematic analysis because it is a more flexible tool for exploratory research and suitable for analyzing understanding and perceptions (Herzog, Handke, and Hitters, 2019). Furthermore, thematic analysis is a reputable method of organising data of this nature and enabled capturing of knowledge and experienced of the participants (Salleh et al. 2017). Thematic analysis helped in understanding of the current practice and what influences it practically (Alhojailan and Ibrahim 2012). The analysis occurred in six phases namely, familiarizing with data, generating initial codes, searching for themes, reviewing themes, defining and naming themes and finally produced the report (Herzog et al., 2019).

3.9 DATA ENTRY

The data from interviews was recorded by handwritten notes and recorded using the recording option from MS Teams (Creswell, 2014) and cellphone recording. Data was then transcribed from handwritten notes to a Microsoft Word Document and to protect the identity of the participants the document was named by date of the interview (DD/MM/YEAR), participant number and initials for example 01082101BAN. Data entry into the Word document started on the 11th of August 2021. The interviews were semi-structured to obtain a comprehensive representation of the participant's insight regarding the role of DSD, communication skills such as probing and active listening (clarifying and paraphrasing) were used to get more information and to capture the information correctly (De Vos et al., 2011). The study tried to understand the role of DSD in the implementation of the ISHP, taking guidance from the objectives of the School Health Programs (Vos et al. 2011).

3.10 TRUSTWORTHINESS

Trustworthiness of data was achieved by using more than one data collection method, thus increasing the credibility of the study (Keothaile, 2016; Moon et al., 2016). Trustworthiness was further ensured through the use of various data collection techniques. Face to face interviews enabled the observation of participant's body language and reactions to questions, and also credible sources in literature, moreover, the research supervisor was afforded an opportunity to provide feedback on the formulated interview questions. (Lenkokile, 2016). The use of purposive sampling enabled selection of participants from the ISHP Provincial Task Team, Chief Directors and Directors providing an in-depth description of the role, thus made transferability possible (Lenkokile, 2016) and also the participants were given an opportunity to review their responses to ensure accuracy thus confirmability (Shenton, 2004). The interviews were semi-structured thus the responses of the participants were recorded in the interview guide and shared with the participants to ensure the accuracy of the recorded responses.

3.11 DELIMITATION OF THE STUDY

The time factor was a major challenge as it made it difficult for members to participate due to competing priorities and different schedules. It was very difficult to reach the Senior management of the Departments, consequently some could not even participate. However, the selected sample from all departments provided the required knowledge. The sample was represented by personnel at different levels due the formation of the different Departments and the availability of the targeted

participants. Some of the participants could not give specific policy related answers but were able to articulate the role of the Department of Social Development as some were indirectly contributing to the ISHP. The major limitation of this study was its time frame, cost and access to the required resources including permission from the three departments to conduct research (Neuman, 2006).

3.12 ETHICAL CONSIDERATIONS

The term ethics refers to principles that give guidance to the way the researcher should conduct the research within a given profession (Vos et al., 2011). To ensure that this dissertation conforms to ethical standards, the ethical clearance was applied for from the University Research Ethics Committee (UREC), MAR031SMAQ01 and permission to conduct research was requested from the three departments and a letter showing approval was received. According to Neuman (2006), a behaviour may be unethical though legal such as power, therefore the participants were guided and assured that their interests are protected (Bryman and Bell, 2014). The research was not represented as anything else other than what it is, was voluntarily and no participants were coerced (Bryman and Bell 2014; Neuman, 2006).

All participants were assured confidentiality and the researcher was the only person that knew the identity of the participants. The participants were informed about the objective of the research so that they are aware of what they are participating in, for purposes of ensuring informed consent and anonymity. The research did not project the findings or data in a way that enabled one to link the responses to any individual. After the participants were assured confidentiality, anonymity and informed about the objectives of the study, they were requested to sign a consent form before partaking in the research (Bryman and Bell, 2014). The research was guided by the Professional Code of Ethics (Vos et al., 2011) and the summary of the research was submitted to all three departments.

3.13 CONCLUSION

The study employed an exploratory research design and a qualitative research method to provide a comprehensive understanding of the phenomena. The study carried the assumption of the constructivism paradigm wherein people are seen as interpreting their reality based on their world view. Furthermore, the targeted population enabled participation of individuals that participated in the activities of the ISHP Programme. Purposive sampling was used to select participants and the Chief Directors were able to provide a broader view of the ISHP Programme. Data collection was conducted via Microsoft Teams due to Covid-19 regulations and where possible face to face

interviews were conducted. Permission to conduct the study was sought from all three departments, health, education and social development and it was granted by all three. The research was guided by Professional Code of Ethics and its findings are presented in the next chapter.

CHAPTER FOUR: DATA ANALYSIS

4.1 INTRODUCTION

Chapter three focused on the research design and methodology relevant for the collection of data which gave insight on the role of the Department of Social Development within the ISHP in Buffalo City Municipality District. Semi-structured interviews were conducted and literature review was also used to enhance the analysis of data, thus, resulting to findings. The documents that participants referred to such as the Memorandum of Understanding, Terms of Reference and implementation plan drafted were further reviewed to support the findings. This chapter therefore presents findings and discussions, these findings are substantiated by the existing literature. The aim of the study was to understand the role of social development in the ISHP. Recommendations were made on delivery of multi-sectoral services to strengthen implementation. Themes emerged and were viewed at the level of policy development, current implementation and strategies to improve implementation.

Table 3: Themes and subthemes that emerged in the study

Theme	Subthemes
Background and context that led to the development of the Integrated School Health Policy	1. The policy impact on the participation of social development in the ISHP. 2. Understanding the mandate of social development in line with the policy 3. Inclusion of a clear programme logic and implementation plan at policy level 4. The current participation of the Department of Social Development in the ISHP Programme 5. Lack of resources to support in-school implementation 6. How does the programme reach the target group? 7. Impact of variation of implementation and

Theme	Subthemes
	accountability
Different ways in which participation of DSD may be enhanced in the delivery of multi-sectoral services.	1. The assumption that the policy made about the three departments 2. Management and Coordination of the three departments in implementation of ISHP

4.2 BACKGROUND AND CONTEXT THAT LED TO THE DEVELOPMENT OF THE INTEGRATED SCHOOL HEALTH POLICY

It was crucial to start the research questions with policy related questions wherein the role of social development is regulated. The policy highlights the mental health and psychosocial support screening for all grades (Department of Health and Department of Basic Education, 2012). This also gave perspective in terms of gaining insight of whether one understands the policy or not. The participants showed a great understanding of the policy and even highlighted how the policies have two signatories from the DOH and DoE, this has been viewed as one of the contributing factors to the resistance.

Furthermore, the participants highlighted that social development was excluded in the ISHP (policy) of 2002 and the focus was on ensuring that proper coordination between the DOH and DoE occur to ensure health services are rendered within the education sector. Rasesemola, Matshoge and Ramukumba (2018) alluded to how ISHP services need collaboration from national to provincial offices of the three departments, health, education and social development and furthermore, these departments must supervise the collaboration.

4.2.1 **The policy impact on the participation of social development in the ISHP.**

The White Paper 6 enforces schools to be inclusive centers of care by responding to emotional needs and mental needs of both learners and teachers. This is conducted through the provision of support to learners that have learning difficulties, and emphasis is on comprehensive support (Babedi, 2013). The participants raised various issues that stem from the policy, of which, some hinder participation of social development in the ISHP such as the minimum inclusion of DSD and the assumptions that the policy holds in terms of implementation. There was a common view of why the policy was developed but the focus was on social development as evidently shown by the responses. One participant responded:

> *"The development of the policy moved from the context of taking care of societal barriers, we moved to a level where we saw that we are in the midst of HIV and AIDS, children have been vulnerable and have been OVC and households are child headed. Health and social welfare needs were a barrier that should be removed through ISHP".*

The response alone shows the transition from one policy to another and how the time and challenges informed the inclusion of the Department of Social Development. Namome, Winnaar and Arends (2021) highlight how epidemics have started the conversation of the need for provision of psychosocial support. The current pandemic has proven a relationship between different health domains, for instance the Gender Based Violence and Femicide is growing in proportion alongside Covid-19 with reported cases that are 37% higher in 2020 than 2019 (Women, Youth and Persons with Disabilities, 2020). The Directorate Children and Victim Empowerment within DSD might not have been part of the ISHP committee because it was perceived as health related. However, the Based Violence rates were worsened by a health-related pandemic, Covid-19 (Women Youth andPersons with Disabilities, 2020). Thus, a complete team of social workers, school health nurses, police services and environmental officers were needed to respond to the disruption caused by pandemics.

One responded even made this clear through echoing that:

> *"The first policy on school health was very much directive of the department of health and was supported by the department of education in implementation but overtime the need was identified for inclusion of social development because the social ills were very much mounting in the schools"*

To support the above, there are various policies that support implementation of the ISHP such as the NAYH policy which highlights how broadening the scope of involvement of the community on providing health at local level is the only way that health can be improved (Department of Health, 2017). The Department of Basic Education (2014) guides how support services can be made available through CSTL. This was supported by the participant that perceived the development of the policy as means for the departments to work together:

> *"All the departments were working in silos even though there was a visible need of collaboration. The minute the programme started we realized that we are doing the same thing but in separate corners and now that we are working together…"*

All the participants shared a common view that there was a dire need for the participation of social development in the execution of the ISHP. The Covid-19 pandemic has proven that DoH and DoE cannot render this policy, DSD as the DoE closed its's doors and its systems needed to provide sufficient psychosocial support to learners so that they develop resilience; thus, the need to strengthen partnerships and relations between DSD and DoE (Namome, Winnar and Arens, 2021). The Women Youth and Persons with Disabilities (2020) proposed that the DSD must implement early intervention for children while BDBE scales up CSTL and Peer Education Programmes. The role of the DSD and its importance cannot be denied. The discussions implied that Orphaned Vulnerable Children (OVCs) belong to the DSD including the neglected child, mistreated and raped. The participants agreed that rendering of services which are targeting children in the school going age are rendered more systematically and less chaotic in the school.

4.2.2 Understanding the mandate of social development in line with the policy

The mandate of DSD has been captured in the development of policy background and context. However, with respect to the mandate of DSD as outlined in the policy, one participant argued that*:*

> *"In the policy, the mandate of social development is only two lines which says that social development will help with transportation of school learners to services of need, of which social development was disputing".*

The study conducted by Lenkonkile (2016) highlights that the transportation of children to referral services, remains a challenge; moreover, the referral service system remains a challenge and needs

strengthening. The issue of transportation emanates from the fact that social workers have been evidently effective in addressing issues of stigma and access to health services, thus access in this case is enabled by the provision of transportation (Saxe et al., 2019). Furthermore, Rasesemola, Matshoge and Ramukumba (2018) deem scholar transport as necessary and integral in the ISHP and also acknowledge the lack of integration of scholar transport to school health services.

In addition, one of the participants argued that:

> *"In the objectives of ISHP, we did not recognize how social development fits into the policy so we had found a bullet that say provision of psychosocial support and that is a wide definition that starts from early identification, the identification that goes with case management, wholeness, disintegration within the family, abuse involving a learner, involvement of police, courts, etc."*

The CSTL Framework is used as a vehicle for many school-health related policies in the education department. Thus, it clearly outlines the services that DSD may partake in. As in the statement above, the framework requires the DSD, the police, courts and other stakeholders ensure that schools are free from all forms of violence, abuse and bullying (Department of Basic Education, 2010). The framework also requires social development to facilitate psychological safety for learners and educators.

One of the responded also echoed that:

> *"Everything that concerns a child is a responsibility of the Department of Social Development starting from birth, primary education, secondary to adulthood"*

These statements were strengthened by a participant that looked at levels of support that exists within the social development:

> *"Social development levels of support are preventative services, early interventions, statutory care and continual care services and department of education actually copied their system, we have screening, identification, assessment and support. Our support, screening, identification is their prevention and early intervention, their statutory process is our placement of our learners in special schools and continual care is when a learner is placed."*

In that case, DSD can also strengthen the SIAS process in the DoE. The policy on SIAS outlines structures that education uses to collaborate with social services to ensure that learners are supported when it comes to social barriers, and where support goes beyond school level (Department of Basic Education, 2014). DSD's range of services goes beyond the scope outlined in the ISHP policy, but includes social grants, protective placements, victim support and empowerment programmes (Department of Basic Education, 2014). When the mandate or role of social development was discussed, the intervention programmes are paramount. Most responses were similar as those echoed below:

> *"The mandate of the department is to come up with programmes that seek to reduce social and structural drivers and the department has programmes targeting children that are in school. The mandate is to come up with content in terms of programmes such as Yolo, IMOJA and Chomi and others that are within different sub-programmes in the department"*

Other participants strongly believe that social development is responsible for the integration of families. The access and availability of promotive services such as Early Childhood Development and partially care services, family strengthening programmes such as family reunions are the responsibility of social development (Department of Social Development et al., 2019). Furthermore, The National Child Care and Protection Policy of 2019 recognizes the Department of Social Development as the leading department in terms of child care and protection systems, however that this responsibility cannot be carried by one department but ought to be shared by other departments, partners, parents and stakeholders (Department of Social Development, National Development Agency and Agency, 2019).

4.2.3 Inclusion of a clear programme logic and implementation plan at policy level

The discussion above shows that the role of the Department of Social Development was not sufficiently articulated at policy level. According to Lenkokile (2016) there is an evident need to clarify the objectives and meaning of the policy. However, the participants had different views even though some strongly highlighted that there are policies within social development that talk about a child in the school space, of which, the participants of the Department of Education and health became conversant of when the Memorandum of Understanding between the three (3) departments was drafted. One of the participants noted that:

"Globally, in the systematic level, it is clear that each department has its role but operationally there is a lot of vagueness, no clarity and no measurable objectives where you can measure the services that are being rendered by social development"

Nonetheless there is a lack of understanding of the policy and also lack of clear roles for those providing the services (Keothaile). Namome, Winnaar and Arends (2021) also found the gap in the policies especially where psychosocial support is concerned in terms of the school setting. Khoza (2017) states that "a comprehensive ISHP is an integrated set of planned, sequential, school affiliated strategies, activities and services designed to promote optimal, physical, emotional, social, and educational development of students". There were participants that argued that:

"The policy is very clear in terms of what services are provided per grade even this Comprehensive Sexuality Education is in the policy as health education. There is no other way to present this policy, it has to presented as it is".

And this was supported by another participant who agreed that:

"Yes, the policy is very detailed because it says what we need to do and says exactly which grades you should attend to, although the schools do not have the same problems, I do not know if the focus should be according to these grades. Hence, I gathered that when the school nurses or social workers go to the school, the teachers pick up issues from learners that may not belong to these grades"

The grades might therefore limit the provision of services that the learners may require. From the discussion, it is evident that psychosocial support is a broad term that needs to be unpacked. The participants kept reflecting on how broad it is, thus arguing that the role of the Department of Social Development needs to be clearly defined at policy level. These views coincide with the studies of Keothaile (2016) who claimed that the focus of the Integrated School Health services was more on physical and nutritional aspects rather than psychosocial support.

The overarching objective of the ISHP policy is guiding the provision of a comprehensive integrated school health programme as part of a primary health care package provided within the care and support for teaching and learning framework (Department of Health and Department of Basic Education, 2012). How school health services have evolved, there are SOPs on SRHR&SS

are advocating for provision of ongoing psychosocial support and therapeutic services onsite (Department of Basic Education et al., 2019).

4.2.4 The current participation of the Department of Social Development in the ISHP Programme

Public policies need to be monitored to determine whether it is in the right direction in terms of implementation so that barriers to be implementation can be dealt with as they occur (Lenkokile 2016). However, the fact that the department of social development's participation was aligned to the existing mandate and existing Key Performance Areas was overly emphasized. The Department of Education and Health always have cases that they refer to the Department of Social Development, of which some emanate from home. The challenges are either emotional or behavioral, nonetheless the presence of social development makes it easier to identify learners with social challenges in the school space.

4.2.5 Lack of resources to support in-school implementation

The Evaluation of the Phase 1 Implementation of the Interventions in the National Health Insurance Pilot Districts in South Africa reported that the lack of sufficient resources hindered the implementation of the ISHP (G:ENESIS and The Centre for Health Policy 2019). This sentiment was shared by the participants when discussing how inputs and activities contributed to the outcome and impact at implementation level. Challenges were highlighted as follows:

> *"The first challenge is cars so the resources are shared, the venue for district meetings were a struggle ……. so, municipality at times made a hall available."*

Mahlangu, Goudge and Veary (2019) did not see sharing of resources as a challenge but the reason why there is multi-sectoral collaboration. Mahlangu, Goudhe and Veary (2019) suggests that the sector governments must work together to realize multi-sector collaboration which can only be achieved through sharing resources, knowledge about the services and approaches that will enable a more holistic intervention and also expertise that will address not only the challenge faced by learners but also its's social drivers including the structural drivers. The lack of resources was supported by a participant who echoed that:

> *"There is no designated funding for ISHP but managed within the existing programmes thus are over stretched."*

It has been a general finding that school health services do not have specific budget nor sufficient budget at all levels of government (Shung-king et al., 2013). This does not only apply to funding, there are also no personnel allocated for school health services though ISHP is an additional task that have been allocated to the official (Khoza, 2017 and M4Health, 2021).

Another participant also referred to placement of ISHP:

> *"ISHP falls under the umbrella Maternal Child and Womens Health so it is just one of the facets but I would not say we point these activities put so clearly because it is a very broad programme but there is a plan"*

These challenges prevented participants from talking about the outputs, outcomes and the impact, as the questions of delivery without resources were posed to the researcher. However, it is clear from the discussion that the Integrated School Health Programme is poorly resourced. Mahlangu, Goudge and Veary (2019) state that, where there is multi-sectoral collaboration, the institutional logics start competing because all sectors operate differently. Furthermore, the multi-sectoral collaborations are time consuming, are always costly and fragile by nature. Therefore there is a need for careful coordination and sound management which stems from appropriate planning, reciprocated obligations and relationship where their sectors trust one another (Mahlangu, Goudge and Veary, 2019). Another finding that peripheral to this is the Key Performance Areas (KPAs) of the Department of Social Development responds to the policy so the department is indirectly participating. This takes us to how the Department of Social Development reached the learners.

4.2.6 How does the programme reach the target group?

The participants agree that there are programmes rendered by the Department of Social Development in schools, even though the department might not be reporting these activities under the Integrated School Health Programmes. Participants agreed that referral comes from different sources and are attended differently. One participant echoed this by stating:

> *"DSD have clients that are coming to the offices from home……. They are comfortable that they are providing social care for the children, but when it comes to the education system, there is a lot of uncertainty.*

The above is often found where multi-sectoral collaboration is concerned as alluded above by Mahlangu, Goudge and Veary (2019). However, Khoza (2017), emphasizes that the programme

refers to "school-based health services", "school environment" and "physical education at school". This therefore emphasizes that services should be school based and referrals should only be done where necessary. Services should thus be conducted in an integrated manner whereby the attitude of a learner and his/her behavior, the environment where he or she lives or function are emphasized (Khoza, 2017). The approach used by social workers is embedded in the ecological systems theory. This was echoed by a responded that argued:

> *"School is the safest environment for learners because learners act out their trauma, vulnerability and pain in schools. Learners are said to have behavioral problems that teachers cannot manage and the challenges maybe from home so the school becomes a safe space where social workers can come in and help"*

Teater (2014) states that social workers intervene at the point where the people interact with their environment. Furthermore, behavioral and emotional problems lead to behavioral challenges that disturb both other learners and teachers. Teachers are then faced with the responsibility to refer learners to needed services (Mwoma and Pillay, 2015; Wood and Goba, 2011). As much as the Department of Social Development never captured their role in the school in response to or participation in the Integrated School Health Programme their participation in schools is visible through the different programmes implemented in schools whether through Zazi, You Only Live Once (YOLO), Social Behaviour Change Programme or attending to a referral from a school through area social workers; but their visibility was evident. The social worker's role involves treating and prevention of psychosocial dysfunction; in other words, social workers are integral in addressing the social determinants of health (Ebue, Uche and Agha, 2019; Saxe et al..2019). of the participants outlined the programmes with ages which is a key element for the ISHP:

> *"We have programmes such as family matters for a child turning twelve (12), there are substance abuse programmes……. The Social Behaviour Change Programmes start at the age of 10-14. There is a programme that starts at 15-24 and we also call it social behaviour change programme. Programmes such as YOLO, KeMoja, and Zazi-which deal with Young Girls and Women, so we cannot say DsD cannot be part of the ISHP".*

To strengthen the above, the Department of Social Development works with the department of education specifically the safety directorate in the implementation of Teenage Against Drugs

Abuse (TADA) and have partnered in the implementation of the Social Behaviour Change Programme. One of the responded echoed that:

> *"The department also conducts psychosocial support and awareness campaigns pertaining to Substance Abuse, Gender-based Violence, Children and Crime Prevention. The department as aforementioned intervenes before the child enters. The Department of Social Development further offers treatment centers for learners between the ages of 13-17 that are suing drugs which ensures that schooling continues while the child is at the rehabilitation center".*

The Department of Social Development et al. (2019) further outline the roles of social development as the provision of quality prevention and early intervention services targeting the orphaned vulnerable children, including their protection from any kind of abuse or harm. The participants also regarded the rights of the child and social protection as the mandate of the Department of Social Development. The above evidently supports the M4Heath report on the ISHP Policy Project which states that the departments were working in silos. Consequently, the Department of Health dominated the other two (2) departments (M4Health and Save the Children, 2021).

4.2.7 Impact of variation of implementation and accountability

The participants focused more on the accountability aspect of the question rather than the variation in implementation. Therefore, variation was responded at the level of accountability as one responded that:

> *"Variation depends on the principal because we have to go to the school through the principals and other principals prohibits access to the learners. The other gatekeepers are our principals who often do not priorities the Integrated School Health Programme"*

This was echoed by a participant that said:

"Some schools believe ISHP is about Deworming ad HPV. DSD is often left out when administering HPV and Deworming but if these can be offered with other baskets of services then implementation will be more comprehensive and not vary much"

The variation reported is not only the challenge of social workers but health nurses as Dibakwane & Peu (2018) also found that challenges faced by nurses include lack of support by school management and this negatively impacts the process of delivering the school health programme.

An accountability officer is required to provide guidance and also support the rollout of ISHP, thus leadership and management is key (Dibakwane and Peu, 2018). Mahlangu, Goudge and Veary (2019) state that there is multi-sectoral collaboration, there is always a struggle of shifting responsibilities from one sector to another and there are always issues of power dynamics hence an accounting officer is required. Variation was also described as a result of geographical location and availability of resources as one participant noted that:

> *"There is not much variation in social ills but implementation varies by resources as urban schools have more resources than rural schools. It is also easy for nurses and social workers to share resources in urban areas because they might come from similar areas than in rural areas where offices and schools might be further apart".*

There is a general view on how variation results from lack of accountability. The Nzululwazi Case Study is the first that implied lack of accountability between the core departments that are responsible for the implementation of the Integrated School Health Programme (United Nations Population Fund - UNFPA and Student Partnership Worldwide - SPW, 2015). The ecological systems theory that forms the basis of this study, supports the participants that placed accountability on each department. Nonetheless there were participants that placed the accountability on the school nurse, the principal or educator appointed by the principal and the School Based Support Team respectively.

The lack of accountability is also reported as due to lack of involvement of senior managers in the coordination of the programme therefore coordination does not occur at strategic level. One of the participants highlighted the challenge of managers at the level of directors refusing to report to other directors, thus suggested that accountability ought to be at the local municipality level. According to the World Health Organisation (2018), the multi-sectoral approaches and collaborations can strengthen governance and coordination by enhancing the responsibility and accountability of sectors that impact health and wellbeing. The participants were in support of this statement, in the case of accountability they responded saying:

> *"I think what am trying to say is each professional person that is trained registered with a professional board will have to take responsibility for that field but you cannot make an SBST responsible for social workers who they are not responsible for and are not appointed by them".*

"Matters pertaining to education should be local government driven. There needs a space where all programmes meet and discuss issues of service delivery".

There is no sense of accountability amongst implementers as one participant alluded:

"I cannot really say we accounted to anyone because even the School Based Support Team is not functional but it is there on the wall by names, the Health Advisory Committee structure does not exist anymore"

This above statement is in line with Khoza's (2017) argument that "programme managers are accountable to the community for programme quality and effectiveness". Furthermore, Mahlangu, Goudge and Vearey (2019) state that the use of structures such as the AIDS Council as a vehicle for multi-sectoral collaboration because collaboration requires coordination. Furthermore, SOPs and Memorandum of Understanding are actually key in defining roles that each sector must play, how these sectors are supposed to interact and under what conditions (Mahlangu, Goudge, Vearey, 2019). One participant highlighted the essence of accountability as:

"There is a Memorandum of Understanding between the departments that binds the three departments, and it even clarifies who is supposed to do what and the sense of responsibility is moving from there, that you are responsible for this, so should this happen, so and so is responsible, the head of each department is responsible".

There is a general view of lack of accountability at all levels as the School Based Support Team is reported to be dysfunctional, the absence of school health nurses, unavailability of principals due to competing demands, overloading of Life Skills/Lo Educators, lack of monitoring and support from all levels and the lack of involvement of senior management. There is really no degree of accountability for the implementation from any of the departments (Lenkokile, 2016). The lack of accountability might also contribute to how the level of participation and /or role of the Department of Social Development is perceived. There are a number of interventions that need to be done to manage this variation and improve accountability.

4.3 DIFFERENT WAYS IN WHICH PARTICIPATION OF DSD MAY BE ENHANCED IN THE DELIVERY OF MULTI-SECTORAL SERVICES.

Currently, there is a shared understanding that the department is playing a role in the implementation of the Integrated School Health Programme. However, this role has been affected by challenges such lack of accountability and poor coordination. The discussion above emphasizes

the importance of a holistic response to learners needs. Chapter 2, alluded on how health and psychosocial support overlaps as both concepts describe the state of wellbeing. However, the departments are working in silos whilst there is a dire need for collaboration. The following were highlighted as challenges that hinder participation, and if improved, then the delivery of multi-sectoral services would be enhanced.

4.3.1 The assumption that the policy made about the three departments

To support the above, the Education White Paper 5 on Early Childhood Education defines early childhood development, "…as a comprehensive approach to policies and programmes for children from birth to nine years of age with the active participation of their parents and caregivers" (Pillay, 2018). The ISHP policy consists of a number of assumptions that the participants did not agree with; such as the provision of transport, which is identified as the only role the Department of Social Development is responsible for. The policy also assumed that because of the broad definition of psychosocial support, the entire role of social development will be clear. The participants also said that the departments are perceived as working together rather than in silos. Some of the participants do support these assumptions but others do not. The existence of the policy does not guarantee that the departments will collaborate, have resources to execute the mandate or share resources. One participant echoed this:

> *"According to the policy, there is no shortage of resources because resources are to be shared. What you do not have will be covered by the other person but it doesn't happen that way."*

Furthermore, one participant said the role of each department is clear:

> *"Globally at systematic level it is clear that each department has a role but operational side of it which is why the programme is not taking off, there is a lot of vagueness, no clearness, direction and no measurable objectives where you can actually measure whether services are being rendered by the Department of Social Development"*

The issue of coordination and sharing of resources can never be overly emphasized as there is a need to strengthen collaboration and coordination. There is also a need for these departments to engage in meaningful participation to discuss the mechanisms and processes that will yield the desired collaboration (Mahlangu, Guodge and Vearey, 2019).

However, others argued that:

> *"The Integrated School Health Programme Monitoring and Evaluation framework does not include social development but puts the responsibility of implementation to the Department of Health and Education"*

According to M4Health and Save the Children (2021), schools receive one or less visits from the school nurse per year and this challenge is also reflected on the monitoring and evaluation framework. The framework does not give any responsibility to a social worker for ISHP, instead gives responsibility to nurses, dentists and optometrists (Department of Basic Education and Department of Health, 2013) as a result one participant confirmed that:

> *"I was the only one attending the meetings because I was working with programmes implemented in the schools so was seen as relevant……In the meeting HPV and Deworming was discussed to an extent that we were out of place but still thought if health goes to schools for these then why not include ZAZI from the DsD".*

There are no indicators in the Integrated School Health Policy that speak to social development but only the health department (Department of Basic Education and Department of Health, 2013). Other than that, the participants also complained regarding support from the Provincial offices.

> *"The Provincial office does not monitor the districts to check how far they are with the monitoring of the plan (accountability) so plans were paper based but implementation was a different story. Monitoring and support of implementation will drive the resources to reach the beneficiaries of the programme."*

The participants argued that operational standards need to be clarified as each department has a role to play, but the non-prioritization of that role has a negative impact on participation. The officials from the Department of Social Development would be left with nothing to report because the indicators of the programmes and focus of the policy is not inclusive of the Department of Social Development. Systems need to be put in place to ensure that the contribution of DSD is captured, including the challenges and resolutions of this will foster trust and improve the effectiveness of the programme (Mahlangu, Goudge and Vearey, 2019).

4.3.2 Management and Coordination of the three departments in implementation of ISHP

One of the emerging findings as participants were sharing their perceptive, is the issue of coordination and involvement of more partners. Coordination came strongly as one of the challenges that hinder effective implementation. Coordination and partnership are a priority in the implementation of a school health programme and all three departments are required to ensure collaboration with partners that will enhance implementation of the programme (Department of Health and Department of Basic Education, 2012).

One of the participants appreciated the policy for being inclusive:

> *"I like it because it does not limit involvement in the three departments but it recognizes that there are other stakeholders that form the implementation of the policies, which is true. You would find so many developmental partners and NGO that are in the school space addressing the socioeconomic needs of the learners in schools".*

However, this inclusivity should be coordinated and structured through the establishment of committees or task teams as platforms where coordination and collaboration can take place. One of the participants suggested that:

> *"The execution of the services by the other two (2) departments in terms of health care, social care should be coordinated by the school health within the context of District Based Support Team in the department of education".*

The Department of Basic Education (2017) also manages coordination and implementation of the National Policy on HIV, STI and TB through committees such as Heads of Education Departments Committee (HEDCom). Collaborative partnership is key in improving health and education outcomes (Kolbe, 2019). One participant shared a view on what the Integrated School Health Team is:

> *"I think the integrated school health team is a team consisting of various departments with various specialists going into one venue, the school environment and coordinate services within their environment, I think that makes a difference rather than social workers going to a home of a child unrelated to a school and healthcare does it separately and education does it separately".*

The role of the department of education is explained as only identifying learners that are vulnerable through inability to access curriculum whether the learner is not performing, have behavioral challenges or emotional challenges. Then such a learner must be referred to a social worker through the School Based Support Team, a team that responds to teachers requests for assistance with learners experiencing barriers to learning (Department of Basic Education, 2014). The participants shared the same sentiments as the responded below:

> *"When the ISHP District Task Team go to a school they would then for that day at that school be supported by the SBST on the day of assessment as their link, access to learners thus the needs of the school will be addressed through the SBST".*

This was strengthened by a participant who echoed that:

> *"Coordination of the programme was done well at district but was coordinated externally as a result because of restructuring and absence of GiZ, the structures were disturbed and the pulse was lost".*

Partnership with GiZ proved that networking enables the non-profit/non-government organisations and municipalities to exchange information, support each other's programmes, and attend workshops/seminars collaboratively (Gumede, 2020). The Integrated School Health Policy (2012) also posits that a joint steering from the three (3) departments and strengthening of coordination is needed.

4.4 CONCLUSION

The execution of the role of social development within the Integrated School Health Programme is impacted by gaps that occurred in the policy development stage. However, it is unquestionable that the Department of Social Development has a fundamental role to play in the implementation. The mandate and Key Performance Areas are already aligned to the policy as each department is required to execute its existing mandate and has a responsibility toward social protection. The provision of basket of services to children who are vulnerable is captured in the legislative framework that guides the functions of the departments. All orphaned vulnerable children, those who suffer from neglect or are raped or their security is threatened in any way belong to the Department of Social Development. The ISHP just brings a vehicle that enables schools to be centers of care and support and it further activates the provision of psychosocial support by the

Department of Social Development. Consequently, reducing burdens on the Departments of Health and Education from responding to social issues.

The emotional and behavioral issues are responded to by the Department of Social Development through their programmes such as the social behaviour change programmes. The Department of Education borrowed the Screening, Identification, Assessment and Support process from the Department of Social Development. However, referral is still a challenge within the school environment, thus ISHP is negatively affected. Therefore, one of the key responsibilities of the social development that should form part of the Memorandum of Understanding is strengthening the referral system at school level. This Memorandum of Understanding with its Terms of Reference is perceived as one document that will standardize services, strengthen monitoring and support, enhance accountability, coordination and multi-sectoral services. The following chapter provides a more comprehensive and in-depth conclusion and recommendations.

CHAPTER FIVE: SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 INTRODUCTION

The purpose of this study was to explore the role of DSD on the ISHP in the Buffalo City Municipality. The key aspects of this research are highlighted by the research question and objectives and were alluded to in Chapter One. This chapter shows how the analysis was carried out to address the area of enquiry. Recommendations were made with careful consideration of the policy context, implementation and multi-sectoral delivery. The focus of this study is guided by literature and empirical findings. However, there are recommendations that are shared for potential further research that may be conducted in this area of work.

5.2 SUMMARY

When exploring the role of social development, it is crucial to start at the policy level where the background and context is provided, after-which proceed to the implementation and delivery of multi-sectoral services. DSD adhoc participation in the implementation of ISHP might have been caused by the minimal inclusion of the department at policy level. The department continues to be a third-wheel in the implementation of ISHP whilst the Department of Health and Education take lead. The Department of Education (2020) recognizes the societal, intrinsic and systematic barriers to learning and these are barriers that the Department of Social Development address through various prevention programmes that are implemented in the schools. The school health policies require a provision of a basket of services when rendering support to learners in school (Department of Basic Education, 2017; Department of Basic Education, 2019; Department of Basic Health and Education, 2012). However, the role of social development is not clearly defined in the ISHP policy but only indicated as provision of psychosocial support and transportation of learners. The participants argued that this is minimal and does not include all activities conducted by DSD in schools.

Key to note, is that some of the interventions used by the Department of Education are adopted from the Department of Social Development. DSD is leading in child care and protection systems. The Department of Social Development levels of support are preventative services, early interventions, statutory care and continual care of which the department of replicated through the Screening, Identification, Assessment and Support process. The intervention of social development where a child is concerned commenced from birth and continues to promote services

such as Early Childhood Development and partial care services and family strengthening programmes (Department of Social Development et al., 2019). Social Behaviour Change Programmes and Peer Education programmes start as early as the age of ten (10) and continue to the age of twenty-four (24). An implementation plan that mirrors the contribution of social development to the ISHP programme was developed through the facilitation of GiZ and a consolidated plan from the three departments was produced by members of the Buffalo City District ISHP Task Team. Structures are applauded for effective coordination and management of ISHP but the need for participation of leaders and managers is still lacking. Accountability is one of the key factors that hinder implementation and enhance variation in implementation. Nonetheless, accountability also lacks where the structure is not functional such as SBST. Strategies are needed to ensure that implementation and participation in the delivery of this multi-sectoral services is improved.

5.3 RECOMMENDATIONS

There are gaps that have been identified at all levels from policy to implementation level. These gaps and findings from the discussion informed the recommendations of how this ship of multi-sectoral services can be driven to reach the targeted beneficiary, the learner. The recommendations emerged from the discussions were informed by the participants and reviewed literature. These recommendations will serve as guidelines and/or strategies to improve the participation of social development with more clarified roles. The recommendations include the need to close the existing gaps found in the policy, strengthening management and coordination, increasing accountability and resourcing the programme.

5.3.1 The gaps that were found in the policy must be addressed

The study found that DoH and DoE continues to lead in the implementation of ISHP while DSD continues to lag behind. This is associated with the minimal inclusion of DSD in the policy. However, health-related epidemics continue to influence policy development and emphasize on psychosocial support. Most policies within the DoE are executed through CSTL, a framework that is inclusive of all stakeholders and how each department and partner can contribute in the provision of care and support. Therefore, it is recommended that the Integrated School Health Policy be read with other policies such as the National Adolescent and Youth Health Policy and the National Child Care and Protection Policy.

Furthermore, the three (3) departments must develop a Memorandum of Understanding and Terms of Reference that highlights the roles and responsibilities of each department, how the sectors interact, when and under which conditions. The fact that the MoU is signed by the Minister of the three (3) departments might close the gaps created in the policy documents. However, it must also be accompanied by an Integrated Implementation plan that will inform how integrated school health services will be delivered. Each department must be held accountable for its own package of services which should be highlighted on the Terms of Reference with budgetary items so that programme implementation is prioritized. The MoU must have minimum standards, for instance, school health programmes must not take place without the presence of a social worker.

5.3.2 The programme must be resourced

Shung-King, Orgill and Slemming (2014) highlights how the 20002-policy failed because of shortage of staff, lack of referral services, lack of collaboration, lack of transport and poor managerial support and presence as well as lack of understanding. However, these challenges are still becoming visible in the current execution of the ISHP policy of 2012. ISHP requires designated social workers to render services to learners rather than just being an additional responsibility or natural responsibility. Sectors of government must work together to achieve multi-sectoral collaboration through sharing resource, knowledge and professional expertise about interventions. Social services should also be delivered where the child functions and interacts, therefore DSD must not focus on referrals. The departments must also engage in processes and discussions that yield positive results of collaboration.

5.3.3 Coordination, Management and Accountability must be prioritized

Poor coordination and management must be alleviated as it continues to impact negatively on the delivery of social work services within the ISHP. Accountability mechanisms including an identification of a transparent accounting officer is required to ensure effective delivery. The support of senior managers cannot be overly emphasised as this enhances accountability, participation and coordination of the programme. Placing the responsibility of resource mobilization to managers is key to the collaborative function. Programme implementation must be monitored at all levels as this will drive the resources and/or services to learners. There are no indicators in the Integrated School Health Policy that speak to social development but health

department (Department of Basic Education and Department of Health, 2013). These indicators must therefore form part of the MoU, ToRs and Integrated Workplans.

5.4 SUGGESTED AREAS FOR FURTHER RESEARCH

The study only focused on the Eastern Cape in the Buffalo City Municipality where GiZ also played a crucial role in strengthening the coordination of the ISHP between the three (3) departments. The study was conducted in an urban area, thus did not cover the rural areas and also other provinces. Moreover, the study did not cover the role of structures that are supporting implementation as much as these structures came strongly in the study. Therefore, the following recommendations are made:

- There is a need to investigate how DSD renders psychosocial support in the rural areas as compared to urban areas. This study enables the understanding of the difference as approaches to service delivery might be different.
- The impact of health-related pandemics in the delivery of care and support programmes. This will enhance the provision of psychosocial support and development of policies that focuses on psychosocial support at school level.
- There is also a need to conduct a comprehensive study on the role of school level social work in the South African context where schools that have social workers are compared to those that do not. This will strengthen this study and assist the departments in understanding social work interventions at school level.

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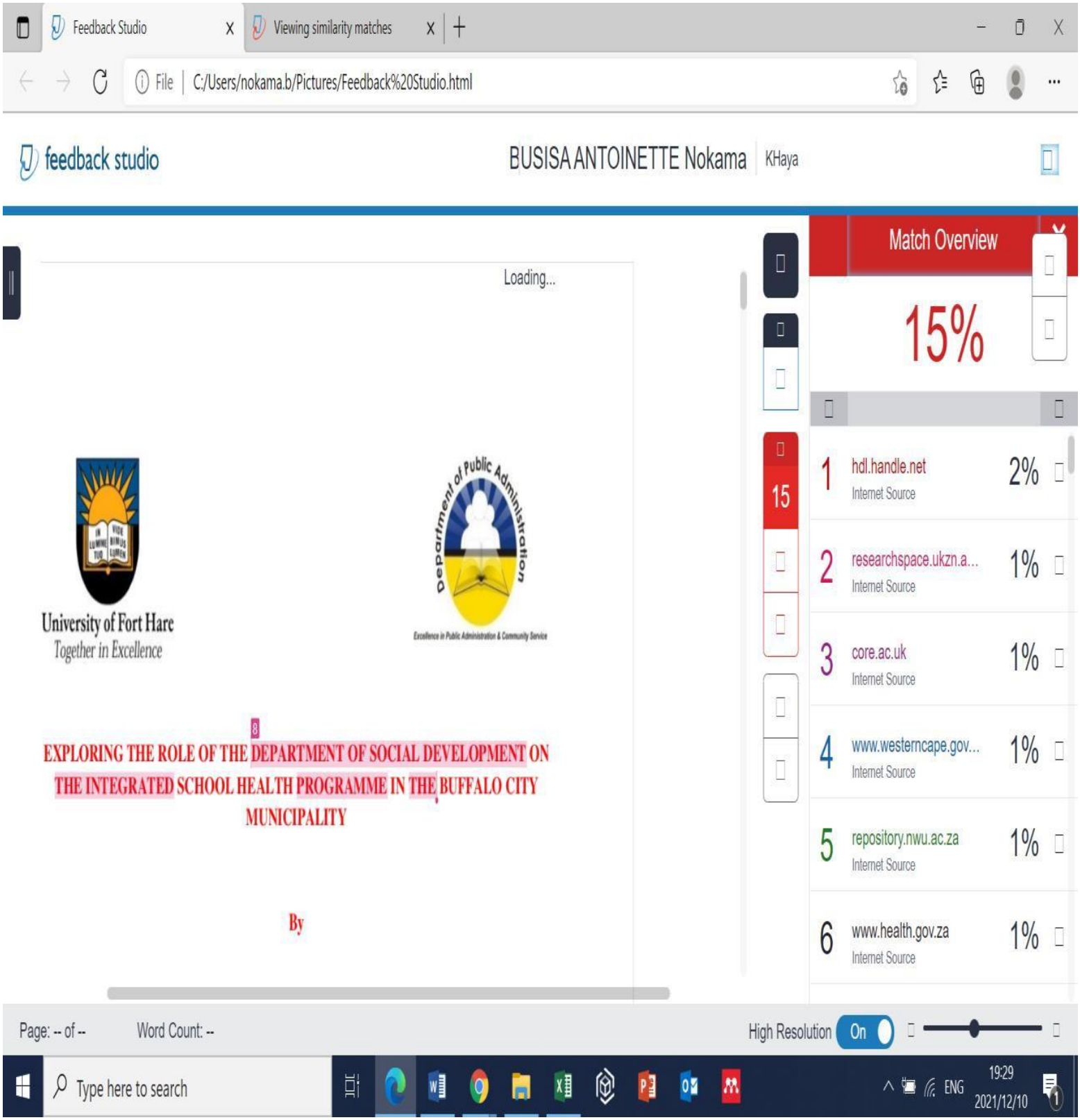

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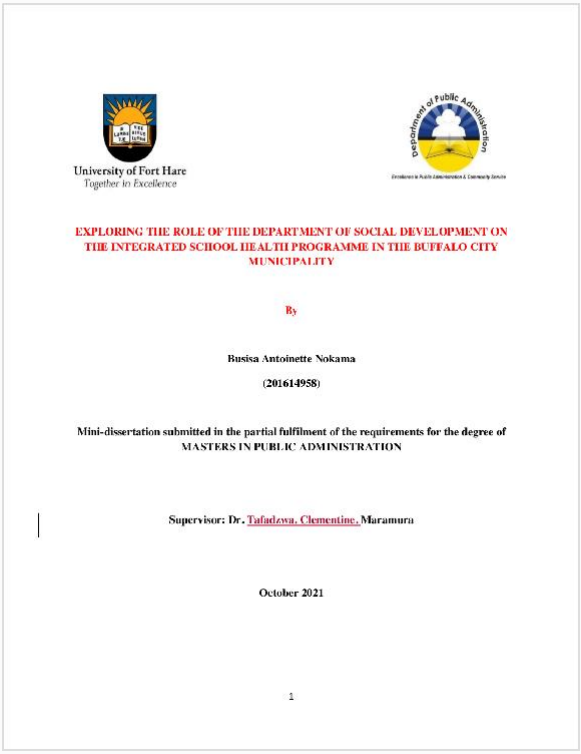

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EXPLORING THE ROLE OF THE DEPARTMENT OF SOCIAL DEVELOPMENT ON THE INTEGRATED SCHOOL HEALTH PROGRAMME IN THE BUFFALO CITY MUNICIPALITY

By

Busisa Antoinette Nokama

(201614958)

Mini-dissertation submitted in the partial fulfilment of the requirements for the degree of MASTERS IN PUBLIC ADMINISTRATION

Supervisor: Dr. Tafadzwa. Clementine. Maramura

October 2021

1

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ETHICS CLEARANCE
REC-270710-028-RA Level 01

Project Number:	MAR031SMAQ01
Project title:	**Exploring of the role of the department of social development on the integrated school health programme within the Buffalo City Municipality.**
Qualification:	Masters in Public Administration (Full Dissertation)
Student name:	Busisa Antoinette Nokama
Registration number:	201614958
Supervisor:	Dr T.C Maramura
Department:	Public Administration
Co-supervisor:	N/A

On behalf of the University of Fort Hare's Research Ethics Committee (UREC) I hereby grant ethics approval for MAR031SMAQ01. This approval is valid for 12 months from the date of approval. Renewal of approval must be applied for BEFORE termination of this approval period. Renewal is subject to receipt of a satisfactory progress report. The approval covers the undertakings contained in the above-mentioned project and research instrument(s). The research may commence as fromthe 01/12/20, using the reference number indicated above.

Note that should any other instruments be required or amendments become necessary, these require separate authorisation.
Please note that UREC must be informed immediately of

- Any material changes in the conditions or undertakings mentioned in the document;
- Any material breaches of ethical undertakings or events that impact upon the ethical conduct of the research.

The student must report to the UREC in the prescribed format, where applicable, annually, and at the end of the project, in respect of ethical compliance.

UREC retains the right to

- Withdraw or amend this approval if
    - Any unethical principal or practices are revealed or suspected;
    - Relevant information has been withheld or misrepresented;
    - Regulatory changes of whatsoever nature so require;
    - The conditions contained in the Certificate have not been adhered to.

- Request access to any information or data at any time during the course or after completion of the project.

Your compliance with Department of Health 2015 guidelines and any other applicable regulatory instruments and with UREC ethics requirements as contained in UREC policies and standard operating procedures, is implied.

UREC wishes you well in your research.

Yours sincerely

Professor Renuka Vithal
Chairperson: University Research Ethics Committee
22 February 2021

Province of the
EASTERN CAPE
EDUCATION

CORPORATE PLANNING MONITORING POLICY AND RESEARCH COORDINATION
Steve Vukile Tshwete Complex • Zone 6 • Zwelitsha • Eastern Cape
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Enquiries: F. Pakade Email: fundiswa.pakade@ecdoe..gov.za Date: 26 August 2021

Ms. B. Nokama

239 Riverside Lifestyle Estate

Nahoon Valley Park

East London

4241

Dear Ms. B. Nokama

PERMISSION TO UNDERTAKE A MASTERS RESEARCH: EXPLORING THE ROLE OF THE DEPARTMENT OF SOCIAL DEVELOPMENT ON THE INTEGRATED SCHOOL HEALTH PROGRAMME IN THE BUFFALO CITY MUNICIPALITY

1. Your application to conduct the above-mentioned research involving 5 participants from DoE in Buffalo City Municipality under the jurisdiction of the Eastern Cape Department of Education (ECDoE) is hereby approved based on the following conditions:

   a. there will be no financial implications for the Department;

   b. institutions and participants must not be identifiable in any way from the results of the investigation;

   c. no minors will participate without the consent from the parent/guardian;

   d. it is not going to interrupt educators' time and task;

   e. the research may not be conducted during official contact time;

   f. no physical contact with educators and learners, only virtual means of communication should be used and that should be arranged and agreed upon in writing with the Principal and the affected teacher/s;

   g. you present a copy of the written approval letter of the Eastern Cape Department of Education (ECDoE) to the Cluster and District Directors before any research is undertaken at any institutions within that particular district;

h. you will make all the arrangements concerning your research;

i. should you wish to extend the period of research after approval has been granted, an application to do this must be directed to Chief Director: Corporate Strategy Management;

j. you present the Department with a copy of your final paper/report/dissertation/thesis freeof charge in hard copy and electronic format. This must be accompanied by a separate synopsis (maximum 2 - 3 typed pages) of the most important findings and recommendations if it does not already contain a synopsis;

k. you present the findings to the Research Committee and/or Senior Management of the Department when and/or where necessary;

l. you are requested to provide the above to the Chief Director: Corporate Strategy Management upon completion of your research;

m. you comply with all the requirements as completed in the Terms and Conditions to conduct Research in the ECDoE document duly completed by you;

n. you comply with your ethical undertaking (commitment form);

o. You submit on a six-monthly basis, from the date of permission of the research, concisereports to the Chief Director: Corporate Strategy Management.

2. The Department reserves a right to withdraw the permission should there be non- compliance to the approval letter and contract signed in the Terms and Conditions to conduct Research in the ECDoE and/or legal requirements to do so.

3. The Department will publish the completed Research on its website.

4. The Department wishes you well in your undertaking. You can contact the Mrs. Fundiswa Pakade on the numbers indicated in the letterhead or email fundiswa.pakade@ecdoegov.za should you need any assistance.

TMASOEU
CHIEF DIRECTOR: CORPORA TE STRATEGY MANAGEMENTFOR

SUPERINTENDENT-GENERAL: EDUCATION

University of Fort Hare
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INDIVIDUAL INFORMATION SHEET AND INFORMED CONSENT FORM[1]

(AGES 18 YEARS AND ABOVE)

Please note:

This form is to be completed by the researcher(s) as well as by the interviewee before the commencement of the research. Copies of the signed form must be filed and kept on record

(To be adapted for individual circumstances/needs)

Title of Study: EXPLORING OF THE ROLE OF THE DEPARTMENT OF SOCIAL DEVELOPMENT ON THE INTEGRATED SCHOOL HEALTH PROGRAMME WITHIN THE BUFFALO CITY MUNICIPALITY

Dear participant,

My name is Busisa Antoinette Nokama and I am studying at the University of Fort Hare.

I am exploring of the role of the Department of Social Development on the Integrated School Health Programme within the Buffalo City Municipality

Purpose of Study

The purpose of the study is to understand how the Department of Social Development is assisting the learners in the Integrated School Health Programme.

[1] Approved by UREC (13 November 2019)

We would like you to allow us to conduct a brief (20 minutes) interview with you about how you understand the role should be and also what you currently see happening in implementation of the programme.

Study Procedure

Some questions may be of a personal and/or sensitive nature. I will be asking some questions that you may not have thought about before. We know that you cannot be absolutely certain about the answers to these questions, but we ask that you try to think about these questions. When it comes to answering questions there are no right and wrong answers.

Please understand that **your participation is voluntary** and you are not being forced to take part in this study. The choice of whether to participate or not, is yours. However, we would really appreciate it if you do share your thoughts with us. If you choose not to take part, you will not be affected in any way whatsoever. If you agree to participate, you may stop me at any time and tell me that you don't want to go on with the interview. If you do this there will also be no penalties and you will NOT be prejudiced in ANY way.

The information will remain confidential. This means that your name and address will not be linked in any way to the answers you give. We study and report on the answers given by all the people we interview and not on an individual basis. The research data will be anonymous – with all personal participant information removed and will be archived at the University.

At the present time, we do not see any risks in your participation. The risks associated with participation in this study are no greater than those encountered in daily life.

There are no immediate benefits to you from participating in this study. However, this study will be helpful in finding out:

- The role of the Social Development within the ISHP programme.
- The current participation of Social Development in rendering of ISHP programme.
- Provision of suitable recommendations on the delivery of multi-sectoral services in the implementation of ISHP programme

Risk-Benefit Ratio: There are no anticipated risks in the study.

Anticipated Benefits

The anticipated benefits of the study will be explained to the participants before the actual study begins. In adhering to good ethical conduct, ethical clearance has been sought from the University Research Ethics Committee (UREC) before embarking on data collection process. Permission was also sought from the Department of Social Development, Health and Education to interview their officials. The departments will not be coerced as room for withdrawal will be provided in the event that the participants would like to withdraw.

Who to contact if you have been harmed or have any concerns

This research has been approved by the Inter-Faculties Research Ethics Committee (IFREC) as per delegated authority of the University Research Ethics Committee (UREC). If you have any complaints about ethical aspects of the research or feel that you have been harmed in any way by participating in this study, please call the IFREC Administrator, [Prof Liezel Cilliers on LCilliers@ufh.ac.za]

Reporting and Complaints

If you have questions at any time about this study, or if you have concerns/questions you may contact the researcher/project leader whose contact information is provided on the first page. If you have questions regarding your rights as a research participant, or if problems arise which you do not feel you can discuss with the researcher/project leader, please contact the IFREC Chairperson, Prof. Munacinga Simatele on [MSimatele@ufh.ac.za] or the UREC Chairperson, Prof. Renuka Vithal on [RVithal@ufh.ac.za]

If you have concerns or questions about this study please feel free to contact the project coordinator:

Researcher/Project Leader:

Name: Busisa Antoinette Nokama

Department: Department of Public Administration (DPA)

Address: 239 Riverside Lifestyle Estate, Nahoon Valley Park, East London, 5401

Phone: 0764509531

Email: banmnokama@gmail.com

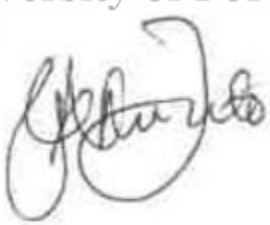
INFORMED CONSENT FORM

(Edit as Required)

I *(name of participant) JOYCE NOLUVUYO MEKUTO* have been informed about the study by Busisa Antoinette Nokama (Researcher).

I understand the purpose, procedures, and risk-benefit ratio of the study. I have been given opportunity to ask questions about the study and have had answers to my satisfaction. I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any procedurals that I would usually be entitled to. I have been informed about any available compensation or medical treatment if injury occurs to me as result of study-related procedures

I understand that I will be given a copy of this informed consent.I understand that if I have any questions or complaints about my rights as a study participant, or if I may have concerns about any aspect of the study or the researcher/s then I may contact the Chairperson of the Inter-Faculty Research Ethics Committee, Prof. Pumla Gqola or Chairperson of University Research Ethics Committee, Prof Renuka Vithal (details available from the Researcher or by contacting the University of Fort Hare or Website www.ufh.ac.za)



Participant signature: ……

Consenting for Audio Recording– when necessary

YES / OR

Participant signature: ……

Witness signature: ……...

(to be altered according to the study)

Translator signature: ……...

(to be altered according to the study)

Data curation – I understand that the information that I provide will be stored electronically and will be used for research purposes now or at a later stage (to be altered according to the study)

Participant signature: ……

Date: 23/07/2021

THE INTERVIEW GUIDE: It is envisaged that the target group will be from the three (3) departments, the department of social development, health and education. The interview will consist of 15 participants where seven (7) will be from Department of Social Development, five (5) from Department of Education and three (3) from the department of Health. The Chief Directors will be part of the interview to get a broach view of each section and the Integrated School Health Programme Provincial Task Team will be included to get the perception of members that are responsible for coordination of collaborative services.

SECTION A:

BIOGRAPHICAL INFORMATION

1. Indicate your choice by marking with an X in the box of your choice

1.1 Gender

MALE		FEMALE	

1.2 Age

21-30		31-40		41-50		51-60		60 and above	

1.3 Educational Qualifications

Grade 12		Diploma		Degree		Honours		Other(state)	

1.4 What is your job title?

SECTION B:

1. **What is the role of Department of Social Development in the Integrated School Health Programme?**

1.1. What is the context that led to the development of the Integrated School Health Policy?

1.2. What is the mandate of the department of social development?

1.3. What is the stated programme logic in the policy with regards to department of social development?

1.4. How is the implementation plan of the department of social development addressing the requirement of the Integrated School Health Policy?

2. **What is the current participation of social development on the implementation of the ISHP Programme?**

2.1. How inputs and activities contributed to producing the outputs that contributed to the desired outcomes and impact at the level of implementation?

2.2. How did the programme reach the target group?

2.3. What is the variation of the implementation in the different schools? Who is accountable for this? Is the accountability mechanism working?

2.4. What can be done to address the variance and improve implementation?

3. What are the recommendation to enhance participation of Department of Social Development in the delivery of multi-sectoral services?

3.1. What assumptions did the policy make about the contribution of the three departments in the Integrated School Health Programme?

3.2. How best can the three departments execute its roles?

3.3. What mechanism can be put in place to ensure that implementation plan address the requirements of the policy?

3.4. How does collaboration impact the implementation costs compare to the actual budget?