Perceptions and views of key implementers on the implementation of the health-promoting school programme in the City of Tshwane, South Africa

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Background. The health-promoting school programme has been associated with numerous benefits for school communities where it is well implemented. In Tshwane, the implementation processes have not been evaluated.

Objective. A qualitative research approach based on grounded theory was used to investigate the experiences of 27 health-promoting school programme implementers across Tshwane.

Methods. Data were collected through a combination of methods, including semi-structured interviews with principals (*n*=6), educators (*n*=10) and school governing body members (*n*=4), one focus group discussion with health promoters (*n*=7), field notes from school observations and memos.

Results. Implementation fidelity was weak in the City of Tshwane, as a result of poor training of implementers, poor leadership and collaboration, weak accountability structures, and lack of resources and communication. A grounded theory was developed which showed that schools needed guidance and accountability to properly implement the programme. The theory offers a framework that could be used to improve implementation and evaluation outcomes.

Conclusion. Implementers were keen on improving the lives of learners – health-wise and academically. With proper guidance, support and accountability measures by government at district and provincial level, implementation of the programme is feasible in the City of Tshwane.

According to the South African Non-Communicable Disease (NCD) Prevention Strategy (2020-2027), NCDs are on the rise in South Africa (SA), including among the youth.[1] NCDs such as diabetes, heart disease, obesity, and other preventable causes of disability and mortality including anaemia, injuries, accidents and mental health problems, are often linked to unhealthy environments, poorly balanced diets, physical inactivity, interpersonal violence, sexual and reproductive health issues, and/or alcohol addiction or use of prohibited substances.[2,3] Traditionally, schools focus only on teaching and learning, while ignoring social and physical factors within and outside schools that affect the well-being of individual learners.[4] Holistic, 'whole-school' approaches to health promotion, like the World Health Organization (WHO) health-promoting schools (HPS) programme, are a possible solution to poor health outcomes in young people of schoolgoing age.[4-6]

Schools are an ideal environment for improving child health, as they can both promote health and enable early interventions.[7,8] Children learn and develop when they encounter others from different backgrounds during school hours.[7,8] The HPS programme promotes an integrated approach to the health, education and social development of learners.[8] It includes cost-effective health-promotion policies and resources, as well as community partnerships, school policies and curricula. All this within an environment where both socio-emotional and physical health of learners is promoted.[2,5] This 'whole-school' approach is essential to maintain collaboration between health and education sectors, scholars and parents.[6] Dadaczynski and Hering[4] have published evidence showing that holistic approaches to health promotion improved body composition, healthy eating, physical activity, fitness and positive mental health outcomes in learners. Access to supportive school environments reduced the number of dropouts while improving health, educational outcomes, employment and productivity.[2]

The HPS approach was adopted in SA in 1994 as a means of redress for past inequalities in education and health. By 2006, all nine provinces had started implementing the programme.[9] School-based health promotion is guided by the Integrated School Health Policy (ISHP), as amended in 2012.

Studies showing the positive impacts of HPS on health, well-being, nutrition and learning outcomes are available but limited.[4] According to the WHO,[2] the HPS programme has improved health, reduced dropout numbers, and increased the productivity of learners. Yet, few countries have made the HPS programme an integral part of the schooling system, and there is little published information on implementation in SA.[9,10] The aim of this study was to use grounded theory (GT) methods[11] to explore key barriers and facilitators to the implementation of the HPS within the study area, by interrogating the views and perspectives of health and education staff. According to the ISHP, both the Department of Health (DoH) and the Department of Basic Education (DoBE) need to work together to implement the programme in schools. Four key stakeholders were identified for inclusion in this study. Health promoters from the DoH are tasked with initiating and supporting the programme; they identify schools and work with them to implement the programme. In SA, health education is taught in the life skills (LS) module by LS educators. Therefore, LS educators are an integral part of the implementation of health programmes.[12] School principals and the school governing body (SGB) were also included as key implementers as they form part of school leadership and governance and are responsible for all programmes implemented and funds in no-fee schools. The SGB also represents the parents and the community at large.[9,13]

Methods
Research design
Grounded theory
GT was used in this study to develop a theory for HPS implementation in the City of Tshwane (CoT), in order to improve current implementation processes and programme evaluation. The advantage of GT is that since the emerging theory is 'grounded or rooted' in the data, it will provide a more sophisticated understanding of the phenomenon as opposed to using an already existing theory.[14]

Setting
Thirteen public primary schools registered with the Gauteng Department of Education as health-promoting schools at the time of the study (2020) were purposively selected; however 3 declined because of various reasons, but mainly COVID-19. The health-promoting schools in CoT included quintiles 1, 2, and 3 primary schools.

Participants
In GT, it is anticipated that when the researcher analyses the initial data, 'it will raise questions, suggest relationships, highlight gaps in existing data and reveal what the researcher does not yet know'.[15] The researcher then takes the new information and uses it to meticulously select participants and adjust questions in the next round of data collection to fill the existing gaps, clarify any uncertainty and develop an emerging theory – a procedure known as theoretical sampling in GT.[15,16] To facilitate this process, during data collection, the participants were made aware that the researcher may contact them again in the event that clarification was needed. The sampling process started with purposive sampling of 37 participants. These included health promoters (*n*=7); principals (*n*=10), LS educators (*n*=10) and SGB members (*n*=10). Some refused to be part of the study; at the start of data collection, only 19 of the recruited school participants had consented. The list consisted of health promoters (*n*=7), educators (*n*=5), principals (*n*=3) and SGB members (*n*=4) (Table 1).

Inclusion criteria
- Health promoters: Working with health-promoting schools in CoT for a minimum of 2 years
- School principals: Working at the participating school for a minimum of 2 years
- LS educators: Teaching LS for a minimum of a year at the participating school
- SGB members: Have been a member of the SGB for a minimum of a year at the participating school.

Table 1. Participant demographics and methods of data collection for purposive sampling

Variable		(*n*)
Gender	Males	14
	Females	5
Designation	Educators	5
	Principals	3
	SGB	4
	Health promoters	7
Type of interview	Telephonic	7
	Face to face	5
	Focus group discussion	1
HPS committee membership	Members	6
	Non-members	6

All seven health promoters were female, aged between 41 and 62 years, and were not members of the HPS committee at schools, although they were occasionally invited as advisors on health matters by schools. The focus group discussion (FGD) was held at the Tshwane subdistrict 3 health offices with 7 participants, who all had experience and expertise in HPS.

Theoretical sampling
During the FGD analysis, theoretical sampling and saturation were applied when concepts that required further exploration emerged. Relevant participants were contacted, and online discussions were conducted to further explore the concepts until saturation was reached. The participants could not be called for another FGD because of COVID-19 regulations but were contacted telephonically. Regarding the interviews, with the initial data collection, it became apparent that some educators, who were not teaching LS and had therefore not been included initially, had more knowledge about the HPS programme. They were subsequently invited to participate. Contrary to the ISHP, not all LS educators were involved in HPS and other health-promotion activities; they taught LS as a curriculum subject, not as part of health promotion. Similarly, some school principals suggested their deputies in management positions should represent the school, as they had more knowledge about the HPS programme. The interview guide was adapted twice during the data collection process to accommodate the new emerging gaps and themes. After theoretical sampling, 8 participants were selected, consented, and were interviewed for the study (Table 2).

Inclusion criteria
- Educators: Working on the HPS programme in the school for a minimum of 2 years
- Deputy principals: Working on the HPS programme in the school in a management/leadership role for 2 years

Data collection
Data were collected between March and August 2021 through a combination of methods, including an FGD, structured interviews based on the results of the focus group meeting and field notes from school observations and memos. The FGD used open-ended questions specific to the implementation and evaluation of the HPS programme (Table 3). The FGD lasted 2 hours and its conclusions were facilitated in initial category development.

The interview guide (Table 4) included general, open-ended, and specific questions, with probes included where the researcher felt the participants needed probing. Though three guides were developed for the three categories of cadres to be interviewed, most of the questions were similar for all participants; they were only different

Table 2. Participant demographics and methods of data collection for theoretical sampling

Variable		*n*
Gender	Males	3
	Females	5
Designation	Educators	5
	Deputy principals	3
Type of interview	Face to face	4
	Telephonic	4
HPS committee membership	Members	2
	Non-members	6

in areas such as 'teaching of health education in the classroom', which was not relevant for the SGB. 'Leadership roles in the schools' were only relevant to the school principals and SGB, but not the educators (Table 4). In line with the nature of GT, in the initial stages the interview questions were semi-structured. However, as the data collection proceeded, the questions became more structured as the researcher had at this point more specific themes to investigate.[16] In the end, no two interviews were exactly the same, though they were all guided by the interview guide.

Outcome
The planned outcome was complicated by the COVID-19 outbreak which limited visits and face-to-face interviews at schools.

Ethical approval
Ethical approval for the study was granted by the Ethics Committee of the Faculty of Health Sciences, School of Health Systems and Public Health, University of Pretoria, Gauteng, SA (ref. no. 609/2019). Approval to conduct the research was granted by the Gauteng Department of Education and a copy is available on request.

Informed consent and voluntary participation
The participants were provided with information on the study and its ethical issues. In the written consent letters, the participants were informed about their privacy, anonymity, integrity, and professional qualities. They were also assured that they could withdraw from the study at any time. To ensure anonymity of participants, no identifying information was included on the demographic forms and transcripts; participants were identified by codes.

Data analysis
Analysis of data obtained using the GT methods involved three iterative stages: (*i*) description; (*ii*) coding; and (*iii*) theory development and testing. Unique to GT was the iterative nature of analysis, which involved going back and forth between the three stages, which ran concurrently with data collection.[15] When information from the grounded data stops adding variation to the codes, theoretical saturation is said to be achieved.[18] The results of the FGD and the interviews were merged to create one comprehensive theory for HPS implementation.

Results
The study aimed to understand the current implementation processes and develop a theoretical framework that could improve implementation processes. Findings showed that there was a central issue that was a common thread among implementers. Schools needed 'guidance and accountability for HPS implementation'. According to implementers, they needed guidance and support from various stakeholders to implement the programme. Without guidance on what was expected and accountability for what was done or not done, schools failed to implement the policy in CoT. Five categories, which are closely tied to the core thread were also identified. These were: (*i*) preparation is key; (*ii*) continuing training of implementers; (*iii*) importance of teamwork; (*iv*) addressing barriers to implementation; and (*v*) evaluate progress and give feedback guidance and accountability for HPS implementation (Fig. 1). Using this framework in CoT could improve HPS programme implementation.

Preparation is key
This category illustrated that proper planning for implementing the programme is a necessary step to ensure that the implementation is effective, so that schools get the desired outcomes from the programme. Despite taking full responsibility for establishing health-promoting schools, health promoters did admit that the ultimate power to authorise the schools to adopt the programme lay with the principals. School principals who did not find the programme acceptable for their schools rejected it. Health promoters estimated that about half of the schools 'marketed' rejected the programme.

Health promoter 7 (HP7): 'Others respond, others don't. It's 50/50.'

This was not appreciated by health promoters who believed in the benefits of having the programme implemented in schools.

HP4: 'Because with HPS we did not focus only on illnesses and disease. We do holistic approach; we don't leave anything behind. So, it's important for our school. It's more needed than what we can say. Maybe we have to force it at schools, because we are going to improve the status of our schools.'

Table 3. Focus group discussion guide
1. How long have you been working with HPS in Tshwane?
2. What are the responsibilities/functions of a health promoter within HPS?
3. Did you get any training specific to HPS? If so, was it continuous? Was it adequate?
4. What is your view of HPS? Is it something schools need?
5. What has been your experience so far, the challenges and strengths?
6. Do you think environmental and social contexts of your particular school/s have an impact on the success of HPS?
7. What is your relationship with the school community and management in the schools and the district (in health and education)?
8. How in your opinion can HPS implementation be improved?

Table 4. Interview guide
1. General experience: What has been your experience with HPS implementation?
2. Curriculum: What is your opinion on the topics taught in LS to promote health and what topics do you think are the most important/priority in your school community?
3. Health-promotion activities: Are you involved in any way in implementing health-promotion activities and do you think that the activities are effective?
4. Social, physical, and environmental factors: What challenges are in the community around the school that affect the school and learners and teaching?
5. Families, community, and interdepartmental engagement: What are the challenges regarding building relationships with the parents and communities?
6. Health services: Do you think that the services provided by the Department of Health and the Department of Social Development are adequate?
7. Leadership/management role: What do think about the role of leadership in health education and health-promotion activities in your school?
8. Evaluation and sustainability: Do you know anything about how your school was accredited as a health-promoting school?

Fig. 1. Five categories for HPS implementation in the City of Tshwane.

When principals did accept the programme, there was usually weakness in the schools' preparation for HPS implementation. The educators who were tasked with implementing the programme, the principals and the SGB, who had a leadership role in HPS, were not conversant with HPS and its activities. This adversely affected implementation plans.

> P11: 'I don't know about this HPS.' (SGB member)

Addressing contextual factors during the preparation phase was crucial, as these factors had an adverse impact on learning. It was important to identify different contextual factors when planning for HPS activities at the different schools across the district. The SGB was responsible for adapting the DoBE policies for their own schools and prioritising the school programmes.

> P16: 'We as the SGB, we draft our own…ehh health and safety regulations and policies which the school must use. But then basically, [it] is derived from, we take from the department's policy. It must align with it and not be too different.' (SGB member)

Lee *et al.*[17] recommended that schools prioritise HPS activities as they may not have the capacity to implement all of them at once. Topics that are most relevant to the particular school can be prioritised so that schools develop strategies to promote these topics among learners, even outside the classroom.

Need for continuing training of implementers
Schools were expected to implement the programme; however, they were never trained in what was expected and how to achieve it. There was a sense of incompetency and lack of confidence among the study participants. Health promoters criticised the training they had received as being non-standardised, as it was informal training done in the field by older health promoters and was also not continuing. This was viewed as a hindrance to effective establishment and implementation of HPS.

> HP4: 'The training was done, but it was only once off. No support or in-service to remind each other, to check, to follow-up what is the progress, what is your challenge.'

Continuing training was seen as a means of improving implementation outcomes, as stated by this health promoter:

> HP1: 'If they can do continuous refresher courses, this programme is going to look like something else.'

Academic institutions had an important role in the training of health promoters. HP6 had received short training from a local university and praised the course for its usefulness and the sense of pride it had given her.

> HP6: 'I got training from the University of Pretoria. It was good, because we even did the practical part of it. We even wrote the exam, and I got a distinction.'

LS educators also reported that they did not receive training specific to the LS subject. Educators did not understand their roles or responsibilities beyond teaching what was in the curriculum, such as handwashing; hence, their health promotion responsibilities did not go beyond the classroom.

> P13: 'I do them in my classroom, every teacher is responsible for his/her class to promote health education.' (educator)

In the HPS framework, health promotion activities are promoted both within and outside the classroom. When LS educators were asked if their roles and responsibilities were explained with regard to health promotion or health-promoting schools, most answered 'No' and some reported that they were teaching the subject because there were staff shortages; they had not chosen LS or specialised in it as part of their teaching education or even received any training by the DoBE.

> P8: 'No, I do not think so. I just fell into it because of shortages. I did not get training in physical education and part of the creative acts.' (educator)

Male teachers felt incompetent and uncomfortable teaching reproductive health. Female educators also expressed their lack of confidence in teaching some topics on reproductive health as they did not understand them fully. They suggested that the school health nurse should conduct workshops with them on these topics or even sometimes come in as a guest educator in the class, as a way of assisting in teaching health topics. They also requested that the DoBE conduct workshops on how they can implement topics as expected.

Effective HPS implementation should not end with training the health promoters and LS educators; the whole school should also get some form of training. Trained principals would have the skills required to support the implementation of the activities, including supporting the LS educators. A trained SGB would help SGB members adapt the HPS programme so it is feasible, and they can support implementation at the schools. SGBs are very important in schools. Though often overlooked, they have power over all school activities.

> HP1: 'If they buy the concept (SGB), it becomes easy. Because they can derail the process; they have got the power of derailing everything in the school.'
> P14: 'They are the engine of the school.' (educator)

Achieve teamwork

This category is related to the role that each stakeholder needed to play to improve HPS implementation. Health promoters reported that collaboration between the various stakeholders involved in HPS (clinics, schools, and the community) improved the implementation of the programme. Collaborative work enhanced the benefits of HPS, which they listed as: (*i*) improved status of schools; (*ii*) a holistic approach to treating learner issues; and (*iii*) reduced absenteeism.

Owing to poor communication and collaboration principals did not receive health promoters well. However, if principals got a directive from the department to implement the programme, this would increase the uptake of HPS.

HP4 had this to say:

'… then we know that if department of education and department of health, though being once, when they meet, they talk about these programmes and this programme must be escalated down to us. Then is where I'm having that power to go to schools as a health promoter. That is when they buy in, if the district communicates with the schools.'

Though parental involvement was reported to be low, participants in the study all reported the importance of parental engagement for improved health and learning outcomes for learners. According to the participants, the positive benefits of parental involvement started during the establishment phase. They reported that to establish a health-promoting school, health promoters needed to garner the support of parents for the process to be successful. After the introduction of the programme, parental and community involvement remained an important facilitator in implementation. For health promotion to be effective, it needed to be promoted within and outside the classroom. Parents needed to assist learners in practising the healthy behaviour they were taught in the school, in the home. One educator put it this way,

P12: 'Parents also need to further what is taught at the schools in the home.' (educator)

- Parental involvement was associated with the following benefits:
- Reduced vandalism and burglaries
- Improved motivation for learners to learn (seeing parents involved has a positive impact on learner motivation)
- Improved school cleanliness (parents volunteered to clean the schools)
- Improved communication with teachers to assist challenged learners
- Increased assistance for learners with homework (parents took interest in children's schoolwork)
- Improved identification and treatment of learners with health or mental challenges.

They suggested simple gestures for improving relationships with parents and the community…

HP6: 'When the school closed why can't the school identify that family, the remaining food of feeding scheme, take it to them, in order to buy their eyes.'

HP1: 'And here is another important thing, if you want a grounds man you start by identifying in the community. If you want food co-handlers for a feeding scheme, start with the very neighbours. For safety's sake consider them, then you will see your things will run smoothly.'

Poor collaboration with nurses was noted as a hindrance to holistic care of learners. Health promoters reported that school nurses worked in silos. According to health promoters, the various teams servicing the schools needed to plan together. School health services form part of the six action areas of the HPS framework. When health promoters were asked about their relationships with the school health nurse:

HP4: 'They are not part of our programme. They are having their programme. …when they go to the schools, they are going to do their duties for that day, whereas they say we must team up when we go to schools.'

Most educators were not aware of the package of services that school nurses were supposed to provide to the schools as stated in the ISHP. After the researcher explained the requirements of the school nurse – as prescribed in the ISHP – they suggested:

P7: 'We need a stationed nurse; we are dealing with children who have special needs. Dietitian and social worker should come once a week.' (educator)

P15: 'Full-time nurse stationed at the school and frequent eye screening.' (SGB member)

P10: 'Frequency should be once a week.' (educator)

Address barriers to implementation

This category explored other barriers as experienced by key implementers in CoT. It illustrated that the barriers were many and similar for all the participants, from health promoters to school participants. Schools need resources for the implementation of HPS services. Participants expressed frustration about not having the resources, which hindered their work and led to low staff morale.

Staff shortages presented a challenge. Health promoters lacked many of the resources required to implement HPS activities. The insufficiency started with the limited number of health promoters within CoT schools to implement the HPS activities. Schools had only one health promoter, who was responsible for other schools and other responsibilities outside HPS. Schools also reported the shortage of staff in general and for LS in particular. LS educators reported that they needed teachers trained in LS to assist in teaching the three components of the subject. In addition, LS educators who had other managerial responsibilities at the school, such as also being a head of department (HOD), expressed their inability to do all the activities owing to time constraints.

P14: 'Time limitation, there is too much work and responsibilities as an HOD. The work is too much for one educator. The government should capacitate more teachers for life orientation and life skills and employ staff to share the workload.' (educator)

Health promoters expressed anger and frustration when speaking about lack of resources.

HP5: 'Also frustrating, you find that different stakeholders they bring something for the kids, pens, etc., but health promotion brings nothing. You just talk, you don't bring anything, and they don't take you seriously. No support, no resources, they will tell you about budget, especially for health promotion … zero, zero resources.'

They spoke about the lack of presentation materials that negatively affected their work.

HP1: 'My heart is sore; as I was saying, for us to win teenage pregnancy, we were using overhead projectors. We were educating learners so now I don't know who came with the idea of taking it from us. Those are the resources that are needed for your programme to run smooth and be effective and to attract the learners.'

Infrastructure was another barrier to implementation. All schools had inadequate toilets to service the number of learners and staff in the schools. School participants reported that this shortage led to constantly blocked toilets. They also added that COVID-19 worsened that problem because schools had assistant educators come in to assist, which further increased the number of people utilising the toilets. The shortage of cleaners also increased blockages, as toilets were not cleaned as frequently as they needed to be.

> P13: 'Toilets are not enough, and this results in frequent blockage.' (deputy principal)
> P2: 'We do not have enough cleaners; the toilets are blocking.' (educator)

The DoBE is responsible for building toilets at schools and for hiring general assistants (GAs). However, most schools hire additional GAs with the school funds handled by the SGB.

> Playgrounds were also an issue raised by school staff that led to poor implementation of activities.
> P11: 'Playgrounds, that one is a big challenge; we do not have anything to play with, it is like we do not have a playground.' (SGB member)
> P12: 'Playgrounds are there. There are no stones; it just needs proper grass and demarcation. But the land is not enough. We need people to come on board so that they can build us a tennis court for boys, netball court for girls.' (educator)

Health promotion in HPS expands far beyond the classroom. The whole school environment should be supportive to health, including what is sold in the schools, what food is served by the National School Feeding Scheme and maintenance of food gardens. Participants viewed food sold by vendors as a hindrance to healthy eating. Some participants attributed health issues such as vomiting, hyperactivity in class and allergies in learners to the food sold by vendors.

> P1: 'Before COVID-19 they sold expired and unhealthy food.' (educator)
> P14: 'Yes, a lot. Some learners vomit and some become hyperactive after drinking sweetened drinks and eating.' (educator)

The interviewer was informed indirectly by one of the participants that vendors paid a fee to the schools from their profits. Schools used the money as petty cash for school needs, making vendors useful to the schools; therefore, stopping them from selling was a challenge as the petty cash would be lost which is used to supplement the government budget.

> P17: 'They cannot be stopped from selling because they give a stipend to the school. The money does make a difference because it helps us buy, for instance some of the cooking ingredients which fall short, such as salt.' (principal)

Evaluate the progress and give feedback

There was consensus among participants that evaluation of the programme was important and necessary to improve implementation efforts, as it would identify gaps and schools could work to improve them.

> Evaluation in HPS starts at the accreditation stage. When schools are assessed, if compliant, they are declared to be health-promoting schools. The health promoters indicated that they were in no way involved in the accreditation process. They even reported that they did not know how the process works.
> HP2: 'We were not involved in the tool, even when they decide to go to accredit a school, they don't involve us.'
> HP4: 'According to the way they give that school accreditation,

sometimes you can see that, but this school was not supposed to get the platinum. They didn't meet the whole criteria of the tool or assessment. They go back to the status that you found it. It's not sustained as an HPS.'

All participants reported that they had never received any evaluation feedback on how they were performing their activities and faring as a school. Without reservation, participants expressed that they would like feedback as it would assist them to know how they were performing, so they could identify the gaps and improve on them.

Discussion

The stakes are high: access to supportive school environments in health-promoting schools has reduced dropouts, while improving health, educational outcomes, employment and productivity in settings where it is implemented well.[2] Implementation in CoT was found to be weak, leaving many learners in these schools in a vulnerable position. The framework developed in this study showed that schools need guidance and accountability to implement this policy. The results also showed that the application of five categories ((*i*) preparation is key; (*ii*) continuing training of implementers; (*iii*) importance of teamwork; (*iv*) addressing barriers to implementation; and (*v*) evaluate progress and give feedback) can improve HPS implementation outcomes. Without the needed political will at national, provincial and district levels, as much as the HPS approach is needed, it would be impossible to implement.

The preparation stage for an intervention is crucial to the success of the programme. This process entails forming a leadership team and an HPS committee, and developing plans on how the activities will be conducted within the school calendar. This process is also known as 'creating ownership'. Lack of ownership by implementers could lead to low interest in the programme and poor sustainability.[18] In this study, implementers emphasised the need to get the support of some stakeholders at this stage, including the principal, SGB, all educators in the school and parents/community. This is an opportunity for implementers to consider the planned activities against the available resources and the time needed to implement activities, and thus, plan activities tailored for the school to reduce compromise to implementation fidelity. [6,19]

Implementers in CoT were not conversant with the ISHP; therefore they were not sure about how the activities were to be implemented and exactly what those activities were. Molete *et al.*[19] reported the same challenge with oral hygienists in CoT, who had not been trained on the SA Oral Health Policy and were uncertain about how to implement its activities or deal with challenges arising during implementation. The lack of training (on the ISHP and HPS) led to incongruity between policy intentions and what was done at the schools. In addition to lack of training on the policy, other factors, such as poor infrastructure, lack of guidance by managerial structures, inadequate resources, and poor involvement of all stakeholders, adversely affected implementation fidelity. The 'whole-school' approach is known to be essential to maintain collaboration between health and the education sector, scholars and parents. [6] However, this evaluation and a study by Rasesemola and colleagues[20] showed that compliance with the ISHP in CoT schools is characterised by poor collaboration and integration of the various stakeholders, local departments, agencies, mental health, social development, and health service staff. Parental involvement was also low in most schools; participants reported that an improved relationship between the schools and parents would reduce absenteeism and improve the mental state of the child, in line with a study by Clelland *et al.*[21]

Schools have the potential to provide intensive, long-term, and large-scale health services to children and adolescents.[2] According to policy, school services should be accessible, available, affordable, equitable, effective and efficient.[10] Despite such policy statements, basic healthcare services offered in SA public schools were not constant, consistent, or systematic.[20] Nurses in CoT were overworked with few resources; they did not manage provide the package of services described in the ISHP. Most learners graduated from school without ever being seen by a nurse or any healthcare worker.[22] Educators in this study requested that nurses should be more involved in the schools, visit schools at least once a week for health services, and even help in teaching of some health topics, especially sexual reproductive health. These requests by educators were not far-fetched; according to Dibakwane and Peu,[10] ideally school health nurses should provide physical, social and academic support to learners and schools. Hung et al.[6] in their review also reported that schools sometimes invited specialists to present and lead discussions on learner concerns, and it was found to have positive outcomes.

The evaluation of health-promoting schools was reported as flawed by participants in this study. Participants in Fathi et al.'s study[23] expressed the same concerns, questioning the validity of the process. They believed that poor-quality processes could reduce implementation fidelity and suggested a reliable, standard, concise and clear checklist. The National School Health Promotion Policy recognises the importance of establishing systems for conducting monitoring and evaluation. The ISHP even calls for research to develop standardised indicators and tools for school programme monitoring and evaluation and inform policy. It is the duty of the district office to conduct research on implemented programmes and facilitate a feedback mechanism for implementers, which was missing with the HPS programme in CoT.[11]

Study limitations
Conducting the study during COVID-19 limited the number of participants as some key implementers were not available for the study because of the academic backlogs and ill health caused by the pandemic. Poor school community dynamics also played a role in low participant numbers. School principals were not keen on having the SGB discuss school issues with the researcher, owing to the fear that the SGB members might speak ill of them.

Conclusion
This evaluation showed that guidance and accountability are the backbone to HPS implementation's success. They encompass training implementers on HPS, engaging with the school community, provision of resources, support for establishing and maintaining health-promoting schools, addressing barriers at each school, facilitating relationships with other services such as academic institutions, monitoring and evaluation. The study was the first in SA to use GT methods for data collection and analysis to evaluate the HPS programme. Future studies should look into validating the framework for future implementation.

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